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AHME AFRICAN HEALTH MARKETS FOR EQUITY

Leveraging private health providers to achieve Universal Health Coverage

Lessons from the African Health Markets for Equity project

Luke Boddam-Whetham. December, 2019

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Introduction

In order to achieve universal health coverage (UHC), many low- and middle-income countries (LMICs) are increasingly embracing government health insurance schemes and other purchasing arrangements wherein publicly-pooled funds are used to purchase services for the poor. Involving private providers in such schemes has the potential to increase access to health services, ease pressure on the public health system and foster greater competition. For private providers, it represents an opportunity to grow their business in a hitherto untapped market.

While the logic of integrating private health providers into existing and emerging government health financing schemes targeting the poor is, for many, simple and appealing; making this marriage work in practice poses many practical challenges. Many private providers are small, offering a limited number of services at low levels of quality. This limits their ability to be accredited to the schemes. The private sector in many LMICs is characterized by extreme fragmentation. Contracting and then managing claims from numerous small private facilities poses an administrative challenge for government purchasers. Delays in payment by government purchasers can be debilitating to private providers who have to recover their full costs.

The African Health Markets for Equity (AHME) project, jointly funded by the Bill & Melinda Gates Foundation (BMGF) and the UK Department for International Development (DFID) and implemented by a partnership of organizations led by Marie Stopes International (MSI), worked to address these challenges in Kenya, Ghana and Nigeria for the past seven years (see box 1 for a description of the project). The purpose of this brief is to reflect on the project's implementation to highlight the top lessons as it draws to a close. To achieve this, we took stock of the rich body of project snapshots, briefs and reports produced by the partners over the course of the past six years documenting their experience from the field (all of which can be found at https://www.hanshep.org/our-programmes/AHMEresources). Through internal discussion, we synthesized the top ten take-away messages[1]. In section 2 below, we briefly summarize the vision behind the AHME project and the strategy AHME pursued in each country. In section 3, we turn to key insights from the field. We offer some concluding thoughts in section 4.

Box 1: Project description – AHME

The AHME partnership was an investment by the foundation and DFID to increase the use of quality essential health services by poor people in Kenya, Ghana, and Nigeria through a market-based approach. The multi-year project, which started in November 2012, focused on improving the range and quality of primary healthcare services provided by low-cost private health providers through social franchising, linking franchised private providers with government health insurance schemes that target the poor, and supporting policies that promote functioning health markets. A diverse group of partners with experience and expertise in complementary domains were involved in implementing the project; this includes MSI, Population Services International (PSI), Population Services Kenya (PSK), the International Finance Corporation (IFC), PharmAccess Foundation (PAF), Grameen Foundation and the Society for Family Health (SFH). While the project concluded its work in Nigeria in 2017, MSI, PSK, PSI and PAF continued implementing AHME activities in Kenya and Ghana until March 2019.

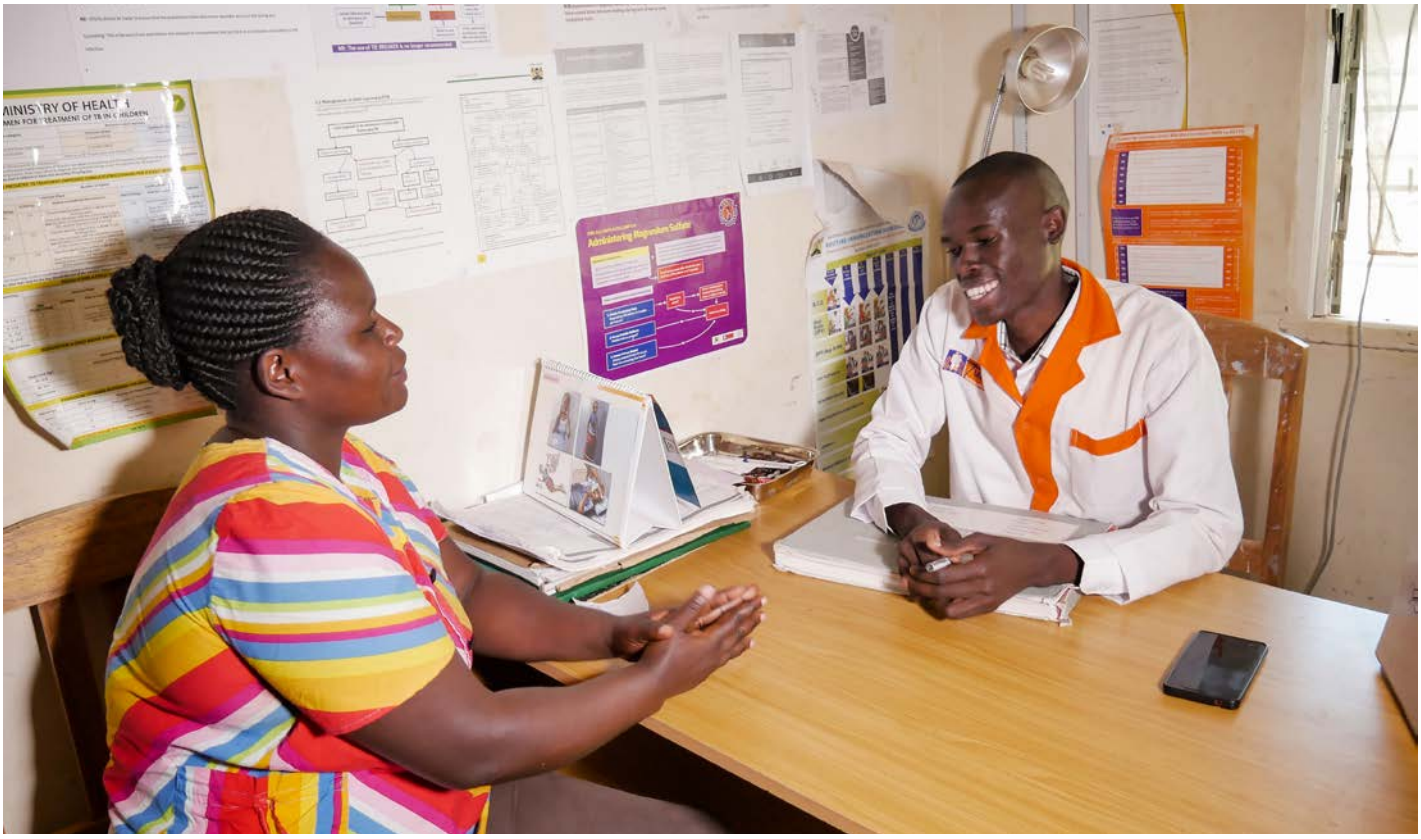
The Vision of AHME

The AHME theory of change

AHME was centred on the premise that private markets for health delivery are critical for expanding access to care for the poor. AHME's vision was to build functioning health markets where a poor woman can walk into a facility of her choice armed with a national health insurance card and receive quality health services free at the point of delivery. The AHME partnership identified five conditions that must be in place for this to happen.

1. **The poor are enrolled in government health insurance schemes.** In most countries, health insurance schemes have traditionally catered to formal sector employees and their families. In order for countries to maximize health equity and extend financial risk protection to all, governments have to subsidize services for the poor. AHME focused on ensuring that government health insurance schemes reach the poor through activities such as improving targeting mechanisms and community engagement to assist with the enrolment of the poor.

2. **Key primary healthcare services are covered.** Though primary and preventative care is the most cost-effective way of improving health status, health insurance schemes are often designed to cater for inpatient care and reduce the risk of catastrophic costs. AHME championed the inclusion of primary healthcare services in the benefit package offered by government health insurance schemes and advocated for reforms in how primary healthcare services are purchased in order to incentivize providers to deliver high quality services to all who need them in a cost-effective way.
3. **Accessible providers are contracted.** National health insurance agencies may prioritize contracting a few large facilitates for reasons of administrative efficiency and quality. However, as they extend population coverage to the poor, they have to grow their network of providers to ensure convenient physical access to health facilities for all their members. AHME worked directly with smaller, low-cost private providers to assist them with empanelment[2], and explored ways for franchisors to serve as a valuable intermediary between the insurer and a network of private providers.
4. **Accessible providers offer quality services.** Getting poor clients to accessible providers will not deliver health impact if the services the clients receive are not of high quality. AHME partners worked to measure and improve the quality of services offered by franchised providers, and to strengthen the regulatory authorities responsible for accrediting them.
5. **Providers run viable businesses.** AHME sought to promote a market for health services in which providers can build their businesses and attract investment by providing quality health services to poor clients. To this end, AHME partners supported providers to improve their business skills as well as gain access to credit to grow their businesses.



Above: A client undergoes a consultation with Tunza service provider in Kenya. *PSK*

AHME in Kenya

Payments for health services at the point of use constitute a critical financial barrier to access and cause financial hardship amongst the poor in Kenya. This is closely related to the fact that only a fifth of the Kenyan population is covered by insurance mechanisms featuring pre-payment and risk pooling according to the most recent Kenya Demographic and Health Survey. Most Kenyans (16%) who have insurance are covered by the National Hospital Insurance Fund (NHIF), which purchases services from both public and private providers. Only 1% are covered by private insurance[3]. Expanding NHIF coverage to the poor and informal sector households is a key priority for the Government of Kenya.

Against this backdrop, AHME's work in Kenya focused on:

- **Removing financial barriers to access for the poor:** AHME partners supported NHIF to test and scale up the Health Insurance Subsidy Program (HISP)[4]. This included both technical assistance from the IFC to design and evaluate HISP, as well as field-based support from PS Kenya, Marie Stopes Kenya (MSK), and PharmAccess to use community health volunteers to engage beneficiaries of the government Health Insurance Subsidy Programme (HISP) and increase their knowledge about program benefits.
- **Strengthening delivery of primary care in the private sector:** PS Kenya and MSK expanded their Tunza and Amua social franchise networks, with a focus on providers situated in poorer geographies. They supported franchised facilities to improve the quality of services offered using both the franchising approach and SafeCare to benchmark improvement in structural quality.
- **Networking private health providers and linking them to NHIF:** MSK and PS Kenya supported franchised health providers to navigate the NHIF empanelment and contracting process, and become better at attracting, retaining and managing NHIF members. PS Kenya developed and tested an aggregation model wherein a social franchisor serves as an intermediary between a healthcare purchaser and private providers.
- **Improving provider business:** PharmAccess' Medical Credit Fund (MCF), PS Kenya and MSK worked collaboratively to assist private health businesses access to working capital, to upgrade their facilities, and improve their business management skills and practices.

AHME in Ghana

Ghana's National Health Insurance Scheme (NHIS) covers approximately 40% of the population. This membership is skewed towards wealthier, better educated, urban populations[5] where there is easier access to healthcare providers. Thus, there is a focus in the development community on how to better reach and retain poor, rural populations in the membership. Households assessed as poor are eligible for their insurance premiums to be waived.

The majority of health care providers see the value of being part of the NHIS. However, for smaller providers, and especially those away from the capital, Accra, achieving the required standards and negotiating the bureaucracy to become accredited is a challenge. Additionally, once accredited and providing services, reimbursements from the NHIS can take over a year. This can result in significant financial challenges for small businesses with little or no cash reserves.

Against this backdrop, AHME's work in Ghana focused on:

- **Removing financial barriers to access for the poor:** AHME partners worked with the National Health Insurance Authority (NHIA) to digitize a proxy means test tool for assessing household poverty. NHIA field workers were trained to apply this tool in rural communities, enabling real time identification of households eligible for NHIA fee exemption.
- **Securing key primary health care services in the benefits package:** Marie Stopes International Ghana worked with the NHIA to identify the key obstacles to the inclusion of family planning in the benefits package and to practically test how inclusion can be actioned. At the same time AHME co-financed the development of an actuarial model for the NHIA to test different scenarios for a PHC package in the NHIS.
- **Networking private health providers and linking them to NHIA**: MSIG supported franchised health providers to navigate the NHIS accreditation process, and become better at attracting, retaining and managing NHIS members. This included supporting providers to be assessed by the Health Facilities Regulation Authority (HeFRA) and to achieve their minimum standards.
- **Quality improvement:** MSIG worked with PharmAccess' SafeCare to evaluate and improve the quality of services being provided to clients.
- **Improving provider business:** PharmAccess' Medical Credit Fund (MCF) and MSIG worked collaboratively to assist private health businesses to access working capital to upgrade their facilities and improve their business management skills and practices.

AHME in Nigeria

Despite having been in existence for 14 years Nigeria's NHIS is yet to cover more than 5% of the population. As a response to this slow development several Nigerian states have looked to roll out their own health insurance. AHME looked to work with the Ogun state health insurance, known as Araya. Despite a promising launch in 2014, political commitment and several progressive policy decisions around equity and private sector engagement, the Araya scheme experienced on-going challenges, forcing AHME to take the difficult decision to withdraw from Nigeria. However, during the time AHME worked in Nigeria the project:

- Removed barriers to private provider participation in health insurance: AHME partners developed and saw passed a policy that enabled franchise networks to participate in State led Health Insurance.

Key Lessons

Lesson 1:

The poor may not automatically enrol in and use a UHC scheme even if it is free

In most UHC schemes targeting the poor, the government typically provides a full or partial subsidy to cover the premium for poor households. The presumption is that once the eligibility of a household is established based on their poverty status, the household will both enrol for the scheme and use the services.

Both countries have covered the full cost of NHI insurance premium for poor households, using poverty assessments to identify eligible households and giving them an entitlement to free access to the NHI. However, the project's experience in Kenya and Ghana suggests that this presumption is naïve; indeed, the poor face a number of hurdles that keep them from enrolling in and using a scheme even when it is completely free of cost. This has been confirmed by several studies that have found that the health insurance systems in Ghana and Kenya have not been successful at reaching the poor [6,7,8].

In Kenya, PS Kenya, MSK and PAF deployed community health workers (CHWs) to assist NHIF with enrolment. The CHWs continued to follow up with the enrolled households for one year after the program started, to both assist the households to better understand the scheme and collect data about their experience. While NHIF officials used community outreach events to explain the scheme and circulated written materials explaining how the scheme works, the one-on-one communication and support provided by the CHWs was critical to get eligible households registered into the scheme Even after registration, many participating households needed extra support to understand how the scheme works and navigate the NHIF system. This underscores the need for ongoing community-based outreach and support for program enrolment, and linking UHC health financing schemes with community health programs in LMICs.

In both country contexts, even once poor clients are enrolled they often let membership drop, as renewing their membership can be costly and registered service providers are hard to access outside of wealthier urban areas. There is little motivation to invest in the process.

Neither health insurance schemes in Kenya nor Ghana prioritized enrollment of the poor from the outset and political will to change this has not translated into sufficient investment to make it happen. The AHME experience suggests that, if countries want to achieve UHC then all major NHI design decisions need to be made with the hardest to reach in mind. For example, premiums are a barrier to NHI membership for the poor in the same way that user fees discourage uptake of health services; and effectively identifying the poor to waive premiums is costly. Where premiums make up only a small portion of revenue, as in Ghana, countries should consider whether collecting them from the informal sector is worth the time and resources. They may decide that the focus should be on improved revenue generation elsewhere in the tax system.

Lesson 2:

Social franchising programmes can reach the poor, when they prioritize working with health facilities close to their communities

Social franchising as a movement has a long history; starting life in the 1990s in healthcare and spreading to other social sectors. SF for health aimed to use existing health care providers, already being used by populations, to provide quality health services.

With donor support, organizations like Marie Stopes International and Population Services International have recruited private health providers into their networks, implemented trainings and supportive supervision programs to enhance their quality and improved access to commodities for FP and other primary healthcare services.

A number of recent evaluations/studies have shown that social franchising initiatives have been successful at improving quality and extending coverage of services but have struggled to reach the poorest of the poor[9]. Indeed, AHME's own client exit interviews showed this to be the case.

This is likely a function of two factors. First, private providers charge fees which the poorest of the poor typically cannot afford. Unless there is a demand-side attempt to remove financial barriers, improving the supply of quality services through the private sector will not benefit such households. Second, the location of the facility matters. Most private providers locate themselves near populations that can afford to pay for their services. To the extent franchisors have not prioritized franchising those health facilities that are situated in the poorest areas, they are unlikely to serve the bottom wealth quintiles.

The first of these two barriers can be addressed by a UHC scheme; indeed, the central purpose of such schemes is to enable program participants to access services from accredited public and private facilities without having to pay any fees. MSIG's experience under AHME speaks to the second issue. Using client exit interview data, the project has been tracking the percentage of its clients that are from wealth quintiles 1 and 2 (Q1 and 2). At the start, the percentage of Q1 and 2 clients attending franchisees was very low. However, MSIG made concerted efforts to identify and franchise smaller health facilities in poorer areas and, as a result, numbers of clients in Q1 and 2 have significantly increased[10]. MSK franchisees are also reaching more clients in Q1 and 2 than other for-profit providers[11].

The "equity" question has been at the heart of recent discussions amongst international development partners supporting private sector initiatives about the future of social franchising. Recent studies showing that franchised facilities are not reaching the poor may cause some to question the whole franchising approach; however, the AHME experience suggests that franchising can still be an effective tool to improve access to quality PHC services for the poor if the facilities are selected smartly.

There is also a lesson here for purchasers of health care. Where public health services are weak and private services are easily accessed, the poor will use them. Thus, purchasers should recruit providers where the underserved are and, where there are few or none, use their purchasing power to incentivize providers to work in those areas.

Lesson 3:

Small private providers face significant bureaucratic hurdles when trying to work with UHC schemes

In Kenya, MSK and PS Kenya supported facilities in their PPNs to gain entry to NHIF. The providers initially view serving NHIF clients as an important business opportunity and are keen to sign up for contracts. For its part, at a senior level NHIF has been eager to onboard more private facilities into the network as it tries to expand its network of facilities. Despite interest on both sides, the smooth induction of facilities into NHIF posed challenges.

This is linked to two issues: the complexity of the process and insufficient clarity on the process. The NHIF empanelment process historically involved many steps, with providers having to pay a fee to apply to the scheme and produce a range of documents; followed by a site-visit by NHIF to assess the facility. If the facility met the requirements, it was presented to the NHIF board for approval. Once approved, the facility had to be "gazetted" by the official government registrar. The whole process was long, costly and prone to delays; all of which were significant obstacles to facilities enrolling. Additional inconsistencies in interpretation of the rules from district to district only exacerbated this.

In the past few years, and in no small part due to the work AHME partners have done to highlight these challenges, NHIF has simplified the process, streamlining the inspection process and removing the application fee. Even so, there is very little written guidance available from NHIF on the precise steps, common challenges, and trouble-shooting strategies. Consequently, providers continue to struggle with the process, unsure about issues like the appropriate category of facility under which they should apply, whether they have the right documents, etc. AHME took steps to address this – see lesson 9.

Given the volume of primary health services accessed through smaller private providers[12] and their corresponding importance in achieving UHC governments/institutional purchasers need to consider their needs when designing and rolling out UHC schemes.

Below: A small business owner and health service provider from an Amua clinic in Kenya. *MSI*

Above: A happy Amua client with her baby. *MSI*

Lesson 4:

Delayed payments by purchasers is never good for any provider; it could be catastrophic for small private healthcare providers

In both Kenya and Ghana, public sector facilities continue to receive significant input-based financing to cover staff salaries, drug costs, etc. The output-based payment from the government health insurance scheme is essentially a top-up to cover their operating costs. This is not so for private facilities, which have to recover the entirety of their costs. In such a context, delays in payment – be it claims reimbursement under fee for service or quarterly payment under capitation – pose a big challenge for private providers.

In Kenya, NHIF has historically performed well in terms of timely settlement of inpatient claims to hospitals[13]. However, payments to smaller facilities under the outpatient scheme face delays – several providers interviewed in Kenya complained about delays in the release of their quarterly capitation payment. Moreover, "sponsored" or subsidized government programmes can be prone to the vagaries of the budgeting process. If treasury is slow to release funds to NHIF for a sponsored scheme, or places a temporary halt, as has happened with the Linda Mama scheme in Kenya, then NHIF in turn halts payments to providers[14].

In Ghana, payments from NHIA are frequently delayed and are unpredictable. AHME partner MCF developed a receivables financing product to assist facilities "weather the storm." Credit is extended to NHIS registered facilities to help smooth their cashflow while their claims for reimbursement are being processed and paid. The capital plus interest is paid back from the NHIS payment, when it arrives.

Some small health care providers are put off joining the NHIA by this payment uncertainty and also consider dropping out of the NHIF in Kenya. If governments want to attract and retain private health providers to UHC schemes, improving payment processes will be critical. In the meantime, market-based solutions like the receivable financing product can help address critical system gaps.

Lesson 5:

Lack of clarity around the benefit package mars the effective implementation of pro-poor UHC schemes

In both Kenya and Ghana, the national health insurance agency does not provide sufficient information about what is (and is not) included in the benefit package to providers.

In Kenya, for example, how family planning services are covered under the outpatient benefit package remains contested. There is extreme inconsistency in the understanding of this issue across NHIF branch officials, county government officials, and facility managers; many of those interviewed on this subject by AHME implementers believed that FP is not included in the outpatient package because it is offered for free in public facilities.

Where FP's inclusion in the package is clearly stated, which specific services are covered is not explained. In the absence of this clarity, providers continue to interpret the benefit package differently and, more critically, deny certain priority services like FP to their clients or continue to charge for them, as they err on the side of caution rather than risk providing a service they will not be paid for.

This underscores the importance of (1) a clearly defined and documented benefit package that is precise about exactly what interventions are covered, exclusions, benefit limits, etc. and (2) proper communication of the same to participating providers and follow-up to ensure that the providers are cognizant of the package.

Right: Enrollment into the Health Insurance Subsidy Programme in Kenya. *MSI*

Lesson 6:

Schemes developed to achieve UHC should include preventative services such as family planning from the start.

AHME experience suggests that governments may not see the need for the integration of vertical programmes such as contraceptive services into UHC schemes such as national health insurance, as commodities and services are often subsidized by donors. This subsidy does little to incentivize the integration of these services and leaves decisions on them vulnerable to donor policies as much as to public health priorities. In the short term this risk serves to show the critical importance of alignment of national and donor policies into a single UHC strategy in country. In the medium to long term[15] countries should be looking to fund these services through the same arrangements as they fund other primary health care. The experience of AHME and those the project has worked with in both Kenya and Ghana is that adding services to the benefits package is a resource intensive, lengthy process with no guarantee of success, made all the more difficult when a service has been vertically funded for many years.

Lesson 7:

Quality improvement does happen when providers are supported, but effective regulation is essential

Quality of care remains a concern in many LMICS, and it is a complex issue to address. While financing schemes can remove financial barriers to access and drive up coverage, this may not translate into improved health outcomes if the services being delivered are of poor quality.

The AHME experience offers several insights about improving quality amongst low-cost private health providers:

Firstly, confirming other studies, social franchising, with the application of robust quality improvement approaches, can improve quality in private providers. AHME franchisees, evaluated and guided using the SafeCare methodology improved across a range of quality indicators.

Secondly, providers need to see the positive benefits of addressing quality to devote resources to it; not just see quality improvement as a box they are required to tick. PAF have worked closely with the quality regulators in both Kenya and Ghana to align their respective methodologies and Safecare was a big influence on the final form of the Kenyan national quality standards. Thus, achieving improvements in SafeCare is seen as facilitating the quality standards needed to become accredited/empanelled in NHI. This is motivating for providers. In Ghana, of the 80 Bluestar facilities that have been enrolled into SafeCare, 65 (85%) started at level 1. As a result of the support provided to those facilities by MSIG and PAF 7% have attained SafeCare Level 4, 29% have attained Level 3, 54% have attained Level 2 and only 10% remained at SafeCare Level 1.

However, thirdly, effective regulation is needed to ensure minimum standards are maintained. Governments/purchasers must invest in active regulation and collaborate across the sector. AHME has worked closely with the Health Facilities Regulation Authority in Ghana and seen firsthand how under-investment results in ineffective quality oversight. AHME has demonstrated how third-party organizations can facilitate the process of quality accreditation for both provider and regulators in Ghana. These partnerships should be explored further by regulators in future. Through its social franchises AHME has seen that without an effective ‘stick’ of regulation, not all providers will prioritize improvements in clinical quality unless there is a strong motivation to do so. Other approaches are needed. Organizations such as MSI, PSI and PAF can improve quality through supporting providers with training and quality improvement. However, this has its own limitations and would be more effective if there were appropriate incentives from regulators and purchasers for providers to improve.

Lesson 8:

Small and medium sized health care providers are often inefficient, but can improve

PS Kenya, MSK and MSIG all recognised the low financial and administrative literacy of many of their franchisees and ineffective business processes. They worked with the franchisees and with PAF to improve their business skills and their eligibility to access formal credit.

The market for credit for health providers is still developing in Kenya and Ghana. AHME was successful in opening it up[16] and in improving provider access to it. In Kenya, PS Kenya saw a range of positive impacts of their business training on franchisees including increased scope of services offered, revenue increases and improved business acumen. In both countries franchisees recognised business support as one of the most valuable elements of the franchise support package

Below: A numerator checks a client's eligibility for a fee waiver. *MSI*

Lesson 9:

A strong intermediary function has the potential to address many of the challenges associated with linking private providers to purchasing schemes

A strong intermediary organization to smooth the interaction between NHI and small private providers has the potential to address several of the challenges discussed above.

In Kenya, MSK and PS Kenya have played an important role to help private providers navigate the empanelment process. MSK supported providers through each step, from helping them to decide which type of contract to apply for, to introducing providers to the NHIF and their requirements, helping providers secure necessary documentation and fill in applications, supporting providers to prepare for inspection visits, following up with NHIF on approvals and facilitating communication between the provider and the NHIF[17].

In Ghana, health care providers in facilities to be accredited by the Health Facilities Regulatory Authority (HeFRA), maintain registration with their professional body and register (and re-register) with the NHIS. Each process is time consuming (some rural providers have to travel up to 13 hours to the capital to submit paperwork), incur cost and can easily be overlooked in small provider set ups with no dedicated administrative function. 80% of franchise ffacilities found the process cumbersome, with inadequate information sharing between HeFRA and providers, and with concerns that this may delay NHIS accreditation. Providers also reported challenges in obtaining the necessary certificates (eg. From the Environmental Protection Agency, Fire Service, District Assembly) required for submission to HeFRA, and stressed the difficulty of travelling into Accra to access HeFRA's offices.

In response, MSIG facilitated the HeFRA licensing process for all of the BlueStar franchise facilities by:

- Enabling the migration of facility information onto the new HeFRA database.
- Delivering and following up on submissions to reduce the time burden on providers.
- Clarifying communication between HeFRA and facilities to ease the process for both sides.
- Handling the transportation of applications and follow up documents to the Accra office, reducing travel costs and time for providers.
- Submitting documents in bulk. (This has proven so effective that HeFRA assigned a designated officer to handling BlueStar cases)[18].

In addition to this practical support, the intermediary can play other roles. It can ease the flow of funds between NHI and providers by assisting smaller providers to submit proper claims, advocating for timely payment by NHI, and serving as a broker for financial products that can serve as stop-gap solutions for delayed payments. An intermediary that networks numerous small private providers can address the problem of fragmentation and can serve a range of other value-add functions, like quality assurance, pooled purchasing of commodities, etc.

This kind of support represents an evolution of the social franchising model.

Under AHME PS Kenya explored this expanded intermediary role with a view to developing a financially self-sustaining model for a private network aggregator. In addition to their standard package of social franchise support to members (quality assurance, demand generation) they offered business skills development, facilitation of insurance administration, investment in a health records/claims management system and cost savings on the purchase of commodities. At the time of writing 50 franchisees and 2 private insurance companies were actively engaged in the model development. The ultimate aim is to engage NHIF as a client[19].

Governments and/or purchasers of health services (both public and private) should consider how intermediary organisations (such as NGOs) could help to consolidate a fragmented private sector – especially lower level providers of primary health care.

Lesson 10:

Health System Strengthening in low-middle income countries requires attention on the private sector as much as the public sector

AHME partners' experience of working with government departments and purchasers of healthcare has shown that they need extra capacity to deal effectively with the varied and fragmented health service delivery sector. Government and national purchasers often focus their efforts predominantly on the public sector and/or large, organized private providers; not the small and medium sized ones that provide a great deal of the primary health care services in many countries. Thus, standards set for providers to work with national purchasers are skewed towards higher level facilities, working with NHI is administratively burdensome, and private providers are often held to a different standard than public facilities. Additionally, in low- and middle-income countries, the majority of private health care providers are not well organized and often do not have the right skills to effectively operate and engage with regulators and purchasers. In collaboration with health sector partners governments, in their role as both stewards of the health system, need to address these challenges to ensure a well-functioning health system.

Below: NHIS registration drive.
MSI

The way forward

AHME set out to show how, by addressing supply and demand side challenges both through technical innovation and policy change, the poor could easily access primary health care services from private providers. This evolved into the 5 market conditions described earlier in this paper as the partners learned more about what combination of factors influenced the projects desired outcome.

In its longevity the AHME project has been unusual in the international development world. With this longevity has come the opportunity to learn and iterate as the project has progressed. The resulting project has produced a diverse set of lessons, the most pertinent of which we have attempted to summarise in this document.

As anyone who works to strengthen health systems knows, creating the conditions for improvements to take place is complex and takes time. The change that is needed is as much political as it is technical.

A call to action

1. AHME's experience has added to a growing body of evidence and debate on the role of the private sector in achieving UHC. The project's experience of working to improve enrolment of the poor in NHI has emphasised the need for public subsidy of health care costs for the poor but cast doubt on whether a health insurance approach that requires resource mobilisation through premium collection is the best approach for low-middle income countries if they are serious about reaching the poor. **Governments and those advising them should consider alternatives to raising premiums from the informal sector.**
2. If governments are serious about reaching all citizens with services then quality services need to be made conveniently available to target populations. The private sector can support the public sector to do this, but **governments needs to make it straight forward for private providers to be contracted into NHI; they need to structure payments to incentivise providers to serve target groups and need to invest in quality assurance – through effective regulation and guidance.**
3. **Technical and donor partners to governments should work with them to:**
    a. **Establish mechanisms by which a fragmented private sector can be represented.**
    b. **Build/support intermediary organisations to facilitate purchaser-provider-regulator interaction and systematically support quality assurance; as partners or contractors to government.**

In the short term, and where fiscal space is limited, this can be done with donor funding but, longer term, it is incumbent on all to find a way to sustain this.

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