Research brief

Understanding pregnancy journeys for value-based care

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By FSD Kenya and Infospective

Abstract

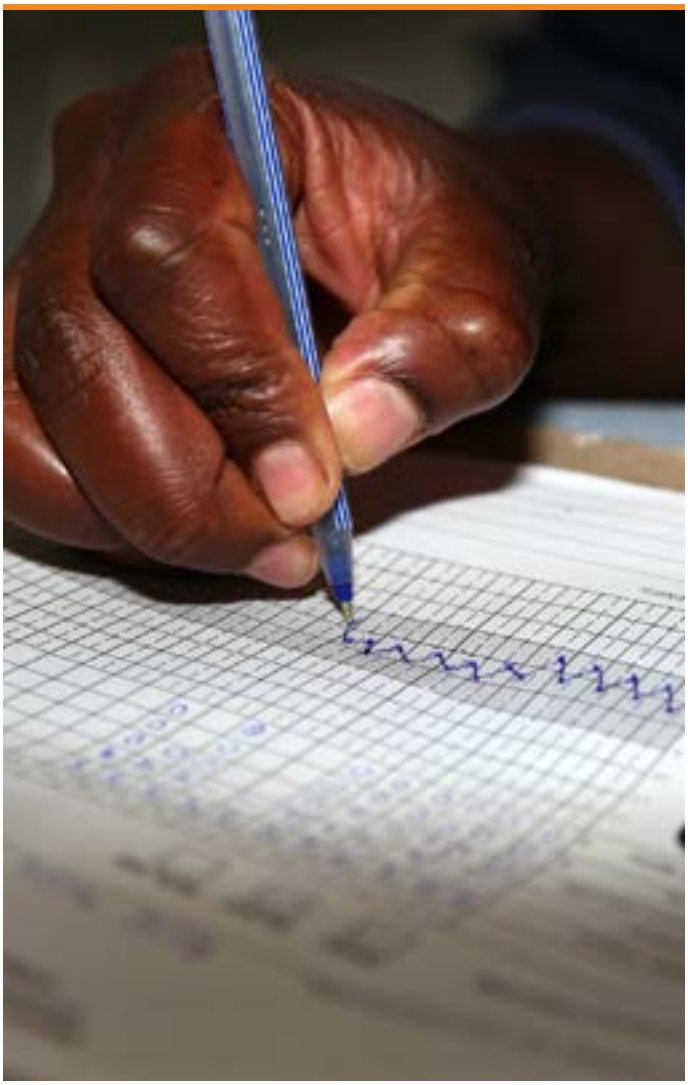
In order to support the design a value-based care (VBC) model for maternity care, FSD Kenya and a partner insurance company commissioned a study to understand the experiences of pregnant mothers who were covered by the company's existing microinsurance product. The research, led by health research firm Infospective, asked: What were the key steps in insured pregnant women's journeys? Where did they run into frictions in accessing quality care? How did they assess quality care? What appeared to drive good outcomes for mothers and newborns?

The research team interviewed twenty-six mothers who had received maternity care under the microinsurance product in the previous three years and an additional two mothers who were in the same income group but had not subscribed to the product. The research highlighted the importance of the insurer acting as a partner in the women's care journey, helping coordinate care across the pregnancy journey. It can be difficult for women to assess clinical care quality when choosing where to deliver. Facilities partnering with the insurer around VBC are also signalling their commitments to quality care to mothers as they make the important decision on where to deliver.

Background

In recent years, Kenya has made maternity care much more financially accessible, but quality remains a serious challenge. The country first eliminated user fees for maternity care in public facilities in June 2013[1] and then introduced Linda Mama in 2016, offering women a free, expanded set of care options in covered facilities. Despite many operational challenges[2], the share of mothers having deliveries with skilled attendants rose from 41% in 2003 to 89% in 2022[3]. Access to skilled ante-natal care (ANC) rose to 98% of pregnant women by 2022[4].

However, improved maternal outcomes have lagged behind improvements in accessibility of care. The World Health Organisation (WHO) considers Kenya's maternal mortality rate, "very high" at 530/100,000 live births in 2020. The country's maternal mortality rose by 55% between 2017 and 2020[5]. While part of that rise may have been triggered by Covid-19, there is some consensus that the country's progress on maternal mortality has not been fast enough. Researchers and scholars are now emphasising the importance of quality of care - not just access- in improving maternal outcomes[6].



FSD Kenya is partnering with an insurer to pilot a VBC[7] approach to addressing some of these quality challenges. VBC is an approach to healthcare delivery that works to align the incentives of insurers, health care providers, and patients to improve patient outcomes.

1 Oyugi, B., Nizalova, O., Kendall, S. et al. Does a free maternity policy in Kenya work? Impact and cost–benefit consideration based on demographic health survey data. Eur J Health Econ 25, 77–89 (2024). https://doi.org/10.1007/s10198-023-01575-w

2 Stacey Orangi et al., "Examining the Implementation of the Linda Mama Free Maternity Program in Kenya," The International Journal of Health Planning and Management 36, no. 6 (2021): 2277–96, https://doi.org/10.1002/hpm.3298

3 Kenya National Bureau of Statistics (KNBS), Ministry of Health, and The DHS Program ICF, "Kenya Demographic and Health Survey 2022, Volume 1," 2023.

4 Kenya National Bureau of Statistics (KNBS), Ministry of Health, and The DHS Program ICF.

5 Integrated African Health Observatory, "Maternal Mortality: The Urgency of a Systemic and Multisectoral Appraoch in Mitigating Maternal Deaths in Africa," Analytical Fact Sheet (WHO, February 2023), https://files.aho.afro.who.int/afahobckpcontainer/production/files/iAHO_Maternal_Mortality_Regional_Factsheet.pdf.

6 Orangi et al., "Examining the Implementation of the Linda Mama Free Maternity Program in Kenya"; Anna Gordon, "In Kenya, These Interventions Are Decreasing Maternal Mortality," Al Jazeera, December 13, 2022, https://www.aljazeera.com/features/2022/12/13/in-kenya-these-interventions-are-decreasing-maternal-mortality.

7 USAID, "Value-Based Care in Low- and Middle Income Countries | Basic Page," U.S. Agency for International Development, August 10, 2023, https://www.usaid.gov/cii/value-based-care.

For expectant women, low quality care can mean extra costs, stress and pain, more time in the hospital, emergency procedures, higher risks of caesarean sections, and re-admissions for mothers and babies. Lapses in quality are also costly to the insurer as they result in more surgeries than necessary and costly follow-on care. These costs work against the insurer's objective of keeping premiums affordable in order to cover more clients in a low-income market. While providers also care about patient outcomes, in fee-for-service models institutional incentives can sometimes make it difficult to put in place the systems to continuously improve quality of care.

Some VBC interventions targeting maternity care in low-income contexts have shown promise for positive impact[8]. For example, PharmAccess's MomCare intervention provides Kenyan mothers a comprehensive package of services, incentivises providers for good outcomes (while supporting quality on the supply side through SafeCare accreditation), and nudges mothers to seek recommended ANC. The results are promising on a range of dimensions[9]. However, the programme requires significant subsidy, limiting its reach.

The FSD Kenya supported pilot is an attempt to implement VBC in the context of private insurance, without increasing the price of premiums. The pilot will be implemented within an existing group microinsurance product sold mostly to small and medium sized organisations, covering employees and their families. Employers choose from four tiers of coverage based mostly on affordability. The maternity package is meant to cover required ANC, delivery, and post-natal care within a network of contracted facilities.

To inform design of the pilot, the partners commissioned Infospective, a health research firm, to interview a sample of existing clients who had used the maternity cover in the previous three years to understand key elements of the existing pregnancy journey. What was it like to be an expectant mother using the existing product? Where were mothers' friction points in accessing care? How did mothers think about quality of care for ANC, delivery, and post-natal care, and what were their experiences with network healthcare providers? Insights from these mothers had important implications for the design of the pilot VBC intervention.

Method and sample

The insurer helped Infospective build a sample for this study by identifying clients with maternity claims in the past three years and reaching out to them directly to assess their willingness to participate in the study and to obtain their consent to share contact information. This alone proved somewhat challenging as sometimes the contact details on file were for the spouse of the maternity patient, requiring additional follow up. In some cases, human resource (HR) departments, rather than individual policy holders were listed, requiring yet more coordination. This itself was a lesson for ensuring the right kinds of information channels are established to enable VBC, given its reliance on patient feedback. Infospective

8 Percept, "Maternity," accessed March 6, 2024, https://percept.co.za/category/research/maternity/.

9 Peter Dohmen et al., "Implementing a Comprehensive Value-Based Healthcare System to Improve Pregnancy and Childbirth Outcomes in Urban and Rural Kenya.," preprint (In Review, November 23, 2021), https://doi.org/10.21203/rs.3.rs-1071399/v1; Jonathan Izudi et al., "Experiences of Mothers and Health Workers

then contacted eligible participants, ensured consent, and scheduled one-hour interviews with them either in person (where feasible) or on the phone. The firm recorded and transcribed these qualitative interviews for analysis.

In total, Infospective spoke with 28 women who gave birth in the past three years. Twenty-six were insured patients at the time of delivery. Most were from around Nairobi and its environs, reflecting the insurer's client base. For more demographics see Table 1.

Table 1: Demographics of sample

Characteristic	Number (%)
Insurance Client	26 (93%)
Principal policy holder	19 (73% of insured)
First-time mothers	5 (18%)
Last delivery was caesarean section (CS)	12 (44% of live births; was also 1 miscarriage)
Outside Nairobi (including Thika)	8 (29%)
Living with spouse/partner	28 (100%)

Key Lessons from Patient Interviews

Private insurance was a valued employment benefit for patients. Most women interviewed were very grateful to be covered by the insurer. Given that this insurance targets the formally employed, the patients also had Kenya's National Health Insurance Fund (NHIF) cover, which is compulsory for that demographic. The participants reported that their private insurance was very useful in both covering unexpected expenses when family members were sick and reducing the financial burden of maternity care. It gave

them more flexibility on where they could deliver their babies affordably and with dignity.

For example, Mary[10], had a complicated pregnancy that required extra care. The same year, her two-year-old had a hernia requiring surgery. Having both NHIF and private insurance helped them get the baby's surgery faster and for Mary to access the care she needed to manage pregnancy complications. She explained:

> *We've been utilising our health insurance card extensively. My husband pays a substantial amount, approximately KShs 1,700 monthly, for our NHIF coverage, but it often doesn't cover as much as we would like...Our insurance card has proven to be a valuable resource...It's been a*

10 All names have been changed for privacy reasons

financial relief during these challenging times, helping us manage our healthcare expenses more effectively.

The insurer could improve women's experiences by making the maternity care package clearer and smoothing pre-approvals along the pregnancy journey. While patients in the study were mostly pleased to be covered by the insurer, administrative frictions affected their care experiences. It was not always clear to women what their cover included and what it did not, leading to unexpected expenses around things like additional ultrasounds and care for their newborns after delivery.

Some women also mentioned delays in processing claims for ANC visits. Speed and convenience were very important for ANC visits as women typically needed to rush back to work. Delays for claims and co-pays for ANC encouraged many women to simply pay out of pocket, limiting the insurer's visibility on the patient journey. Needing pre-approvals for ultrasounds and delivery costs was frustrating for women who felt like these predictable expenses should be approved in advance. The inconvenience of complicated paperwork and delays on settling hospital bills were also unpleasant for some mothers who wanted to focus their attention on their recovery and caring for their newborns.

Jane told us that she used her insurance card for her first two ANC visits, then just started paying cash. When she used the card, what would otherwise be a 30-minute visit stretched into two hours or more while she waited for processing. She was able to pay out of pocket for all the care her providers recommended but was frustrated at not being able to know what the insurance covered upfront.

I preferred using my cash... The other challenge that I found is they would tell you that this is likely to be approved, then you go and do the tests, but when you come back, they tell you this one cannot be approved.

Another mother was frustrated at the administrative processes required for delivery.

The admission process is very long. It takes too long to get approval. When I went for my delivery, I arrived there by 6 a.m. but got admitted at 10 a.m... And it was the same for discharge; the process was too long... I don't mind the approval process any other time, but it should be different for expectant employees. We are at the office, and we also give information on our due date. Why can't the HR from both sides follow up and make sure that by the time the mother is ready, everything else is ready too?

Convenience was a very important factor in the choice of an ANC facility, but quality also mattered. Women viewed a welcoming attitude, attentiveness, and giving them sufficient time during appointments as very important. They trusted providers who proactively offered information and who checked for comprehension instead of waiting for women to ask questions. They appreciated providers setting expectations for the next visit and provider engagement aimed at addressing misinformation. Physical examinations, scans, and tests provided women with helpful reassurance on their journeys.

Mothers invested in healthy pregnancies. Based on the claims data, the insurer was concerned about what appeared to be low utilisation of ANC services. It seemed like few mothers were receiving the recommended

four or more visits, and lower visit numbers appeared to be correlated with readmissions after delivery. However, the women in the study sample made an average of six ANC visits but this was not visible to the insurer in claims data. The women were paying cash for convenience, as explained earlier. In addition to ANC visits, the mothers in the sample adhered to recommended dietary supplements and ultrasound scans, even when the costs exceeded what was covered. It is important to keep in mind that this might not be possible for all Kenyans. The study sample was skewed towards employed workers who were the target market for the insurance product.

Edna, the headmistress of a school, and her husband had been trying to conceive a second child for some time. She was thus thrilled to learn she was finally pregnant. Like several other mothers in the study, her husband accompanied her on her first ANC visit, which assured her that they were going to walk the journey together, emotionally and financially. She wanted to do everything right even though she had already delivered a healthy baby before. When her delivery facility

suggested a third ultrasound, one that would not be covered by insurance, she didn't hesitate and paid for the extra scan out of pocket.

> *Once I confirm that I am pregnant, the first thing I do is visit a hospital. In that moment, life stops being just my own and becomes mine and someone else's. So, I go to the hospital to seek advice on blood supplements, nutrition, and overall self-care during pregnancy.*

Women chose their delivery facility based on quality. The mothers in the study selected their delivery facility well in advance. Though they also had NHIF, they only considered facilities that also accepted their private insurance in order to reduce their out-of-pocket costs. They attempted to choose the highest quality facility among those in the network that were also geographically accessible. As maternal health outcomes by facility are not publicly reported, they would rely on their own experiences, the experiences of friends and family, tours of the facilities and, for some, Google or Facebook reviews. They tried to determine if staff were attentive and if the facility could manage emergencies. Cleanliness and food quality were sometimes seen as proxies of healthcare quality.

Like other women, Rachel started shopping around for a delivery facility early in her pregnancy. She looked at the list of facilities accepting the insurance cover.

> *I checked around my area, looked at Google reviews, then again word of mouth, reviews from other people, such surveys...Then I visited them in person, and I got to know the environment well, like [how] everything is organised. I also had to check if they had the necessary facilities in case of an emergency. I realised that they had everything that I required, so I said I think this is the best place to go.*

She decided to also do her ANC visits at the facility which reassured her even more: "The gynaecologist and the nurses were very friendly during the checkup."

But it can be hard for women to ascertain quality on their own. One patient in Kisumu chose her delivery facility based on glowing recommendations from colleagues. Her ANC visits all went well; she thought the staff were very caring. But when she went into early labour, she found they were not equipped to handle an emergency. They rushed her by ambulance to another facility, after warning her that she and the baby were in danger:

> *They had already injected me with the labour-inducing solution, so I felt the contractions. But they told me not to push. They just told me that my case was now between me and God, and if I dare to push then it's over. When I arrived at the new facility, things were still uncertain. I can say their emergency services were horrible because we got there, the doctor was not there, the tools of operation were not there, we had to wait for them. I had to wait for like ten to fifteen minutes, and I was in a critical condition.*

When things went wrong for mothers, there were typically lapses in medical protocols, attentiveness, or compassion. Among the 28 mothers interviewed, five had negative experiences. All of these situations could have been avoided with more attentive and compassionate care, provider adherence to care protocols, and information sharing on danger signs.

In one case, a mother raised concerns about inexperienced staff. One nurse shouted at her

for the way she was breastfeeding. Her infant developed a boil at an injection site, and she was told by another provider that the baby had been given the wrong injection. She felt the doctor who administered the jab was young and inexperienced, working without supervision.

For one first-time mother, multiple challenges with communications from nursing staff put her and her baby at risk. During her ANC visits, little information was shared unless she asked questions. Being a first-time mom, she didn't know what to ask. She found out later that her blood pressure had become dangerously high. Though it was recorded in her booklet, nurses did not tell her this nor help her interpret the blood pressure reading. During delivery, a nurse gave her induction solution and told her to administer it to herself every 20 minutes but did not provide the dosage. She recalled him being distracted, scrolling on his phone. She took too much of the medication and had to have an emergency C-section. Nurses did not confirm that the baby was feeding properly before discharge. The mother did not know that the baby was getting insufficient milk. After two weeks, the baby was readmitted with severe dehydration and an infection. The experience made her lose faith in private facilities: "I would go to the public hospital [next time]... They may not treat you as a princess, but at least they are giving you what you need, not what you want."

Another mother had a wonderful experience at a facility the first time but called her second time "distressing." She knew in advance that she would need a C-section and was prepared for it, but she became unconscious for 10 hours after the procedure. When she woke, the nurse was rushing her out to clear space in the ward. She tried to stand and collect her belongings but was very dizzy. The nurse thought she was exaggerating her condition. As she moved, she felt her stitches coming apart. "I remember looking at myself in the mirror and noticing that my bandage was coming off, and the wound was exposed. The nurse made a dismissive comment about me not loving myself too much." The wound became septic, and she had to have a surgical procedure to address this, two weeks after her delivery.

When women did talk about post-partum care, this was almost exclusively focused on their babies. Ensuring their own recoveries, receiving family planning consultations, and checking in on post-partum depression were not happening systematically. Nor did mothers seem to be aware that this kind of care is recommended as part of a maternity journey. Again, stronger care coordination could ensure that this key part of the journey is not overlooked by mothers or care providers.

Without direct, systematic patient feedback, hospital administrators and the insurer are both in the dark about negative experiences and incomplete post-partum care. From claims data alone, the insurer cannot determine how well facilities are doing and whether complications are random or driven by shortcomings in service delivery.

Implications for Value Based Care

Understanding patients' maternity journeys suggested key features to incorporate into the VBC pilot.

First, it will be important to **position the insurer or payer as a woman's partner** in her pregnancy journey. This means providing clear information on the journey and package of covered care early on, supporting care coordination along the way, and streamlining approvals to enable faster, more convenient service delivery.

Second, the insurer should **partner with facilities which are committed to improving the care experience and outcomes** for mothers and babies. Patients themselves cannot always observe commitments to care quality. Providers who agree to participate in VBC are both signalling their commitments to quality and to a process of continuous improvement that involves constant patient feedback on their services.

Finally, the pilot VBC programme must **systematically track patient outcomes and experiences.** While strong standardised indicators to assess patient health outcomes are required, the insurer would also need to evaluate how well patients are informed at key steps along the journey and the extent to which they are treated with dignity and respect. The pilot will put in place multiple mechanisms for capturing and incorporating patient feedback to improve the quality of patients' experiences.

Overall, understanding these patient journeys in detail provides reassurance that there is indeed scope to improve an already valued insurance product by applying VBC principles. Improving the patient experience through VBC will require both expected changes in contracting and paying health care providers as well as improving the way insurance products are administered at the patient level.

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About FSD Kenya

Financial Sector Deepening Kenya (FSD Kenya) is an independent trust dedicated to the achievement of a financial system that delivers value for a green and inclusive digital economy while improving financial health and capability for women and micro and small enterprises (MSEs).

FSD Kenya works closely with the public sector, the financial services industry, and other partners to develop financial solutions that better address the real-world challenges that low-income households, micro and small enterprises, and underserved groups such as women and youth face.

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