



Private Sector Analysis for the DPP Kenya and RSA

November 2020

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Key Themes: Private Sector Introduction for the DPP – Kenya & RSA

1

User patterns in DPP target populations cleanly align with private sector channels.

Young women in particular meet their FP needs, including OCPs, through private sector channels. Most of that care is paid for out of pocket. In Kenya, stated preferences to access PrEP in private sector indicate opportunity for the DPP.

2

Lean on existing private sector engagement models and public-private partnerships (PPPs) to address financing challenges

RSA in particular has deployed diverse and strong models to address financing and product access. PPPs such as down-referral models and the Central Chronic Medicine Dispensing (CCMD) and the PIMART program open doors to delivery, which Kenya can draw from.

3

The private sector is not immune from provider challenges

Data from ECP, PrEP and OCP delivery reveal that provider knowledge, attitudes and capacity present real challenges in the private sector. Approaches must build in robust provider behavior change interventions to support women on their pathway to care.

4

Private sector engagement for the DPP will be closely tied to the roll out of National Health Insurance (NHI) and inclusion in NHIF

DPP private sector models need to align with evolving NHI and NHIF priorities, ensuring the DPP is included in the final minimum benefits package. The NHI and NHIF includes strong support for private providers and will be rolled out soon.

5

Reach deep to target providers within channels that serve low-income populations

Highest priority service delivery channels are 1) pharmacies and 2) private providers. Pharmacists are now able to prescribe PrEP. Consider targeting independent community pharmacies that are more likely to serve lower income populations, and GPs with a lower income client base. Build on existing private sector contracting out models with both channels.

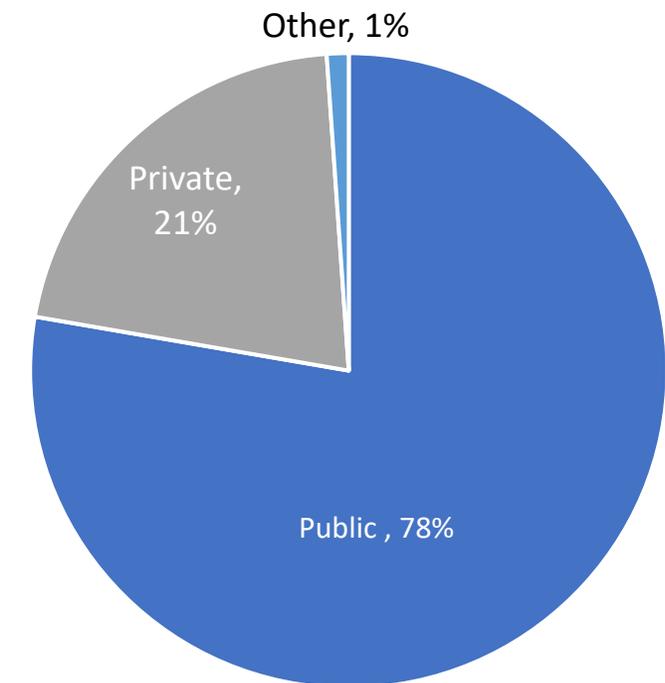
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- **About 27% of the population access** care through private doctors, clinics and hospitals.
- 20% of the population accesses contraceptives through the private sector & 'other' sources such as shops, workplaces, and community centers.
- Of those that use OCP, 21% access through private providers.
- Users in the private sector obtain OCPs from pharmacies and private doctors.
- ***Perceived quality of care is high: 92.6% South Africans report being very satisfied with private healthcare institutions (SAGHS, 2018)***

Source of OCP





Target Population: WRA; rural and urban; low to middle-income

Evidence

- 24% of the population reports consulting a private doctor when ill or injured.
- Private practitioners **already prescribe & sell ARTs, PrEP & FP.**
- Practitioners **serve large populations in DPP priority provinces**, including low-income populations without insurance.
- SAHIVCS has initiated training of doctors on PrEP.
- GPs are **targeted for inclusion within NHI.**
- **Experience in PPPs** found that clients perceived private GPs to provide improved confidentiality / privacy; quality of care; less wait time; improved enrollment and appointment-making.
- **PPP down-referral models** have enabled free services to the end user through donor funding.

Benefits

- ✓ Private providers perceived as less stigmatizing, offer high reach, convenience, quality, and confidentiality.
- ✓ Contracting GPs is seen as the future of private providers w/NHI.
- ✓ Strong existing models of down-referral from public to GPs; can integrate DPP into PPP mechanisms for HIV.
- ✓ Benefit from broader efforts to engage GPs in delivery of HIV care in NGO and contracting models such as Right to Care.
- ✓ Well organized clinician associations to leverage, such as SAHIVCS.

Limitations

- ✗ Financing presents challenges for a product exceeding user ability to pay. Requires engagement of 3rd party payer, with incentives designed for differentiated services component.
- ✗ Data systems aren't aligned with public sector systems.
- ✗ Capacity limitations: targeted training required to dispense, support adherence, counsel, & refer (for testing).

Private providers/GPs identified as priority channel for DPP introduction, positioned for Phase 3 implementation



Alignment with User Behaviors & Preferences	Cost-effectiveness	Health System Readiness	Strength of M&E Systems	Scalability
<ul style="list-style-type: none"> - GPs serve WRA; rural and urban; low to middle-income. - Experience in PPPs found that clients perceived private GPs to provide improved confidentiality / privacy; quality of care; less wait time; improved enrollment and appointment-making. 	<ul style="list-style-type: none"> - Financing presents challenges for a product exceeding user ability to pay & requires engagement of 3rd party payer. - GPs are targeted for inclusion within NHI. - Strong existing models of down-referral from public to GPs with free services; can integrate DPP into PPP mechanisms for HIV. - Can benefit from efforts to engage GPs in delivery of HIV care in NGO contracting models such as Right to Care. 	<ul style="list-style-type: none"> - Private practitioners already prescribe & sell ARTs, PrEP & FP, although low numbers for PrEP. - Data systems aren't aligned with public sector systems. - Capacity limitations: targeted training required to dispense, support adherence, counsel, & refer (for testing). 	<ul style="list-style-type: none"> - Despite the frequent use of electronic records, these are rarely integrated with hospital or provider system. - 2 successful down referral models for ART employed electronic data systems. 	<ul style="list-style-type: none"> - Over 14k GPs. - 70 nurse-run Unjani clinics serving 40,000 clients/month. - Well organized clinician associations to leverage such as SAHIVCS.

**Numbers in country columns correspond to the phase recommended to introduce DPP in that channel. "X" signifies channel will not be prioritized.*



Target Population: AGYW/WRA; urban/per-urban/rural; low to middle income

Evidence

- **Pharmacies play modest but important role for FP** - while 15% women access OCPs through pharmacy. Exception is EC; sales total ~1.2m/year.
- **Pharmacy sites have started prescribing PrEP, PEP and ARVs through the EPIC project; 1,500 pharmacy sites expected to be up December 2020, 390 pharmacy sites are already prescribing.**
- Pharmacies are **aligned with DPP priority** provinces: 71% are community pharmacies, which are more likely to serve DPP target pops.
- The 1,100 Independent **community pharmacies**, predominantly in peri-urban and rural areas and serving low-income populations, drive 60% volume/value.
- (Community) pharmacies are **already contracted and engaged in diversity of PPPs** to deliver FP, immunization services, chronic care (through central medicine dispensing) and HIV self-tests.

Benefits

- ✓ **Pharmacies are perceived as accessible, discreet, convenient, and of high quality**, specifically for AGYW. Well positioned to address re-supply. Retail pharmacies are fastest growing type, potential for DPP.
- ✓ Pharmacies are a priority cadre for coverage under NHI, and seen to enable reach to the “missing middle” for HIV.
- ✓ Well organized pharmacy associations to leverage such as ICPA.
- ✓ Opportunities to learn from existing FP and nascent PrEP/treatment models of delivery & payment in pharmacies; PrEP/PEP delivery recently started through EPIC project building off ART wins.

Limitations

- ✗ Capacity limitations: variable quality, targeted training required to sell and support adherence, counsel, & refer; lack of space for counselling.
- ✗ Financing challenges for a product exceeding user ability to pay & requires engagement of 3rd party payer.
- ✗ Data systems aren't aligned with public sector systems. But has been done in projects, e.g. Right to Care project in Gauteng.
- ✗ Current contracting models don't cover full costs to pharmacists.



Pharmacies viewed as high potential and targeted for Phase II introduction

Alignment with User Behaviors & Preferences	Cost-effectiveness	Health System Readiness	Strength of M&E Systems	Scalability
<ul style="list-style-type: none"> - Pharmacies favored by AGYW / WRA; urban/peri-urban/rural; low to middle income populations - Pharmacies are perceived as accessible, discreet, convenient, less stigmatizing, and of high quality, specifically for AGYW. - 71% are community pharmacies, which are most likely to serve DPP target pops. 2/3 of the DPP priority provinces, Gauteng and Mpumalanga, report the highest community pharmacy density. 	<ul style="list-style-type: none"> - Financing challenges for a product exceeding user ability to pay & requires engagement of 3rd party payer. - Pharmacies are a priority cadre for coverage under NHI, and seen to enable reach to the “missing middle” for HIV. - (Community) pharmacies are already contracted and engaged in diversity of PPPs to deliver FP, immunization services, chronic care (through central medicine dispensing) and HIV self-tests. - Current contracting models don’t cover full costs to pharmacists. 	<ul style="list-style-type: none"> - Plan to provide Section 22 permit to pharmacists to prescribe PEP, PrEP, and ART. - Pharmacists have started prescribing PrEP, PEP and ARVs through the USAID EPIC project; 1,500 pharmacy sites are planned to be supported by December 2020, currently 390. - Capacity limitations: variable quality, targeted training required to sell and support adherence, counsel, & refer; lack of space for counselling. - Well positioned to address re-supply. 	<ul style="list-style-type: none"> - Some pharmacists use electronic dispensing systems to file claims with medical aid schemes, but few report into national systems. 	<ul style="list-style-type: none"> - 3,400 community pharmacies; Retail pharmacies are fastest growing type. - Electronic pharmacies (<u>RightE Pharmacy</u>) are expanding access, using automated dispensing and telemedicine.



Three High Potential Financing Mechanisms can Support Rollout

Payer (Financing Mechanism)	Description	Implications for the DPP
<i>Out of Pocket Payment</i>	<ul style="list-style-type: none"> 12.5% of total health expenditure in the private sector is out of pocket. 	<ul style="list-style-type: none"> Despite pricing regulation, the DPP is likely to be out of reach for the vast majority of low-income South Africans who use OOP payment to access medication.
Private Insurance (<i>medical aid schemes</i>)	<ul style="list-style-type: none"> Private insurance schemes accessed through an employer or purchased directly by a client. 90+ medical aid schemes exist, majority are through employers. Legally required to cover services defined in a minimum prescribed benefits package (MBP). 	<ul style="list-style-type: none"> Some misalignment with DPP target populations: private insurance serves older women Mandated to cover core services in the prescribed minimum benefits package. HIV testing/treatment are in the MPB, contraception infrequently covered, and PrEP not yet. Significant work required to get schemes to include a new medication in their formularies for reimbursement. Data require include pharmaco-economic evaluations as well as price negotiations. Price of DPP should not exceed combined price of PrEP and cheapest OCP. Early engagement is required as important to get in MBP.
Government & Donors (<i>Services contracting</i>)	<ul style="list-style-type: none"> History of public-private partnerships, particularly HIV treatment. GPs / pharmacies engaged to manage clients and dispense medicines for critical health services. NHI rollout prioritises contracting out to private sector GPs and pharmacists. Expected to grow w/ roll out of NHI. 	<ul style="list-style-type: none"> Private sector engagement models central to discussions about NHI, which will phase in health care delivery to a single payer system; full implementation expected by 2025. Under several PPP initiatives, drugs are provided by NDOH directly to providers and pharmacists. This supply chain has expanded rapidly in the last several years with the introduction of central chronic medicine dispensing.

3rd Party Payer Model Assessment: Strengths, Weaknesses and Implications



Payer	Strengths	Weaknesses	Implications
<p>Direct AIDS Intervention (DAI) Model <i>Expand uptake of HIV services covered by medical aid schemes, e.g. Right to Care</i></p>	<ul style="list-style-type: none"> Leverages existing healthcare system where private providers are comfortable. 	<ul style="list-style-type: none"> Medical aid schemes do not always align with DPP priority populations. Requires medical aid schemes to approve DPP within their formularies – a challenge DPP will need to fit into existing initiative to expand access to FP or HIV as a product specific initiative is unlikely. 	<ul style="list-style-type: none"> Ensure implementation studies answer key questions for scheme medication assessments. Target open medical aid schemes which have lower average beneficiary age and greater racial diversity. Explore opportunities to integrate DPP within existing DAI models.
<p>Contracting to private providers/NGO clinics: <i>Contract private providers for quality HIV care, e.g. Right to Care, BroadReach and clinics offering subsidized services e.g. Unjani</i></p>	<ul style="list-style-type: none"> GPS are priority cadre for engagement w/ NHI. Strong models of down-referral exist; patients choose from a list of qualified GPs. Voucher programmes could reach most vulnerable. Already delivering OCPs (Unjani) 	<ul style="list-style-type: none"> Funding dependent, but NHI provides a pathway to achieve this. Data systems not aligned with public sector systems. PrEP delivery has been weak to date (but fluid) While growing, reach is limited. 	<ul style="list-style-type: none"> Integrate DPP within bigger initiatives to engage providers in HIV delivery As NHI discussions advance, ensure DPP included in the NHI package for GPs. Work needed to integrate private and public sector HMIS systems to ensure effective collaboration. Target initiatives that already work with providers that reach OOP payers with low-cost services.
<p>Contracting out to pharmacies: <i>Engage pharmacies to deliver primary health services on behalf of the public sector</i></p>	<ul style="list-style-type: none"> More easily allows for a product specific approach, rather than integration with a package of services. Priority cadre for engagement w/ NHI. Voucher programs potential to reach vulnerable. Already delivering OCPs and PrEP/PEP, ART delivery through EPIC. 	<ul style="list-style-type: none"> Not all pharmacies will have capacity to dispense without further training and requires Section 22A permit to prescribe PrEP. Requires sustainable financing; NHI provides pathway. 	<ul style="list-style-type: none"> Learn from PrEP and FP models of delivery in pharmacies, apply to introduction of DPP. Learn from EPIC project experience and integrate DPP into package.

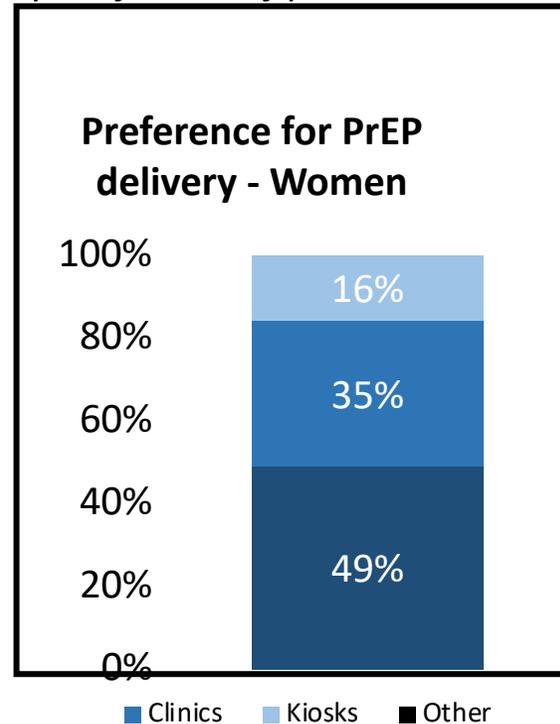


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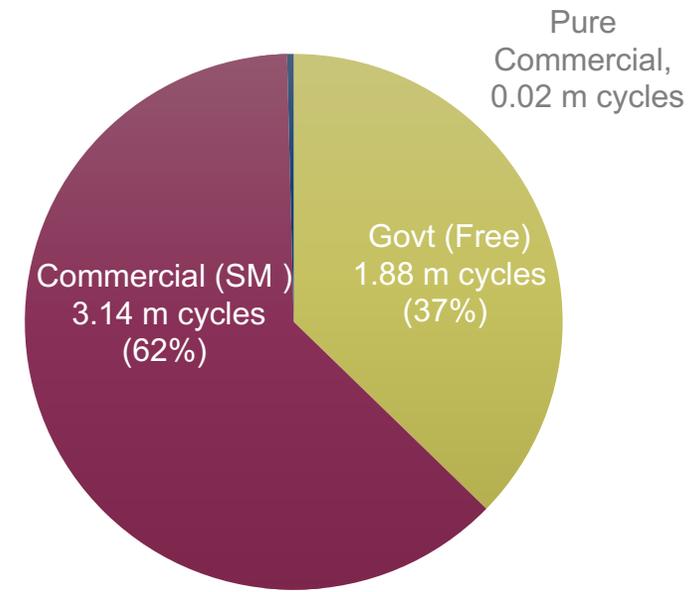


OVERVIEW: Private providers serve a critically important role in provision of health care in Kenya

- Priority Populations access their care through private providers: *About 47% of the poorest access care through the private sector, and nearly 40% of women overall.*
- Private providers are accessible: *Nearly 50% facilities overall in Kenya are private – 37% are purely commercial (11% faith based)*
- Willingness to pay is high (but represents a barrier) *Nearly 80% of health expenditure in the private sector is paid for out of pocket.*
- Private sector outlets overlap with DPP priority counties – utilization of private sector high in urban areas, although lower in lake region
- Women would prefer to access PrEP through the private sector: *While PrEP delivery through private sector is low, many women expressed preference to access through private outlets.*
- Ancillary support (HIV testing, referrals) is also high in private sector: *50% of private providers report offering HIV testing*



OCP Distribution driven through Private sector



Of those that use an OCP, 62% of supply is driven through private providers.

Franchised private providers identified as priority channel for DPP introduction, positioned for Phase 2 implementation



Alignment with User Behaviors & Preferences	Cost-effectiveness	Health System Readiness	Strength of M&E Systems	Scalability
<ul style="list-style-type: none"> - Nearly 40% of women use the private sector and the high utilization (20-40%) of private HIV ST, FP, and SRH - When given a choice women prefer to access PrEP through private sector - Bring strength in catering to women, AGYW - A significant portion (75%) women purchasing EC were young women between ages 20 and 29, aligning to target populations. 	<ul style="list-style-type: none"> - Financing presents challenges for a product exceeding user ability to pay & requires engagement of 3rd party payer. - Franchising traditionally have been more resource intensive - While . - Can benefit from complimentary investments in FP, HIV, MCH interventions. 	<ul style="list-style-type: none"> - Private practitioners already prescribe & sell ARTs, PrEP & FP, although low numbers for PrEP - Capacity limitations: targeted training required to dispense, support adherence, counsel, & refer (for testing). 	<ul style="list-style-type: none"> - Franchised clinics more likely to be supported with stronger M&E systems; most franchised clinics feed into DHIS2 for program and business data mgt. - PS Kenya is supporting Clinic Mgt systems (CMS) through Tunza facilities, reaching 40 	<ul style="list-style-type: none"> • ~5 social franchises, supporting 1,000 + clinics presents learning opp prior to scaling. • Over 3,500 clinics overall • Strong associations to help coordinate training (Kenya Healthcare Assoc, Africa Health Business, etc)



Pharmacies viewed as high potential and targeted for Phase II introduction

Alignment with User Behaviors & Preferences	Cost-effectiveness	Health System Readiness	Strength of M&E Systems	Scalability
<ul style="list-style-type: none"> - The traditional ‘entry point’ to health care system - Pharmacies are perceived as accessible, discreet, convenient, less stigmatizing, and of high quality, specifically for AGYW. - While (registered) pharmacies are primarily urban, high levels of overlap with DPP priority counties - Likely to offer lower cost products - ~50% preferred pharmacies to access PrEP (PriYA project) - 	<ul style="list-style-type: none"> - Financing challenges for a product exceeding user ability to pay & requires engagement of 3rd party payer – most likely direct supply of subsidized product. - Tiered pricing will be required to support service element of DPP. - Engaging pharmacies early in prescription aligns with opportunity to cost effectively support resupply. 	<ul style="list-style-type: none"> - While some task shifting required to support prescription, but dispensing / refilling possible. - Pharmacy-based PrEP dispensing allowed in Kenya’s national PrEP guidelines; pharmacies can already support with HIV test. - Kenyatta University/ KEMRI/ UofW Pharmacy-based PrEP initiation (PPI) implementation study paving the way for pharmacy prescription and refilling. Supports with critical element of oversight by remote physician and prescription on rapid HIV test. - Capacity limitations: variable quality, targeted training required to sell and support adherence, counsel, & refer; lack of space for counselling. Weak referral mechanisms. 	<ul style="list-style-type: none"> - Limited number of pharmacies are regularly feeding into MIS systems. 	<ul style="list-style-type: none"> - Over 6,300 registered pharmacies and opportunities early to support resupply of private clinics. - HIV ST scaling represents opportunity to piggy back.



Three High Potential Financing Mechanisms can Support Rollout

Payer (Financing Mechanism)	Description	Implications for the DPP
<i>Out of Pocket Payment</i>	<ul style="list-style-type: none">26% of total health expenditure in the private sector is out of pocket	<ul style="list-style-type: none">Despite pricing regulation, the DPP is likely to be out of reach for the vast majority of low-income Kenyans who use OOP payment to access medication.
Private Insurance	<ul style="list-style-type: none">A proliferation of private insurers, with larger insurers (>30) primarily offering supplemental coverage to employed individuals. Micro – insurers proliferate including those that target the informal sector. Private health insurers collectively cover just 1% of the Kenyan population.	<ul style="list-style-type: none">Significant misalignment with DPP target populations: private insurance serves primarily employed, older professional women.Most policies don't cover treatment, contraception infrequently covered, and PrEP not yet. Including DPP and Ancillary services such as testing requires significant investment.
Government & Donors	<ul style="list-style-type: none">The National Health Insurance Fund (NHIF) is the main health insurer in Kenya, covering ~16% of Kenyans.Treatment, PrEP, and other major health commodities heavily donor dependent.	<ul style="list-style-type: none">The NHIF continues to include more private providers, leveraging capitation models. While FP is officially covered under NHIF packages, doesn't fit neatly into capitation models, and most providers are unaware of how to claim reimbursement for a fee for service component. Significant work required to increase awareness then understanding of process (for consumers, providers)