TRANSLATABLE LESSONS FROM THE KENYAN HEALTHCARE LANDSCAPE

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"**TRANSLATIONAL MODELS OF PRIMARY CARE**: UNDERSTANDING THE REPLICABILITY AND SCALABILITY OF HIGH IMPACT PRIVATE SECTOR BUSINESS MODELS FOR LOW-COST PRIMARY CARE, DEVELOPED AND IMPLEMENTED IN KENYA, WITHIN THE SOUTH AFRICAN HEALTHCARE LANDSCAPE."

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EXECUTIVE SUMMARY

SOUTH AFRICAN POLICY MAKERS CAN TAKE ADVANTAGE OF THE LESSONS LEARNED FROM THE KENYAN HEALTH CARE SYSTEM, AND ITS RELATIONSHIP WITH THE PRIVATE HEALTHCARE SECTOR.

By breaking down the siloes that exist within the sectors of health care delivery, an open dialogue can be created that will promote transparency, build trust, and ensure the recognition that across the sectors there exists similar agendas; focused on providing health care to all members of the national population.

There are many different mechanisms and models that have been and can be used to stimulate participation by the private healthcare sector in supporting and supplementing the goals of the public sector. There will always be those healthcare consumers who fall at either end of the healthcare provision network, i.e. solely private or solely public, but there is a gap which may be characterized as the lower-middle class or the working poor. The individuals who exist within that economic band are able to purchase primary care services from the private sector using discretionary funds while still not being able to afford or being willing to purchase healthcare insurance.

Coordination of care would relieve the burden on a system that is suffering from severe capacity constraints [xxxvii], would provide support through leadership and mentoring to those health care providers and ultimately allow for the optimal delivery of patient-centered care. Learning from the lessons provided by the Kenyan healthcare system, it is arguable that private sector healthcare providers – whether Kenyan or South African – are ready to provide priority health services to underserved populations who have evidenced the willingness to pay for this care provision. However, this opportunity must be supported by policies and market conditions that will allow private healthcare providers to support the goals of the South African National Health Insurance plan.

[xxxvii] Healthy Partnerships: How Governments Can Engage the Private Sector to Improve Health in Africa. World Bank, 2011

1 INTRODUCTION

THE FUTURE SUCCESS OF THE SOUTH AFRICAN HEALTHCARE SYSTEM LIES IN UNDERSTANDING THE ISSUES OF INTERDEPENDENCY AND SUSTAINABILITY – AND IN HAVING THE COURAGE TO MAKE INNOVATIONS POSSIBLE.

The evolving health landscape in South Africa and the reforms being undertaken to prepare for a National Healthcare Insurance, presents the opportunity to understand effective models of care provision as developed in other African contexts and translate the applicability of these models as appropriate to the South African environment. A main focus of the South African Ministry of Health in regards to the National Health Insurance is the delivery of high-quality accessible primary care to all citizens and, thus, research on translational models of primary care would hold value for local policy makers.

Kenya's innovative approach to primary health care provision is particularly ripe for examination, as, contrary to the South African health system, almost half of Kenya's poor utilizes the services provided by the private health sector. There could further be other key lessons that South Africa could gain in regards to the policy and regulatory environment and the innovation ecosystem of other African countries. For example, mobile health has been used more extensively in countries such as Kenya and Uganda, as compared to South Africa, to support care delivery of care in low-income communities.

Kenya's health care is organized as a devolved system. In 2010, the provincial, district, and local government administrations were replaced by the county administrative structure. At a national level, the Ministry of Health provides leadership; key mandates include development of national policy, provision of all technical support, and M&E activities for all health care provision. The national government is also responsible for all national referral systems. County health departments are responsible for providing the institutional and management structures necessary for health care delivery while also overseeing community health services, primary care services, and county referral systems.

Kenya's private health care sector is extremely dynamic and the Kenyan government has recognized the critical role that the private sector plays in the provision of care to even the poorest citizens. Kenya's Vision 2030 plan specifically contains strategies to develop the private sector. These strategies include social insurance, a reduced role for the Ministry of Health in delivery of care, and promotion of a greater number of public-private partnerships.

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COUNTRY HEALTH SYSTEM BACKGROUND

IT IS GENERALLY RECOGNIZED THAT THE STRUCTURE OF A HEALTH SYSTEM, AND THE NATURE AND EXTENT OF HEALTH REFORMS UNDERTAKEN, MAY ALL AFFECT THE ABILITY OF THE SYSTEM TO RESPOND APPROPRIATELY TO CHALLENGES AND OPPORTUNITIES FOR REFORM.[i]

A broad comparative overview of the Kenyan and South African health care systems, their histories, current state, and associated challenges proved helpful in highlighting the commonalities and divergences between the two countries.

CONTEXT AND SETTING

Kenya is situated right along the equator, on the eastern coast of the African continent. It has a population of 44.4 million people. Kenya has had some success in reaching Millennium Development Goals such as reduced child mortality, near universal primary school enrolment, and narrower gender gaps in education, and has decreased its poverty rate from 47% in 2005 to 34-42% in the most recent household survey[ii]. Within the continent, Kenya has seen steady growth economically and its government has continuously shown commitment towards driving development.

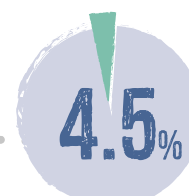
DATA POINTS

45,925,301
TOTAL POPULATION

$3,100
GDP PER CAPITAL

40%
UNEMPLOYMENT RATE

HEALTH EXPENDITURE PER PERSON



4.5%
HEALTH AS A % OF GDP

[i] Dawad, S. and Veenstra, N. Comparative health systems research in a context of HIV/AIDS: lessons from a multi-country study in South Africa, Tanzania and Zambia. Health Research Policy and Systems 2007, 5:13, [ii] World Bank, 2013

[1](Central Intelligence Agency 2015)
[2] (World Bank 2015)
[3] (United Nations Development Programme 2014)
[4] (United Nations Children's Fund 2014)
[5] (Joint United Nations Programme on HIV and AIDS 2014)
[6] (World Health Organization 2012)

COUNTRY OVERVIEW

COMPONENT	DETAILS/ INDICATOR	DATA
POPULATION	Total population	45,925,301 (2015)[1]
	Rural vs Urban	25.6% urban, 74.4% rural (2015)[1]
GEOGRAPHY	Eastern Africa, bordering the Indian Ocean, between Somalia and Tanzania[1]	
ETHNIC COMPOSITION	Kikuyu 22%, Luhya 14%, Luo 13%, Kalenjin 12%, Kamba 11%, Kisii 6%, Meru 6%, other African 15%, non-African (Asian, European, and Arab) 1%[1]	
GOVERNMENT	Kenya is a republic, with governance over 47 counties and the capital at Nairobi. President Uhuru Kenyatta serves as chief of state and head of government; president is elected by a popular vote for up to two five-year terms. Parliament consists of the Senate, elected by a proportional representation vote, and the National Assembly, elected by a simple majority vote. Highest court is the Supreme Court, whose justices and judges are nominated by the Judicial Service Commission and appointed by the president.[1]	
ECONOMIC SITUATION	GDP per capita	$3,100 (2014 USD, 2014)[1]
	Economic growth % in GDP	5.3% (2014)[2]
	Gini-index	47.7 (2013)[2]
	HDI	0.535 (2013)[3]
	Number of people living on <$ 1 / day	43.4% (2012 est.)[1]
	Unemployment	40%[1]
	Adult literacy	Total 78% (male: 81.1%, female: 74.95%, 2015)[1]
	Girls vs Boys education	98% (2012)[1]
	% population access to sanitation	Access to improved drinking water: 61.7% (urban: 82.3%, rural: 55.1%, 2012)[1] Access to improved sanitation facility: 29.6% (urban: 31.3%, rural: 29.1%, 2012)1
HEALTH SYSTEM	Health as % of GDP	4.5% of GDP (2013)[1]
	Annual public expenditure on health (%)	41.7% (2013)[2]
	$ health expenditure per person	$45 (2013)[2]
	No doctors/1,000 population	0.2 physicians/1,000 population (2013)[2]
	No nurses & midwives/1,000 population	0.9 nurses/1,000 population (2013)[2]
	% births with skilled attendance	44% (2008-2009)[4]
	Infant mortality rate	39.38 deaths/1,000 live births (2015)[1]
	Under 5 mortality rate	71 deaths/1,000 live births (2013)[2]
	Average life expectancy	63.77 years (2015)[1]
DISEASE BURDEN	HIV/ AIDS prevalence among adults aged 15 to 49	5.3% (2014)[5]
	Deaths due to AIDS	33,000 (2014)[5]
	Maternal mortality ratio	400 deaths/100,000 births (2013)[2]
	Deaths to non-communicable disease	98,400 (2013)[6]
	Deaths due to homicide	3,174 (2012)[6]

COUNTRY HEALTH SYSTEM BACKGROUND... CONTINUED

ORGANIZATION OF HEALTH CARE

The tiers in Kenyan health system defined in the Kenya Health Policy are

COMMUNITY LEVEL

The foundation of the service delivery system; this includes both demand creation (health promotion services) and specified supply services that are most effectively delivered at the community level. In the essential package, all non-facility based health and related services are classified as community services – not only the interventions provided through the Community Health Strategy as defined in the National Health Sector Strategic Plan II (NHSSP II).

PRIMARY CARE LEVEL

The first physical level of the health system, comprising all dispensaries, health centres, and maternity / nursing homes in the country. This is the 1st level care level, where most clients' health needs should be addressed.

COUNTY LEVEL

The first level hospitals, whose services complement the primary care level to allow for a more comprehensive package of close to client services.

NATIONAL LEVEL

The tertiary level hospitals, whose services are highly specialized and complete the set of care available to persons in Kenya.

In addition to these services, there are private and faith based organizations (FBOs) that work with the national and county Ministries of Health. According to PEPFAR, FBOSs make a significant contribution to healthcare delivery in Kenya.

The Kenya Episcopal Conference and the Christian Health Association of Kenya provide about 65% of healthcare services in the country; together, the FBOs provide services in 17 referral facilities, 59 mid-level hospitals, 133 clinics, and 657 dispensaries[iii]. The private sector, which includes for profit organizations and NGOs, also runs a number of health facilities in Kenya and these range from high level hospitals to low-cost health centres..

HEALTH SYSTEM CAPACITY TO DELIVER CARE

As the Kenyan population continues to grow, there is also an increasing pressure to create an integrated infrastructure to meet the growing demand on its health system. Large disparities exist within Kenya's health system, and this is due to the influence of underlying socio-economic, gender, and geographical disparities[iv]. The reported ratio of doctors and nurses is 0.2 and 0.9 per 1000 population respectively. This impacts the quality of care patients receive - especially by those who are poor. More pressing is the uneven distribution of staff between urban and rural areas. According to the Kenya Health System Assessment "rural dispensaries have 20 percent fill rates of their nursing establishments, while district hospitals have 120 percent fill rates. Approximately 25 percent of the HRH budget for the entire public sector is taken up by the two referral hospitals[v]".

Moreover, drug regulation and availability remains a problem despite regulation policies. Kenyan citizens, especially those whom are poor, readily pay for medicines from unlicensed providers and this can have detrimental consequences to their health. Expenditure trends still show that Kenyans pay for medications out-of-pocket. This illustrates that there is a willingness to pay for healthcare but there is poor regulation in the sector to ensure that the services and drugs offered are of good quality[vi].

HEALTH FINANCING

Healthcare is financed from various sectors; these include government, external donors, the private sector and out of pocket payments. By 2014, the proportion of out-of-pocket payments (OOP) from individuals made up 36.7 % of healthcare expenditure followed by external donors at 34.5% and the government took up 28.8% of healthcare costs[vii]. It is estimated that most of the OOP were to private healthcare providers[viii]. The burden of healthcare costs in Kenya has devastating consequences for poor households, and this is also linked to the issue of access. **Although services may be provided at no cost in government facilities, geographical constraints for those in rural areas means that health facilities may be hard to reach and they would incur travel costs seeking healthcare. This means that underserved**

iii U.S. President's Emergency Plan for AIDS Relief (2012). A Firm Foundation: The PEPFAR Consultation on the Role of Faith- based Organizations in Sustaining Community and Country Leadership in the Response to HIV/AIDS. Washington: U.S. Department of State, [iv] Healthy Action, 2011, [v] Kenya Health System Assessment: 34, [vi] Kenya Health System Assessment 2010; Private Sector for Innovation for Health, 2014, [vii] Private Sector for Innovation for Health, 2014, [viii] Private Sector for Innovation for Health, 2014

rural populations need to weigh the cost of receiving healthcare against the cost of transport, and the time and expense spent away from their livelihoods. Because the health system does not have the capacity to provide care to all Kenyan citizens most people use private healthcare providers to purchase medicines[ix].

Kenya's ongoing health insurance scheme is the National Health Insurance Fund (NHIF), which was initially designed to serve employees in government and in the private sector earning Ksh 1000+, when it was introduced in 1966. A major challenge in the scheme has been the integration of the expanding informal sector and inclusion of the poor[x]. Although 40% of Kenyans live in poverty, most still purchase healthcare in the private sector and this means that accessing healthcare for the poor is a major factor keeping them poor: "38% of sick Kenyans did not seek health care because they lacked money while another third resorted to self-medication; 15.3% of those lacking money run into debts or sell personal assets to offset health care expenses[xi]". PSP4H calls this the "poverty penalty". However, the point that a large segment of the Kenyan population is willing to pay out-of-pocket for private healthcare is an important one, because it contradicts the "conventional wisdom [that] accepts that the primary reason that low income (aka working poor) Kenyans are underserved by healthcare providers is that they cannot pay for care". Instead, according to research conducted by the Private Sector Innovation Programme for Health (PSP4H), an initiative funded by DFID, **the informal and uninsured workforce in Kenya represents around 83% of the population. This population actively accesses the private sector for healthcare for a variety of reasons, such as the perceived quality of care provided by the private sector versus the public sector**. In addition, many specialized services like diagnostics or oncology treatment, are not available in the public sector which forces patients to access the private sector for treatment.

POLICY ENVIRONMENT

The policy environment as it relates to healthcare in Kenya has multiple actors who are also responsible for implementation; these partners include government agencies and non-governmental organizations (NGOs). These collaborations are focused mainly on major disease areas such as HIV, TB care and malaria ranging from vaccines and health programming.

The six objectives of the Kenyan Health Policy Framework (1994-2010) explicitly state that there is a need to collaborate between various actors and the document further endorses the establishment of its own Kenya Health Sector Wide Approach (KHSWAp). This outlines the understanding between different stakeholders providing healthcare within Kenya's health system. Through the devolution that took place in 2010, subsequent policies, namely The Kenya Health Policy 2012 – 2030, have been developed to guide partnerships between the state and external actors within the new constitutional framework. Moreover, the newly decentralized system has given the Ministry of Health (MOH) some autonomy over service delivery to country ministries.

The Public Private Partnership Act of 2009, passed by the Kenyan Ministry of Finance and implemented by the Ministry of Health, regulates the authority of the government to create partnerships with private health sector organisations, or its ability to contract with private sector organization(s) to deliver services that advance public sector goals[xii]. However, there are various barriers within the enabling environment that still exist, such as a uncertainty over the role of the private health sector in advancing national health priorities; burdensome regulatory processes; weak enforcement of regulations and standards; and limited incentives for private providers to serve the working poor and alleviate the burden on the public health care sector[xiii].

[ix] Private Sector for Innovation for Health, 2014, [x] Mathauer et al., 2008 as cited in Muiya and Kamau, 2013:3, [xi] Health Action, 2011:14, [xii] Private Sector Innovation Programme for Health. 2014. Private Provider Challenges. Series No. 10, [xiii] Private Sector Innovation Programme for Health. 2014. Private Provider Challenges. Series No. 10,

3

OBJECTIVES AND METHODOLOGY

THE OBJECTIVES OF THIS RESEARCH WILL BE

- Understanding the replicability and scalability of high impact private sector business models for low-cost primary care, developed and implemented in Kenya, within the South African healthcare landscape.
- Determining illustrative models of where these market mechanisms have been successful within the Kenyan environment and lessons learned.
- Recognizing the enabling and inhibiting factors in the Kenyan environment that have impacted the success of these business models.
- Ascertaining the translatability of the innovative Kenyan business models to the South African health care environment and developing recommendations for local policy makers.

METHODOLOGY

To better understand the relationships and successful integration of high impact private sector business models for low-cost primary care within the Kenyan health system landscape, the Bertha Centre team synthesised data gathered during literature reviews as well as key interviews conducted during a research visit to Nairobi, Kenya in June 2015. Follow-up interviews with South African stakeholders were conducted to determine the translatability of Kenyan models as well as to understand the current South African primary care landscape and ability to learn from and implement lessons learned from Kenya.

Key stakeholders interviewed included governmental officials, health care workers, and members of third-party organizations. In addition to the in-person interviews, which were conducted over a period of five days, the Bertha Centre was also able to conduct site visits to various private primary care clinics. The triangulation of data collected through the interviews conducted with key stakeholders within the Kenyan health care system assisted in synthesising several key findings.

DATA COLLECTION

The main method used in this research were case studies; cases in this instance are organizations that have been identified from an initial scoping exercise and that have used one of the financing mechanisms described below to deliver high impact primary care in Kenya. Organizations were selected to represent not only a variety of financing mechanisms but also rural, peri-urban, and urban areas. Through these cases we gained a deeper understanding of the model-structure, the implementing organization, the implementation journey and the barriers experienced.

Expert interviews were conducted to supplement the case study research performed during onsite visits. These interviews provided an intersectional analysis of the appropriateness and applicability of these models in the Kenyan context, so as to identify these features in our local South African context (see Interview Schedule below and Interview Guide in Appendix 1).

The literature reviewed for this research identified gaps in South Africa's health sector where these high impact models would be appropriate. Finally, the research findings were then translated to the South African health system context and recommendations for local policy makers were developed.

INTERVIEWEE	ORGANIZATIONS	CAPACITY
Caroline Simumba	Africa Capacity Alliance	Expert
Ron Ashkin	PSP4H	Expert
Moka Lantum	2020MicroClinic Initiative	Incentivization
Steven Mwandawiro	2020MicroClinic Initiative	Incentivization
Rachel Waireri – Onyango	GE Healthcare Kenya	Expert
Liza Kimbo	Viva Afya	Cross-Subsidization
Alie Eleveld	SWAP	Franchising
Manya Dotson	Jhpiego	Expert
Eric Buch	University of Pretoria	Expert
Ashraf Grimwood	Kheth'Impilo	Expert
Ernest Darkho	BroadReach Healthcare	Expert

3.1 ADAPTATION FRAMEWORK

THE ADAPTATION FRAMEWORK, AS DEVELOPED BY THE CENTRE FOR HEALTH MARKET INNOVATIONS, SERVED AS THE LENS THROUGH WHICH THE RESEARCH, EXAMINATION OF BUSINESS MODELS, AND THE ANALYSIS OF FINDINGS WAS CONDUCTED.

The framework is a valuable tool that will help to focus efforts on isolating the active ingredient that makes a particular innovation, or in this case, innovative business model, successful and which in itself is replicable on a cross-boundary basis.

Identification of an active ingredient renders it free of contextual constraints, and enables stakeholders to apply the solution to different models. This is particularly helpful when considering replicability and scalability of innovative business models for the South African health care landscape. For example, Kenyan childhood immunization programs that incentivize parents by awarding them with agro-credits would not translate perfectly to the South African health care system, but the idea could be used in another context, such as to incentives within the chronic disease realm.

Use of the Adaptation Framework is especially relevant when recognizing those innovative business models or market mechanisms that have overarching implications for policy-makers. Identification of an active ingredient that has a high probability for impactful replicability is likely to spur policy or regulation changes in order to implement new approaches for access to primary health within the private and public sectors.

3.2 BUSINESS MODELS AND APPLICABLE EXAMPLES

FRANCHISING

Franchising, as it is traditionally known, is a business model guided by a legal and contractual agreement whereby one firm or party pays the other for the rights to sell their products and use their branding and trademarks for a set period of time [xiv]. **Social franchising is a model guided by the principles of franchising but these are directed toward improving and addressing societal challenges. Within healthcare, social franchising has been used as a scaling mechanism to accelerate impact**. Social franchising in the context of healthcare is defined as:

"A network of private sector healthcare providers with the intention of providing health that are linked through agreements to provide socially beneficial health services under a common franchise brand. A 'franchisor' (typically a non-profit) manages the brand and oversees the administration of the program" (http://www.sf4health.org/).

The Safe Water and AIDS Project (SWAP) in Kenya is an illustration of how this model works. The NGO establishes business centers, called Jamii Centers, that train women in selling water purification and other health related products to their communities. Women trained by SWAP are easily identifiable through their unique branding and trademark. SWAP works to deliver hygiene education and sanitation services to rural communities and it does this through a three-pronged approach that fundamentally seeks improve health outcomes through improved hygiene practices and also empower communities from low-socio economic settings:

- Research on sanitation products use and monitoring
- Procurement and selling products to communities
- Training and empowering women from communities who are do door-to-door sales and training on the use of these products.

The social impact envisaged by SWAP is developing families and communities by empowering women who are predominantly affected by HIV/ Aids and have very little income opportunities. SWAP works with community members who are widows, government employed community health workers and women from HIV support groups. These groups of women are often subjected to stigma and poverty. Therefore, the focus on them as key health promoters helps to raise their economic status which in turn has a positive impact upon their health outcomes and that of their families. SWAP also reaches out to schools and clinics in the surrounding areas to offer products and training in better hygiene practices.

Women recruited are trained to be Community Health Promoters (CHP), and their training includes marketing skills, business skills, hygiene, and use of various products meant to promote health. Following their completed training, they are given the products on credit to sell and once they have sold their stock

> The past years have been dynamic and turbulent years of starting, testing, evaluating, adjusting, scaling up and now professionalizing and commercializing. SWAP with its wealth of experience and diversified skills is now at a point of outsourcing its activities, offering consulting services, training, research and lab activities for other partners. SWAP aims in the future to become self-reliant and less donor dependent by increasing revenue from sales of health and hygiene products while continuing to address public health concerns.
>
> **Alie Eleveld (In 2014 Annual Report)**

[xiv] Beck, Deelder and Miller, 2010. Franchising in Frontier Markets: What's Working,What's Not, and Why. Dalberg Global Development Advisors Innovators.

they reconcile their debt and take home their 10% profit from the sales. The point of access for SWAP into communities is through Jemii Centers located in rural areas, which are run by professionals from each respective community. This is where the CHPs come to collect new stock and return the profits made from products. The Jemii Centers are also hubs for training and support, and also for the selling of products for surrounding households. SWAP has lab facilities that test various products to ensure efficacy and quality for the products that reach communities. This testing process includes feedback from the CHPs who are directly reaching their individual community, and this information is triangulated in order to procure products that are in demand and are successfully improving health outcomes.

Photographers credit: Bev Meldrum

Arguably, the *active ingredient* which animates SWAP is the strong relationship that the community health promoters forge both with SWAP itself as well as with their fellow community members. One of the challenges the organization has faced is competition from other local vendors who sell the same products, sometimes at a lowered rate. However, CHPs have been able to sustain their trade because of the time they spent training people to use their products and this has therefore ensured that CHPs have gained trust within their communities.

Another key element contributing to SWAPs success within communities is that product placement is a result of an iterative and empirical process that keeps SWAP relevant and in tune with the community's needs and, most importantly, disease trends. Going into communities, SWAP engaged extensively with various stakeholders such as health ministries and chiefs which allows them to be part of village communities and the organizations deploy community members into Jamii centers who understand the people and the context.

INCENTIVIZATION

According to Dow and White (2013) incentivization in healthcare has been surrounded by some controversy from an ethical standpoint, as it has been claimed to undermine people's agency and ability to make independent decisions. Moreover, the use of programmes involving incentives introduces a power dynamic that, to some, is unethical. However, the conversation has now shifted to exploring where this model can be used in an effective and equitable manner. So far, **effective use of incentivization to encourage positive behaviour changes has been applied in the areas of vaccinations and in delivery of family planning and prenatal care**.

The benefit of this approach has been that in certain cases, those improved health outcomes which were motivated by incentives have themselves been motivators for changed health behaviours more so than the actual incentives offered. For example, a mother's attitude and approach to antenatal care changes significantly when she has a healthier child. Long standing examples of incentivization programmes

3.2 BUSINESS MODELS AND APPLICABLE EXAMPLES... CONTINUED

include Marie Stopes International (MSI), which has used this approach in a number of developing countries, including Kenya, to encourage better family planning and use of antenatal services.

An example of this model is the barcode vaccination card developed by Dr Benson Wamalwa from the University of Nairobi. The barcoded vaccination card was designed to address a barrier to access which is not unique to Kenya, namely that rural mothers are unable to travel easily to the nearest clinics to receive necessary immunizations both for themselves and their children. The remoteness of their home communities, the cost and time associated with travel, and the expense of the immunizations and vaccines themselves compounds the difficulty in accessing care and results in immunizations drop-outs as well as pervasive non-vaccination. Dr Wamalwa therefore developed the barcoded vaccination card to specifically address these critical issues. The impact of successful implementation would be the appreciable improvement of the survival rates of children <5 years by tackling vaccine preventable health issues and diseases.

The card has been carefully designed to appeal to a broad spectrum of community stakeholders, with the effect that use of this innovation will be proactive and will lead to a grassroots movement to immunize. This self-mobilization means that the burden for manpower and resources spent

on immunization campaigns or equipping and transporting health workers to remote and hard-to-access regions is shifted from the public health sector. The innovation of the card is that it specifically targets families, pregnant women, and/or caregivers who live on remote smallholdings.

Once registered at first contact with a primary health facility, the child's caregiver or the pregnant woman is issued with a card equipped with a unique barcode that enables redemption of agrocredits. The card is pre-loaded with agrocredits each time that the pregnant woman/child attends either an antenatal care appointment or a vaccination clinic. The card is then redeemable in the form of price discounts from a local Agrovet shop. This enables families to "purchase" essential farm inputs for their smallholdings or it allows them to save the discount via a layaway account. This is an empowering mechanism, as it enables users to establish savings that can then be leveraged in a variety of ways. For example, the funds can be used for out-of-pocket expenses related to transportation or other healthcare related needs, such as the childbirth process itself.

This is a creative and innovative solution that has as its ***active ingredient*** **the integration of the healthcare delivery function with rural livelihood practices**.

By providing an incentive to rural mothers to travel to health clinics, the program ensures that expectant women access necessary antenatal care and that children are no longer lost to unregistered home births while encouraging the mothers/caregivers vaccinate them against preventable diseases. By doing so, the household is then

able to purchase vital farming and equipment needs for their smallholdings at a discount, positively impacting their harvest and their income. The solution is also sustainable, as the Agrovet stores attracts clientèle thereby boosting their social capital as well as their margins, and the the families impacted are able to grow their personal savings in a journey towards financial empowerment.

CROSS-SUBSIDIZATION

Cross subsidization in health is a financing mechanism that fundamentally seeks to equalize risk[xv]. In practical terms, this means that in every method of pooling funds, such as medical schemes, community health schemes, or National Health Insurance, resources are placed according to need despite how much members contribute. In South Africa, the distribution of resources in the private sector is inequitable; thus, those who need healthcare services cannot access them. In a country that has a Gini-coefficient of 0.65 and visible inequality, cross-subsidization would decrease disease burden because often-times those who are wealthier are healthier; therefore, their funds can be used to treat those who are poor and sickly[xvi].

Viva Afya, a healthcare enterprise providing high-quality, comprehensive, and low-cost primary healthcare services in Nairobi's low-income areas, is an example of an effective cross-subsidization model. The organization functions as a hub and spoke model, whereby the use of anchor and satellite clinics enable the provision of health services to wider populations of low- and middle-income groups living within poorly served urban environments where there is limited access to quality care. Expensive resources and equipment are concentrated at the hub or anchor clinics, which are in turn supported by the referrals generated from the smaller spoke or satellite clinics; this model also promotes internal and supply chain efficiencies. This model has ensured that affordable primary health care and specialist consulting services are provided underserved populations.

Viva Afya's success means that it is now operating the largest network of outpatient clinics in Nairobi's low-income areas. The clinics are staffed by appropriately qualified and licensed healthcare professionals, including clinical officers, nursing staff, and pharmaceutical and lab technologists. Each clinic is managed by a clinical officer, who is then incentivised to grow their patient base while maintaining affordability, quality of care, and ease of access for key populations.

Viva Afya clinics are conveniently located for local residents; for example, per CEO Liza Kembo, close to 100% of health service seekers are able to walk to the clinics from their homes. In addition, all clinics are open at least 12 hours every day, with one open 24 hours per day. This means that people are able to access care in a manner that is convenient to their own employment schedules. Since 2014, Viva Afya has provided high quality, low cost health care services to 59,000 clients.

Viva Afya's *active ingredient* is the utilization of community outreach to better educate the residents living in the communities in which each clinic is located. By employing locally based community health workers, Viva Afya is able to build bridges between communities and clinics through organized group meetings, community outreach, and promotional activities. Through these efforts, the organization is able to educate its target market regarding what high quality health services are available, what preventative measures are appropriate, when they should be seeking care, etc. Since 2014, Viva Afya's community outreach has reached over 21,000 people.

This type of effective targeted community outreach also helps to address the pernicious impact of the unlicensed health facilities that are hugely popular in Nairobi. These types of facilities offer users low quality primary health care at very low prices; services are offered by unqualified providers and counterfeit pharmaceutical products are widely distributed. This increases the health risks to the communities in which the Viva Afya clinics are located, and it increases the financial and social burden on families and patients attempting to mitigate the effects of seeking care from such unlicensed facilities as well as on the public health sector that must then treat those impacted by such low quality, harmful care.

[xv] Ataguba & Akazali, 2010. Healthcare financing in South Africa: Moving towards universal coverage. CME, Volume 28 (2), [xvi] Ataguba & Akazali, 2010. Healthcare financing in South Africa: Moving towards universal coverage. CME, Volume 28 (2).

4 KEY FINDINGS

THE KENYAN HEALTHCARE SECTOR IS A VIBRANT ONE CHARACTERIZED BY DIVERSE AND INNOVATIVE BUSINESS MODELS THAT ARE ABLE TO TAKE ADVANTAGE OF THE LOWER MIDDLE CLASS, OR WORKING POOR, SEGMENT OF THE POPULATION.

This slice of the healthcare market totals more than 20 million people[xvii]. The private sector already comfortably accesses the upper and middle/middle-low tiers of health consumers, and is willing to leave the healthcare needs of the absolute poor to the public sector. Therefore, understanding how the working poor access healthcare, the services available to them, the attitudes around health seeking behaviour, and the complex socio-economic, gender, and cultural implications is extremely valuable.

Following is a brief description of each of the findings derived from data collection and interviews with key stakeholders.

HEALTH SERVICE DIVERSITY

Diversity of affordable private sector service offerings within Kenya allows organizations and service providers to leverage the buying power of the informally employed or jua kali, a sector that comprises 83% of Kenya's population. This population purchases their healthcare out-of-pocket at a time when they need it rather than devoting a portion of their disposable income towards purchasing an intangible such as health insurance. Private providers have a high interest in creating and marketing services to the working poor, since this segment of the population has demonstrably proven its willingness to demand high quality health services and the willingness to pay for these services and products. This willingness to pay is linked to the perception that the services accessed in the private healthcare sector are of a far superior quality and are more convenient than those found in the public sector.

In a recent survey conducted by PSP4H of 435 working poor households in peri-urban areas of Nairobi, only 24.9% of respondents indicated that financial constraints contributed to failure to seek necessary healthcare services[xviii]. Proponents of innovative healthcare business models, such as those highlighted in this report, have recognized that offering the working poor better value for money in the healthcare services available to them will allow access to a potentially huge market. To appropriately implement successful low-cost, high quality delivery models of care, PSP4H advocates "match[ing] pricing to existing spending patterns, which are closely tied to daily income, instead of requiring new spending behaviours[xix]". The key, therefore, as argued by Ron Ashkin from PSP4H, is to market to the organized informal sector on an aggregate level.

The quality, cost, and physical accessibility of public health services available often-times negatively impact the decision to seek care from these facilities. An additional factor that makes seeking health services more attractive in the private versus the public sector is not only the diversity of healthcare models

[xvii] Private Sector Innovation Programme for Health, 2014. What we Learned about Private Health Sector's Ability to Serve the Working Poor in Kenya. Series No. 2, [xviii] Private Sector Innovation Programme for Health, 2014. The Myth that "The Poor Can't Pay": Health Spending Behaviour among Low income Consumers in Kenya. Series No. 15, [xix] Private Sector Innovation Programme for Health, 2014. The Myth that "The Poor Can't Pay": Health Spending Behaviour among Low income Consumers in Kenya. Series No. 15

but also the diversity of actual services being offered. The public health sector focuses its efforts on HIV/AIDS, malaria, and child and maternal health services while neglecting non-communicable diseases, dentistry, and mental health, for example[xx]. These gaps in provision allow private healthcare providers to offer targeted services to the working poor. These services might be seen as balancing the public service offerings available; therefore, the private models that target low-income groups fill the disparities left by the public sector. The public sector is operating under constrained resource needs and maintains a strong focus on national health priority issues, and this leaves others services and needs under-supplied.

Many of the service delivery mechanisms discussed refer into the public sector, and do not view themselves as in competition with the public sector but rather as fulfilling a complementary role which then uses the necessary channels to ensure patients return back to the public health referral chain as appropriate.

HEALTHCARE CONSUMPTION ATTITUDES

As active consumers of healthcare, the working poor in Kenya make strategic decisions whether it is deciding to seek care from unregulated pharmacies or whether it is in accessing care from a licensed, qualified private provider.

Kenyans have a fine-tuned sense of themselves as consumers of a product, i.e. healthcare. They are able to recognize and take advantage of the fact that healthcare is a service and commodity to be shopped for. Kenyans scan the healthcare offerings and services available, and make informed choices based on what they are willing to pay, how far they are willing to travel, etc. In addition, Kenyans are sophisticated users of the internet; in 2015, 22.3 million internet users or 54.8% of the population had ready access these services[xxi]. The very high penetration rate of the internet means that almost all populations have easy access to research about health conditions, services, etc. and are therefore more likely to make discerning choices based on their healthcare needs and willingness to spend. Overall, patients value efficiency and consideration of their time, which are areas that organizations such as 2020MicroClinic Initiative and VivaAfya focus on.

Cultural beliefs play a significant role in influencing healthcare consumption attitudes. Widespread education about the importance of preventative health measures as well as the pursuit of healthy lifestyles does not exist[xxii]. This contributes to the "poverty penalty", which means that consumers do not access necessary health services in a timely manner because they either a) choose to self-medicate; b) seek care from informal providers; or c) feel that they cannot afford appropriate care. Therefore, once they finally do seek treatment it

[xx] Private Sector Innovation Programme for Health, 2014. A Formative Survey of the Private Health Sector in the Context of the Working Poor, [xxi] Communications Authority of Kenya, 2015, [xxii] Private Sector Innovation Programme for Health, 2014. Private Provider Challenges. Series No. 10

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KEY FINDINGS... CONTINUED

can be very expensive, or in some cases, may even be too late to be effective. Educating consumers about healthcare ensures that they understand the importance of seeking care and the concurrent importance of compliance with follow-up treatment. Innovations like the barcode incentivization card mentioned above, help to encourage access to care. By providing an incentive to rural mothers to travel to health clinics, the program ensures that expectant women access necessary antenatal care and that children are no longer lost to unregistered home births while encouraging the mothers/caregivers vaccinate them against preventable diseases.

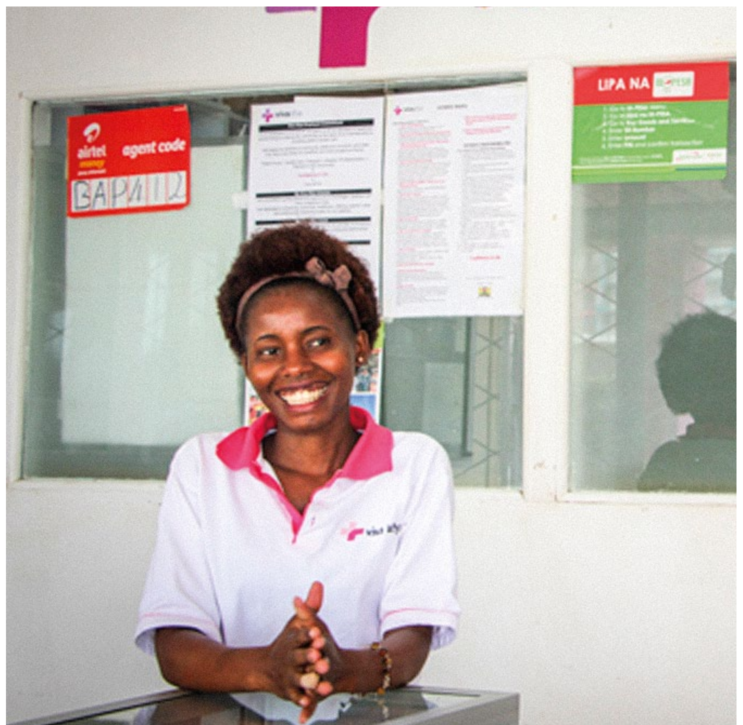
As discussed previously, Kenyans defined as members of the "working poor" have demonstrated their willingness and ability to pay for provide healthcare services within the private sector. A study conducted by PSP4H across 12 Kenyan counties included focus group discussions with 518 participants. This study revealed that the reasons the working poor chose to access the private sector include[xxiii]:

- Perceived quality of care and services
- Confidentiality
- Convenience (longer opening hours)
- Easy access to the facility
- Positive provider attitude and behaviours
- Availability of specialized services
- Shorter waiting times
- Availability of staff, particularly doctors
- Availability of equipment and supplies

These reasons clarify that the working poor are willing to pay for quality patient care but that they also want value for their money. This is arguably why a business model such as Viva Afya has been so successful, because its make-up addresses each of the preferences listed above. Viva Afya clinics are conveniently located for local residents; for example, per CEO Liza Kembo, close to 100% of health service seekers are able to walk to the clinics from their homes. In addition, all clinics are open at least 12 hours every day, with one open 24 hours per day. This means that people are able to access care in a manner that is convenient to their own employment schedules.

CHALLENGES FACING THE PRIVATE SECTOR

The private sector is able to be extremely nimble and responsive to the needs identified by its target population, in this case, Kenya's working poor. However, **Kenyan private healthcare providers face constraints in market penetration that prevent them from fully engaging with potential consumers in the lower-middle class and working poor segments of society**. Barriers to access include operational and regulatory concerns, as well as challenges around cost and competition.



[xxiii] Private Sector Innovation Programme for Health, 2014. What we Learned about Private Health Sector's Ability to Serve the Working Poor in Kenya. Series No. 2

OPERATIONAL AND REGULATORY OPPORTUNITIES FOR IMPROVEMENT

- The Kenyan national Ministry of Health has not clearly spelled out what kind of role the private sector can play in provision of services around national health priorities [xxiv]. Without formulating a clear policy framework for collaboration, the private sector lacks the necessary clarity to align activities to national health priorities.

- In common with many countries, national policies and regulations are burdensome and costly to comply with. Processes are not streamlined, are confusing, and functionalities are shared across departments, creating a time-consuming and exhausting practice of ensuring regulatory compliance.

- Kenya does not actively incentivise the private sector to serve the working poor. Without appropriate encouragement, the private sector will not leverage its resources to help shift the burden of ensuring national health priorities are realized while also offering targeted specialized services.

COST AND COMPETITION

- Business start-up costs, which include licensing, personnel training, medical and capital equipment, property purchase or rental fees, and drug supplies, can prove to be prohibitive. According to PSP4H, labour costs for healthcare professionals are the number one expense for private providers while drugs are the second most expensive line item [xxv].

- Private healthcare providers might have the entrepreneurial spirit necessary to pursue business in this sector, but often-times they lack the business and financial management skills to ensure success [xxvi].

- Strategic market planning is a major concern, especially with a high risk group such as the working poor. Moreover, the ability to develop a compelling and strongly focused market plan is hampered not only by this type of high risk group but also by the types of areas target populations reside in. When underserved areas are lacking necessities such as running water and electricity, are considered unsafe, and are inhabited by transient residents, it is difficult to retain a solid customer base and it is difficult to recruit qualified personnel whom are willing to work under such conditions.

- Drug regulation and availability remains a problem despite regulation policies, as Kenyan citizens, especially those whom are poor, readily pay for medicines from unlicensed providers and this can have detrimental consequences to their health. More broadly, unlicensed and/or informal healthcare providers create real competition for private healthcare providers.

Compounding the issues of operational and regulatory

concerns, as well as the challenges around cost and competition, are the breakdowns in information and knowledge sharing. The private health sector struggles to be included in MoH policy and strategy creation, while in return "the MoH still struggles to motivate the private health sector to regularly report its activities to the MoH health management information system" which means that decision-making on both sides is not made by including all stakeholder groups [xxvii]. Finally, updates on regulations are not timely, dissemination of standards is not widely done, and few clinical training opportunities exist for private providers [xxviii].

[xxiv] Private Sector Innovation Programme for Health, 2014. Private Provider Challenges. Series No. 10, [xxv] Private Sector Innovation Programme for Health, 2014. Private Provider Challenges. Series No. 10, [xxvi] Private Sector Innovation Programme for Health, 2014. Private Provider Challenges. Series No. 10,

KEY FINDINGS... CONTINUED

PRESENCE OF NGO'S AS A CHALLENGE FOR SOCIAL ENTERPRISES

Externally funded healthcare dominates the Kenyan healthcare landscape, where services provided by faith based organizations, for example, comprise 65% of healthcare provision[xxix]; and, where 26% of Kenya's health expenditure is donor funded[xxx]. Donors, therefore, function as a real form of competition for private health sector providers. Donor subsidies, for infrastructure, drugs, and medical equipment and testing services, support the public health sector while ensuring that private providers are unable to compete within the marketplace[xxxi].

Working within environments that are heavily populated with NGO's often-times makes it difficult to sell products. One the major challenges Community Health Promoters from SWAP noted is that people were not willing to purchase items they receive free from NGOs. The downside to this is that they noticed the products were not used properly and to some extent could be harmful because of this. Furthermore, this is not sustainable as a mechanism of maintaining health and creates unrealistic expectations in vulnerable communities, especially if a donor subsequently pulls out.

PROACTIVE CULTURE

Kenyan society is marked by strong reliance on and support of social groups like Savings and Credit Co-Operations (SACCOs) and "chamas", which are analogous to the stokvel clubs found in South Africa. These societies, originally founded to combat poverty and run in an informal context, have become powerful organizations that account for a significant portion of the Kenyan GDP. Community organizations such as these have implications for the healthcare sector, particularly regarding insurance because developing a relationship with SACCO leadership ensures access to the potentially thousands of SACCO members.

SWAP has been able to leverage the power of these types of organizations. A number of the community health promoters were endorsed through their village health committees, chamas, and/or support groups. These are key features of village health systems that offer support and funding for members when seeking healthcare. Organizing of this nature is a not only seen in rural spaces, as people from these communities still contribute to chamas in their villages even when they move into urban areas such as Nairobi. One interviewee noted that the reason some Kenyans are able to access private healthcare are due to chamas, such as in cases where community members pull together funds for a neighbour or acquaintance having an operation or needing to access expensive services.

Chamas are community groups founded on what Kenyans call "Harambe" culture, the equivalent of Ubuntu in South Africa; the distinction however, is that in Kenya this is shown through proactive responses to the needs of fellow community members. Chamas are a pooling mechanism and funds contributed by its members are used to pay for a variety of things, these range from paying for university fees to medical procedures. Surprisingly, these have survived without governmental regulations, as existing traditional systems and cultural norms still drive the success of these groups. By

[xxvii] Private Sector Innovation Programme for Health, 2014. Private Provider Challenges. Series No. 10, [xxviii] Private Sector Innovation Programme for Health, 2014. Private Provider Challenges. Series No. 10 [xxix] U.S. President's Emergency Plan for AIDS Relief (2012). A Firm Foundation: The PEPFAR Consultation on the Role of Faith- based Organizations in Sustaining Community and Country Leadership in the Response to HIV/AIDS. Washington: U.S. Department of State, [xxx] Kenya National Health Accounts 2012/13, [xxxi] Private Sector Innovation Programme for Health, 2014. Private Provider Challenges. Series No. 10

developing a low-cost model that will tap into the organization occurring through these informal networks, private providers will be able to access huge pools of potential healthcare consumers [xxxii]. An example of a health insurer that is attempting to do this is Afya Poa, which is a micro-insurance product developed by Jawabu Empowerment. One of the strategies employed by Afya Poa was to leverage the power of the chamas and to sell insurance policies through these community groups [xxxiii]. Barriers to its success include regulatory issues and negotiation with chamas and other jua kali community groups.

SHIFTING GENDER NORMS

Barriers to healthcare access do not only include financial considerations or remoteness of location, but also include issues such as delayed treatment related to the status of women [xxxiv] or general financial decision making processes within individual households. As a fairly traditional society, the head of household – usually a male – generally makes major financial decisions for Kenyan families. Therefore, men "as the financial providers and custodians of the household, [make] decisions that require[d] a significant amount of money [xxxv]". This type of dynamic can even extend to health seeking behaviour itself, and therefore Kenyan men, through their willingness to provide funds, can have a significant impact the ability of women to access healthcare [xxxvi]. During time spent with SWAP, we interviewing female CHPs on how their work affected their relationships with their spouses/partners. They noted that there was an appreciable shift in their lifestyles and relationships because they were contributing to the household and alleviating pressure on their husbands. Collaborative decision-making within the household was also mentioned as a different and pleasant result of the women's financial contributions to their homes. Gender norms that lead to domestic violence were a key consideration for SWAP. Thus, when recruiting community health promoters, their husbands and partners were also invited to observe the process and to celebrate with the women when their training was complete. A number of women who were married had some assistance on weekends from their children and husbands when doing their round of sales, making this a family affair.

[xxxii] Private Sector Innovation Programme for Health, 2014. A Comparative Analysis of Health Markets and Private For-Profit, Pro-Poor Interventions in East Africa, [xxxiii] Private Sector Innovation Programme for Health, 2014. A Comparative Analysis of Health Markets and Private For-Profit, Pro-Poor Interventions in East Africa, [xxxiv] Private Sector Innovation Programme for Health, 2014. What we Learned about Private Health Sector's Ability to Serve the Working Poor in Kenya. Series No. 2, [xxxv] Private Sector Innovation Programme for Health, 2014. A Formative Survey of the Private Health Sector in the Context of the Working Poor, [xxxvi] Fotso JC, and Mukiira C. 2011. Perceived Quality of and Access to Care Among Poor Urban Women in Kenya and their Utilization of Delivery Care: Harnessing the Potential of Private Clinics? Health Policy and Planning 27[6]:505-15

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RECOMMENDATIONS FOR SOUTH AFRICA

SOUTHERN AFRICAN COUNTRIES HAVE LIMITED RESOURCES AND GOVERNMENTS MUST PRIORITIZE ACTIVITIES AND RESPONSIBILITIES IN ALL AREAS, INCLUDING THE HEALTHCARE SYSTEM.

Private and third-sector organizations can supplement the resource needs and narrow the demand gap that exists within the healthcare sector.

From the learnings within the Kenyan context, the following recommendations have bearing on the South African context:

INCREASE PARTNERSHIP WITH THE PRIVATE SECTOR

Achieving efficient, effective, and equitable access to healthcare, that is responsive to all citizens, requires the unlocking of dormant resources present in the private and third-sector organizations especially those that are already responsible for increasing healthcare access. Collaboration with these organisations can enhance what government is already able to provide and would ensure better access and continuity of care for those in need of health care services especially looking forward to implementation of the National Health Insurance plan. The private sector organizations play a valuable role in fostering innovation, competition, quality patient care, responsiveness to system constraints, and sensitivity to management capacity constraints [xxxvii]. Furthermore, collaboration and integration between government and the private sector can have positive repercussions in other areas of health care delivery due to increased dialogue and information exchange, and can serve as a catalyst for further cross-sectoral engagement [xxxviii].

Governments across sub-Saharan Africa may struggle to fulfil their mandate to effectively deliver health care services to their populations unless they practice some minimal level of engagement with private healthcare service providers. **Partnering with the private sector, in policy setting, planning and implementation of health care delivery would lessen the burden on governments while opening up the possibility to access effective and innovative models of patient care delivery**. As further discussed below, partnership between the sectors can take the form of shifting the burden of care from the heavily utilized public sector to the private sector; of employing the private sector to train medical professionals; or of actively working to change consumers attitudes about healthcare consumption.

The South African Ministry of Health, at both the national and at the provincial levels, is able to draw on various policies and regulations that will enable it to work towards achieving access, affordability, and quality of health services for the entire South African population [xxxix]. These tools include financing policy interventions, such as subsidies, which can have significant impacts upon health market dynamics [xl]. If not kept in balance, these interventions can stifle competition with the private healthcare sector. Therefore, to effectively engage the private sector, **it is important to ensure the free flow of information across the health system so that private actors can align their activities with public health goals**. Transparency will also enable the government to involve the private sector in developing and implementing policies and regulations, while also taking advantage of "strategic opportunities to harness private sector resources and expertise [xli]".

PROMOTE BURDEN SHIFTING WITHIN HEALTHCARE SECTORS

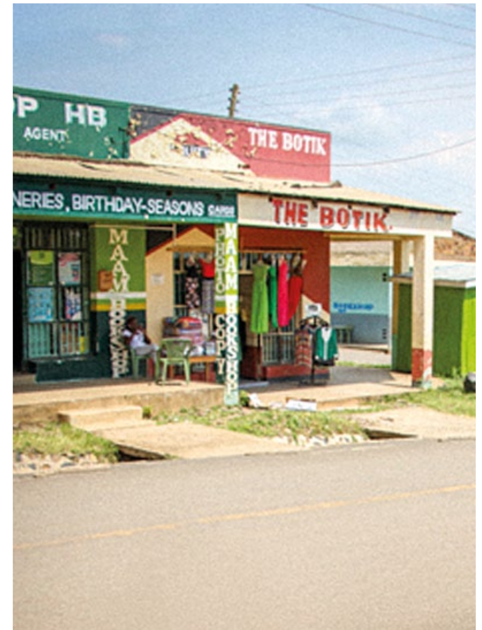
In the public sector there is a substantial shortage of health workers especially in rural areas. The ratio of physicians per 10 000 population is 8 and there are 5.1 nurses per 10 000 populations. The first obstacle that has been identified is the issue of retention of health professionals in poor, rural areas. This shortage of healthcare professionals is providing South Africa the opportunity to explore other cadres of health workers and the greater involvement of lay people in the delivery of care. The lessons learned in this respect from Kenyan healthcare delivery providers such as Viva Afya, which employs clinical officers versus doctors in its clinics, are extremely valuable.

Finding alternative models to address this current reality is a national imperative. Private health sector engagement mechanisms such as down referral innovation and/or contracting out GP services, particularly in the context of declining or stagnant external donor funding, presents a strong opportunity to expand health sector capacity to meet public needs. A model that addresses this need in an innovative fashion is the BroadReach Healthcare GP Down Referral Model.

The BroadReach Healthcare GP Down Referral Model was developed to address the need to shift the burden of delivering HIV/AIDS treatment to stable patients from the public to the private sector. Specifically initiated within the North West province, the BroadReach model funnels stable patients into a private sector down referral program for provision of routine care. This allows public health facilities within the province to focus on managing complicated patients, non-compliant patients, and initiating new ART-eligible patients. Burden shifting in this manner fulfils a number of key goals, such as 1) reducing the drain on the public sector; 2) improving access to treatment; and 3) enhancing patient outcomes. This is a unique model of care, and it aligns with the stated goals and objectives of the National Health Insurance plan to enhance the quality of treatment within the primary healthcare sphere. Factors to success include development of a strong working relationship with the North West Department of Health, alignment with provincial and national health plans and policies, and maintaining close relationships with existing GP referral networks.

Another example of burden shifting within the South African healthcare landscape is the Kheth'Impilo Pharmacist Assistant Project. South Africa currently suffers from a skills gap within the public pharmacy sector as most qualified pharmacists choose to practice in the private sector. To address this gap, Kheth'Impilo initiated a pharmacist assistant training program through the utilization of external grants. Candidates are recruited from marginalized communities and placed in government facilities where they are trained to deliver a service from the first day of training. To date, more than 230 post basic pharmacist assistants have been trained, and their impact has had the result of reducing patient waiting times, improving quality of patient care, and overall reducing the burden on the public pharmacy facilities in which they are placed. A pharmacist completes studies after five years while a nurse completes studies after four years. Through the Kheth'Impilo program, a pharmacist assistant can qualify in two years, resulting in a faster, more cost effective and efficient intervention as it allows each professional to operate at their maximum skill level.

Mid-level providers and medical workers can play an essential role in health systems. The success of task-shifting as a systems intervention with the integration of community health workers has been successful in alleviating the congestion in the public health sector. Another area where this has been effective is in allowing nurses to take on tasks traditionally ascribed to doctors such as ARV prescriptions and training them to prescribe treatments for primary care.



[xxxvii] Healthy Partnerships: How Governments Can Engage the Private Sector to Improve Health in Africa. World Bank, 2011, [xxxviii] Healthy Partnerships: How Governments Can Engage the Private Sector to Improve Health in Africa. World Bank, 2011, [xxxix] Private Sector Innovation Programme for Health, 2014. A Comparative Analysis of Health Markets and Private For-Profit, Pro-Poor Interventions in East Africa, [xl] Private Sector Innovation Programme for Health, 2014. A Comparative Analysis of Health Markets and Private For-Profit, Pro-Poor Interventions in East Africa, [xli] Private Sector Innovation Programme for Health, 2014. A Comparative Analysis of Health Markets and Private For-Profit, Pro-Poor Interventions in East Africa

RECOMMENDATIONS FOR SOUTH AFRICA... CONTINUED

PROMOTE SKILLS DEVELOPMENT WITHIN THE PRIVATE SECTOR AS WELL AS TRAINING OF MID-LEVEL PROVIDERS

South Africa is currently suffering from a severe skills shortage across medical professions, and this shortage is exacerbated by the in-equal resource distribution across the private and public healthcare sectors as well as between rural and urban areas[xlii]. This shortage is of particular concern given the approaching implementation of the proposed National Health Insurance plan. While currently in its pilot phase, implementation of the NHI with its focus on primary healthcare calls for even greater numbers of qualified medical professions across all competencies. Therefore, the ability of the education system to meet this need has a direct impact upon achieving the goals of the NHI.

South Africa currently has eight public medical schools, and there is a prohibition on private universities offering medical education and training; therefore, there is practical limitation on "the private sector's ability to help lift this burden, and leaves training in the public sector constrained by limited funding and resources"[xliii]. In a 2015 study conducted by Econex on behalf of the Hospital Association of South Africa, the findings suggested that the private healthcare sector has two possible avenues of participation within the provision of medical education. Firstly, allowing the establishment and accreditation of private medical colleges would allow the training of a greater number of medical doctors at the least cost to the public; and secondly, encouraging greater participation of private hospitals and specialists in the clinical training of South African undergraduate students would be a cost effective way in which the private sector can contribute to capacity training[xliv]. There are already examples that exist that prove the efficacy of such an approach, i.e., Mediclinic South Africa has partnered with the University of Stellenbosch to provide opportunities where internal medicine students can complete a portion of their rotation at a Mediclinic facility[xlv].

Viva Afya provides an excellent example of how the use of clinical officers or associates meets an immediate clinical need within underserved populations. **Mid-level providers, such as clinical associates or physician assistants, play an important role in alleviating service burdens while also addressing human resource shortages**. South Africa began training cadres of clinical associates in 2008 as an attempt to deal with its critical shortage of medical workers. These clinical associates were envisioned as a means to strengthen primary healthcare provision at a district level, by allowing them to support over-burdened doctors and reduce the need for costly referrals[xlvi]. Clinical associates operate under the supervision of doctors, and are generalist rather than specialist providers. Challenges to this programme include overly rapid implementation, which left the public sector unable to support the influx of this new type of medical[xlvii] expert. In addition, funding shortfalls, poor support for clinical associates placed in rural or peri-urban areas, and lack of posts within the public sector all contributed to negatively impact the sustainability of the programme[xlviii]. Possible recommendations to address this issue would be to partner with the private sector to cultivate initiatives that would mirror those developed by Kheth'Impilo and BroadReach Healthcare, i.e. using clinical associates to actively participate in down referral models to facilitate burden shifting from the public health sector.

[xlii] Econex, 2015. Identifying the Determinants of and Solutions to the Shortage of Doctors in South Africa: Is there a Role for the Private Sector in Medical Education?, [xliii] Econex, 2015. Identifying the Determinants of and Solutions to the Shortage of Doctors in South Africa: Is there a Role for the Private Sector in Medical Education?, [xliv] Econex, 2015. Identifying the Determinants of and Solutions to the Shortage of Doctors in South Africa: Is there a Role for the Private Sector in Medical Education?, [xlv] Econex, 2015. Identifying the Determinants of and Solutions to the Shortage of Doctors in South Africa: Is there a Role for the Private Sector in Medical Education?, [xlvi] Doherty, Conco, Couper, & Fonn, 2013. Developing a new mid-level health worker: lessons from South Africa's experience with clinical associates, [xlvii] Doherty, Conco, Couper, & Fonn, 2013. Developing a new mid-level health worker: lessons from South Africa's experience with clinical associates, [xlviii] Doherty, Conco, Couper, & Fonn, 2013. Developing a new mid-level health worker: lessons from South Africa's experience with clinical associates

DEVELOP HEALTHCARE SERVICE MARKET PLAN TO MEET NEEDS OF VARIOUS INCOME CLASSES

Public health facilities are very congested because the ratio of patients to health workers is disproportional, thus they have long waiting times and often times people miss work while waiting to be attended to and health workers are stretched. Private health facilities do not face these challenges but are not affordable for those who are in low socio-economic settings. **One of the noticeable trends in South Africa is a growing middle class, defined as earners above R25 000 per person per year[xlix]. This group has steadily grown from 3.6 million to 7 million since 1993[l]. This growing group presents an opportunity for private healthcare providers which can develop and market service delivery to serve various income groups**.

Kenya has been filling this gap with a competitive private sector. The health system in Kenya is not as restrictive as in South Africa where those in who cannot afford private healthcare are completely relegated to the public sector. Micro insurance schemes for example have been a key financing mechanism that has allowed Kenyans in the middle to lower middle income group access to private care. Furthermore, those in the informal sector can make the choice to access private healthcare even though their income is irregular.

HEALTHCARE CONSUMPTION ATTITUDES

Kenyans have a fine-tuned sense of themselves as consumers of a product, i.e. healthcare. They are able to recognize and take advantage of the fact that healthcare is a service and commodity to be shopped for, versus what is arguably the traditional South African mindset that healthcare is a benefit that devolves to them rather than a service being purchased. Kenyans scan the health care offerings and services available, and make informed choices based on what they are willing to pay, how far they are willing to travel, etc. The very high penetration rate of the internet means that almost all populations have easy access to research about health conditions, services, etc.

Actively attempting to understand healthcare consumption attitudes would be invaluable in developing market interventions that would encourage broader use of the South African private healthcare sector by the lower middle class and the working poor. This would service the public health goals of the National Health Insurance plan, by encouraging burden shifting in the provision of primary healthcare services. Lessons learned from the Kenyan healthcare landscape encourages the assumption that South African health consumers likewise prefer to access the private sector due to perceived quality of services, convenience, availability of specialized services, and shorter waiting times. However, shifting the focus from healthcare as a public good to healthcare as a product that consumers can be discerning in purchasing will not occur unless there are more options available to the working poor that would encourage them to pay for services within the private sector versus simply taking advantage of what is provided by the public sector simply because that is the default option.

[xlix] Kotzé, du Toit, Khunou, & Steenekamp, 2013. The Emergent South African Middle Class, [l] Kotzé, du Toit, Khunou, & Steenekamp, 2013. The Emergent South African Middle Class

6 CONCLUSION

South African policy makers can take advantage of the lessons learned from the Kenyan health care system, and its experiences with the private healthcare sector. By breaking down the siloes that exist within the sectors of health care delivery, an open dialogue can be created that will promote transparency, build trust, and ensure the recognition that across the sectors there exists similar agendas; focused on providing health care to all members of the national population.

Coordination of care would relieve the burden on a system that is suffering from severe capacity constraints, would provide support through leadership and mentoring to those health care providers and ultimately allow for the optimal delivery of patient-centered care. Learning from the lessons provided by the Kenyan healthcare system, it is arguable that private sector healthcare providers – whether Kenyan or South African – are ready to provide priority health services to underserved populations who have evidenced the willingness to pay for this care provision. However, this opportunity must be supported by policies and market conditions that will allow private healthcare providers to support the goals of the South African NHI plan.

7

REFERENCES

1. Ataguba, J., & Akazali, J. (2010). Healthcare financing in South Africa: Moving towards universal coverage. *CME*, Volume 28 (2).

2. Beck, S., Deelder, W., & Miller, R. (2010). Franchising in Frontier Markets: What's Working,What's Not, and Why. *Dalberg Global Development Advisors Innovators.*

3. William, D., & White, J. (2013). Incentivizing use of healthcare. *United Nations Department of Economic and Social Affairs, Expert Paper no. 2013/13.*

4. *World Bank.* (2013, June 09). Retrieved from Worldbank.org: http://www.worldbank.org/en/country/kenya/overview

5. Dawad, S. and Veenstra, N. Comparative health systems research in a context of HIV/AIDS: lessons from a multi-country study in South Africa, Tanzania and Zambia. *Health Research Policy and Systems* 2007, 5:13

6. Private Sector Innovation Programme for Health. 2014. Private Provider Challenges. Series No. 10

7. Beck, Deelder and Miller, 2010. *Franchising in Frontier Markets: What's Working,What's Not, and Why*. Dalberg Global Development Advisors Innovators

8. Private Sector Innovation Programme for Health, 2014. *What we Learned about Private Health Sector's Ability to Serve the Working Poor in Kenya. Series No. 2*

9. Private Sector Innovation Programme for Health, 2014. The Myth that "*The Poor Can't Pay": Health Spending Behaviour among Low income Consumers in Kenya. Series No. 15*

10. Private Sector Innovation Programme for Health, 2014. *A Formative Survey of the Private Health Sector in the Context of the Working Poor*

11. Private Sector Innovation Programme for Health, 2014. *A Comparative Analysis of Health Markets and Private For-Profit, Pro-Poor Interventions in East Africa*

12. Fotso JC, and Mukiira C. 2011. *Perceived Quality of and Access to Care Among Poor Urban Women in Kenya and their Utilization of Delivery Care: Harnessing the Potential of Private Clinics?* Health Policy and Planning 27[6]:505-15

13. Healthy Partnerships: How Governments Can Engage the Private Sector to Improve Health in Africa. World Bank, 2011

14. Econex, 2015. *Identifying the Determinants of and Solutions to the Shortage of Doctors in South Africa: Is there a Role for the Private Sector in Medical Education?*

15. Doherty, Conco, Couper, & Fonn, 2013. *Developing a new mid-level health worker: lessons from South Africa's experience with clinical associates*

16. Kotzé, du Toit, Khunou, & Steenekamp, 2013. *The Emergent South African Middle Class*

17. U.S. President's Emergency Plan for AIDS Relief (2012). *A Firm Foundation: The PEPFAR Consultation on the Role of Faith- based Organizations in Sustaining Community and Country Leadership in the Response to HIV/AIDS.* Washington: U.S. Department of State.

18. Kenya National Health Accounts 2012/13

APPENDIX 1: INTERVIEW GUIDE

SECTION A:
BACKGROUND AND DESCRIPTION OF PROJECT

1. Please tell us when the project started and how did it come about (Who and what motivated the project/organization)?
2. Could you describe in detail all the various components of the model?
3. What was the motivation behind the model you chose?
4. Do you think your model has been effective? Please explain why?
5. What metrics have you used to assess your success as an organization?
6. What metrics are used to assure the quality of care provided?
7. Within the health system, how does your model add value?
8. What is your annual revenue?
9. How do you ensure the sustainability of the model?
10. How much investment have you had? How much has been donor funded?
11. How much turnover have you had since implementation?
12. What is the cost of the service being provided?
13. How are you seeking to expand? What is your timeline for this?
14. What successes are you proud of?
15. How do you see your organization as being different from other similar organizations?

SECTION B:
CONTEXTUAL FACTORS

16. Which community or group does your organization target? Why have you chosen to work with this group?
17. How do you market your model?
18. What has been the response to your organization from the communities/people you work with?
19. Are there aspects of your organization that have changed since you first started your work?
20. What are the factors or activities that are inherent to the success of the organization? (What makes it work?)
21. What are the challenges you have experienced in implementing the model?
22. Do you think there are certain elements of your model that are dependent on the local context and cannot just be replicated?
23. What is your relationship with government? How are you able to interact with policy makers, on a local and national level?
24. What sort of evidence would you, as a decision-maker, like to see before you adopt a change of practice?
25. What recommendations do you have for government? What other stakeholders could be engaged to contribute more? Interview Guide II: Experts

INTERVIEW GUIDE II: EXPERTS

1. Why do you think that the Kenyan environment has been so receptive to innovative business models around primary care delivery?

2. What do you think are your most pressing challenges in the health sector?

3. What have been some governmental responses to these?

4. What are the private sector models and trends that have been implemented to address healthcare challenges in Kenya? (Particularly in primary care)

5. Do you think these have been successful? Please explain?

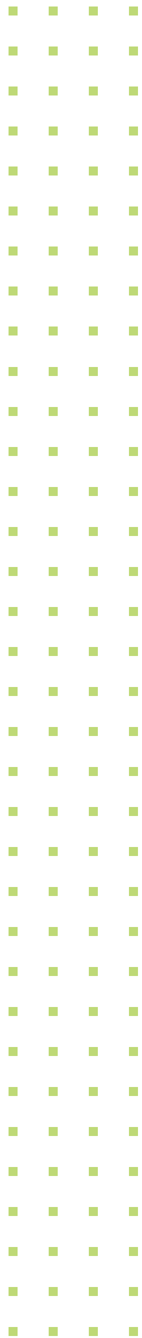
6. Why do you think these have been successful in Kenya?

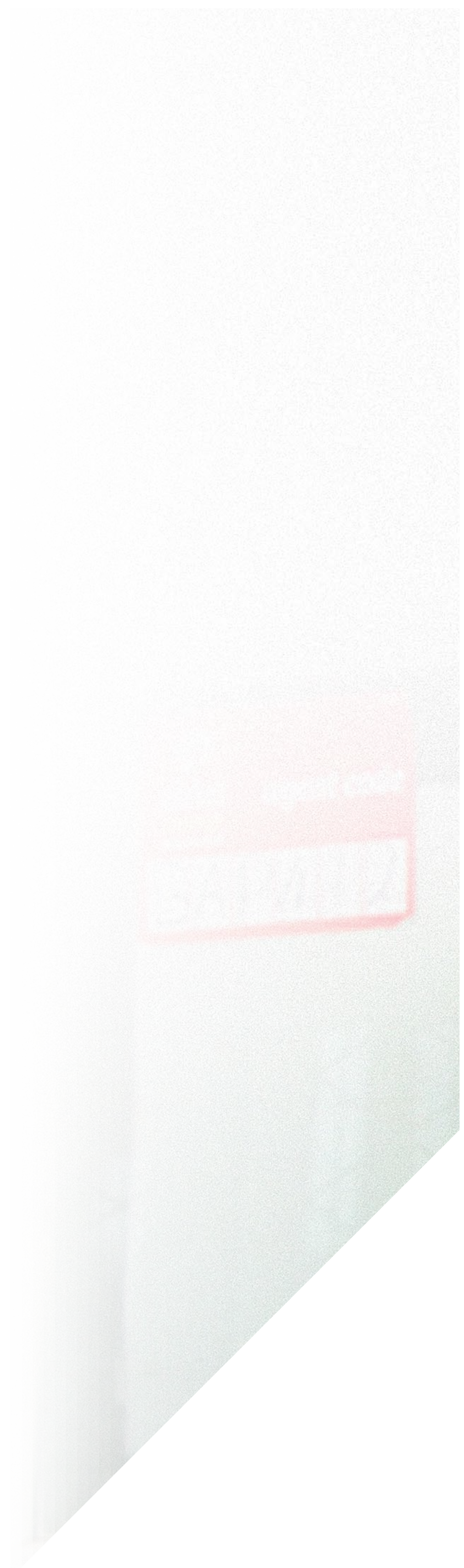
7. How has the structure of the devolved healthcare system either inhibited or encouraged the proliferation of innovative business models for primary care service delivery?

8. Do you think these can be replicated somewhere else? If so, which conditions are best suited to implement these models and why?

9. What are some innovative business models or market mechanisms that you are excited about?

10. Looking at the Kenyan healthcare landscape, where do you think the next big area for innovation lies?





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