Short Report 1 | Market Condition 4: Quality Services Available

Background:

The African Health Markets for Equity (AHME) project aims to make quality, affordable health services accessible to low-income populations in Kenya and Ghana. AHME aims to achieve this goal by: franchising private providers; offering them access to SafeCare, a step-by-step holistic quality improvement program; and providing access to Business Support and the Medical Credit Fund (MCF) loans program. In addition, AHME is assisting franchised providers to become accredited with National Health Insurance schemes in both countries; the National Hospital Insurance Fund (NHIF) in Kenya and the National Health Insurance Scheme (NHIS) in Ghana. To increase accessibility from the client side, AHME is assisting poor communities to become enrolled in the NHIs so that they are able to receive care at accredited franchised facilities. However, these clients have obvious financial constraints when paying out of pocket and likely need to make tradeoffs between quality and cost when accessing health services.

This short report examines what counts as "quality" care for patients and when they are more likely to prioritize quality over cost. It also examines the ways in which the AHME interventions mitigate the cost/quality tradeoff.

Methods:

Data was collected from patients in 2013 and 2017, and from private providers in 2013, 2015 and 2017. Working under the guidance of the AHME Qualitative Evaluation Team at the University of California, San Francisco (UCSF), Innovations for Poverty Action (IPA) field staff in Kenya and Ghana conducted interviews with providers to learn about their experiences with the AHME interventions, as well as exit interviews with women at private clinics to learn about their care-seeking behavior. IPA also conducted focus group discussions (FGDs) with community members in 2013. These FGDs focused on care-seeking behavior for a subset of the community. After each round of data collection, the research team at UCSF used an open coding approach to code and analyze interview and FGD transcripts using Atlas.ti qualitative data analysis software. The coding process indicated that data saturation was reached.

Results:

What counts as "quality"?

Patients described good quality in terms of the way they were treated in the clinic, the relationship they had with their provider, and perceived effectiveness of treatment. They sought out providers who treated them respectfully and in a friendly manner, in contrast to providers in public facilities who they often felt were rude or disinterested, and made them wait a long time to be seen. Further, patients appreciated doctors who took the time to listen and talk with them, and wanted their provider's guidance and counseling. This was especially relevant in relation to what patients saw as provider's professional knowledge and effectiveness; patients wanted to return to providers who appeared knowledgeable and had adequately treated their ailments in the past.

When patients prioritize quality

Although most patients tended to prefer the private clinics to a public hospital, they generally believed that public providers were better qualified and also better equipped than their counterparts in the private sector. So, clients were more likely to seek out public services when they needed specialty treatment. Since most acknowledged that public facilities are cheaper than private clinics, this choice did not involve a cost/quality tradeoff. However, patients were willing to make this tradeoff when dealing with day-to-day ailments and family planning (FP) needs; in these cases, they prioritized their relationships with private providers and the respectful treatment they received in private clinics, and were more likely to pay for services that would be cheaper or free in the public sector.

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AHME interventions mitigating the cost/quality tradeoff

- **Cost**: The **Franchising** and **Business Support** interventions have potential to ease the cost burden for patients. Through franchising, a steady supply of FP commodities and supported demand creation activities (Kenya) made FP services in particular more affordable. Training in drug stock management and basic bookkeeping through the Business Support program should also translate to fewer out-of-pocket costs for patients. However, it was unclear if this was happening.
- **Quality**: The **Franchising** and **SafeCare** interventions were useful for improving clinic quality. Providers appreciated SafeCare and were proud of their accomplishments through the program, often naming specific improvements they had made to their clinics as a result of participation. Patients appreciated the caring, respectful treatment they received from private providers and providers themselves felt the training they received in bedside manner from the franchise helped them better serve and retain clients.
- **Cost & Quality**: The **NHIF Accreditation Assistance** intervention (Kenya only) has potential to improve quality *while also* reducing costs to patients. To become accredited, providers must meet minimum quality standards. At the same time, accepting NHI payment makes clinics more affordable for clients.

Barriers to accessing affordable quality care

While achieving NHI accreditation is promising for mitigating the cost/quality tradeoff for patients, limited understanding of NHI coverage remains a barrier. Patients rarely knew exactly what was covered by the NHIs, leaving them vulnerable to informal out-of-pocket charges when they visited a clinic. Further, providers did not understand that capitation* entails risk-pooling across an entire patient population and often saw it as a "cap" on individual coverage. As a result, they often limited services to NHI-enrolled clients or charged them inappropriately when clients required services above this perceived cap.

Conclusions:

In conclusion, we found that specialty services did not involve a cost/quality tradeoff, but patients were willing to pay for quality when it came to basic outpatient services. Although patients preferred the respectful treatment they received in private clinics, they believed that public providers were both better qualified and better equipped to offer specialty services; these providers also are cheaper than visiting a private provider. However, patients chose small private providers they had relationships with for day-to-day services, such as treating fevers and receiving FP services. In these cases, patients often reported paying a small amount out-of-pocket. The AHME interventions played a role in balancing this cost/quality tradeoff, with NHI accreditation assistance particularly promising for decreasing cost while also ensuring quality of private providers. However, providers and patients need a better understanding of insurance in general, and specifically how capitation works, in order to more effectively ease financial constraints among low-income patients and make quality healthcare more accessible.

*All NHI-reimbursable outpatient services are covered under a capitation system in Kenya. Ghana has piloted capitation and is planning to scale up the system across the country.

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

For further inquiries regarding the AHME Qualitative Evaluation and to obtain copies of our 2017 Comprehensive Midline Report or most recent publications, please contact:

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