AGGREGATION: REORGANIZING HEALTHCARE SYSTEM AND FINANCING

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Introduction

People in developing countries spend half a trillion dollars each year on out of pocket health expenses pushing over 100 million globally into extreme poverty according to World Bank. Coupled with the inefficiencies in the health sector leading to 20% to 40% of health spending being, World Bank projects 176 billion dollars per year deficit by 2030, creating doubts on whether UHC is achievable by 2030. [1]

In Kenya, 78% and 22% of outpatient and inpatient household health expenditures respectively are out of pocket[2]. Partly because a lot of health facilities within easy access of the population are not contracted by the insurers.

This projected tested a new way of enabling contracting through aggregation of private health facilities and contracting them with insurance companies as an aggregated unit. This was to save time and cost of contracting several health facilities for the insurers while helping to open up health facilities for insurance businesses which they would otherwise miss out on. Overall, the net effect was hypothesized to be widening access to health services to the insured persons hence tackle the OOP challenges.

Methods

Through implementation research, PS Kenya tried out new ways to make insurers – health service providers contracting easier, PS Kenya interviewed the only national insurer in Kenya- National Health Insurance Fund (NHIF) and 6 private insurers to understand their pain points.

On the service providers' side feedback was received from 67/400 of the PSI/ PS Kenya run Tunza family health network members out of which 40 were aggregated to contract with the insurers.

Results

Private insurers offering both micro and conventional health insurance products wish to cut cost, increase their top line and make profits. All private insurers indicated that contracting health facilities individually is costly and that lack of oversight contributed to huge losses due to fraud.

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[1] http://documents.worldbank.org/curated/en/641451561043585615/Driving-Sustainable-Inclusive-Growth-in-the-21st-Century
[2] https://ir-library.ku.ac.ke/handle/123456789/17969

At the time of execution, 2/6 insurers were ready while the other four stated that they wished to see it tried and tested first.

National insurer on the other hand indicated that the model needs to be tried out however there must be policy changes to execute such contracts. In their current standard operating procedure, each facility is treated individually with assessments done and points awarded per unit even if an already contracted facility opens a branch elsewhere.

Health facilities indicated that there is a huge mistrust between insurers and the health facilities leading to claims rejection rate of up to 19%. This makes health providers to charge premiums for services rendered to insurance clients.

Conclusions

Driving cost of health services lower and support development of affordable health financing products health services providers and insurers must work together. With the inefficiencies and several cost drivers in place, a new model of contracting with better ways of containing fraud, improving reimbursement turnaround times needs to be put in place. These learnings could help government sponsored social insurers to cut cost and serve more people.