PROFIT

Promoting Financial Investments and Transfers to Involve the Commercial Sector in Family Planning

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AAR HEALTH SERVICES

KENYA

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by

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in association with:
Boston University Center for International Health · Multinational Strategies, Inc. · Development Associates, Inc. · Family Health International

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The PROFIT (Promoting Financial Investments and Transfers) Project seeks to mobilize the resources of the commercial sector to expand and improve the delivery of family planning services in selected developing countries. The PROFIT Project is a consortium of five firms, led by the international management consulting firm of Deloitte Touche Tohmatsu and including the Boston University Center for International Health, Multinational Strategies, Inc., Development Associates, Inc., and Family Health International.

This report is part of a series of PROFIT Evaluation Reports, which grow out of PROFIT subprojects within the following three strategic areas: innovative investments, private health care providers, and employer-provided services.

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ACRONYMS

AAR	AAR Health Services (formerly African Air Rescue)
AVSC	Association for Voluntary Surgical Contraception
FPPS	Family Planning Private Sector
GOK	Government of Kenya
IEC	information, education, and communications
KDHS	Kenya Demographic and Health Survey
MSH	Management Sciences for Health
PROFIT	Promoting Financial Investments and Transfers Project
STDs	sexually transmitted diseases
TA	technical assistance
USAID/G/PHN/POP	U.S. Agency for International Development's Office of Population
WHMC	Williamson House Medical Center

EXECUTIVE SUMMARY

The PROFIT Project provided a loan of $414,000 to AAR Health Services (formerly, African Air Rescue) for the establishment of a clinic system, including one large outpatient clinic and several outreach clinics in the industrial area of Nairobi, Kenya. AAR is a rapidly growing health service company, providing emergency rescue services and operating outpatient clinics. AAR markets its package of prepaid health services to area employers. This subproject incorporated family planning services into the basic package of prepaid health services while introducing managed care principles in order to manage costs. In conjunction with this loan, PROFIT provided training and technical assistance in three areas:

family planning methods
marketing/promotion
information, education, and communications (IEC) activities.

The Odyssey Plaza Medical Center opened in September 1995, two months after USAID's approval of the subproject. In January 1996, AAR began offering family planning services to its members at no additional cost. Due to limitations in the real estate market, however, AAR has opened only one outreach clinic. This clinic opened in December 1996, many months behind schedule. This delay affected the family planning outcome, because it was envisioned that the outreach clinics would be key providers of family planning services. A second outreach clinic in Kangemi is scheduled to open in the first quarter of 1998.

This subproject successfully achieved many of its objectives during its first two years of operation. AAR staff were trained in managed care concepts, family planning counseling and delivery, and implementation of IEC campaigns. AAR membership has increased over 68 percent in two years—from 9,600 to 16,130 members. AAR was able to generate record profits while maintaining stable premiums for its members. The total number of family planning clients was low, however. With the opening of additional outreach clinics and an intensive promotion effort planned for the next year, it is anticipated that usage of AAR's family planning services will increase. Increasing the number of family planning clients is the first step toward achieving the long- term objectives of shifting family planning users from the public to the private sector and increasing the number of new users.

Based on the first two years of operation, PROFIT learned three lessons:

Employers are increasingly willing to pay for high-quality health services for their employees.

- A private, well-managed, and entrepreneurial company has the ability to take risks, to act quickly, and to produce quick results.
- Even if a health care plan offers family planning services, there must be specific incentives in place to ensure that it is financially advantageous to promote family planning usage.

INTRODUCTION

I.

The PROFIT Project was funded by the U.S. Agency for International Development's Office of Population (USAID/G/PHN/POP). The project was designed to mobilize resources of the for-profit commercial sector to pursue family planning objectives. In Kenya, PROFIT provided financial and technical assistance to the managed care operations of AAR Health Services (formerly, African Air Rescue), a health care company based in Nairobi.

A. Brief Description of AAR Health Services

AAR Health Services is a privately owned Kenyan commercial entity that established itself as an emergency rescue company in 1984. In 1991, with the opening of the Williamson House Medical Center (WHMC) in Nairobi, the company began providing full-scale health and medical services. AAR has since developed into a rapidly growing health care service company, and it now owns and operates five outpatient clinics—three in Nairobi, including Odyssey Plaza which is financed by PROFIT, one in Mombasa, and one in Uganda—and plans to open a sixth medical center in the city of Thika. AAR also provides financing for inpatient care via a third-party insurance company.

AAR markets its health services primarily to large employers. Until its involvement with PROFIT, AAR had focused on upper-income executives and middle-level managers. AAR management shifted its strategy to include more middle- and lower-middle-income members, which constitutes a higher- volume but lower-margin segment of the market. In order to make this shift, AAR adopted a managed care approach to lower its costs and thus allow it to lower its premiums.

The main focus of PROFIT's collaboration with AAR Health Services was to establish a clinic system—including one large outpatient clinic, the Odyssey Plaza Medical Center, and three outreach clinics in the industrial area of Nairobi—which deliver family planning services. To date, one outreach clinic has been opened, and there are plans for a second clinic to open in the beginning of 1998. The Odyssey Plaza Medical Center serves both the industrial area's workforce (primarily males) and dependent women and children who reside in the area. The outreach clinics, located in surrounding residential areas, was designed to have a patient flow comprised primarily of women and children. The outreach clinics were meant to offer convenient and easily accessible family planning and minor curative services, including:

family planning services and products

immunizations and vaccinations

basic maternal and child health care
diagnosis and treatment of sexually transmitted diseases (STDs)
health education
HIV diagnosis and counseling.

The outreach clinic is staffed by a Kenyan registered nurse, a community nurse, and a nurse aid.

A nurse practitioner with extensive experience in family planning is responsible for coordinating all family planning activities at AAR, including information, education, and communication (IEC) activities. All physicians and nurses, including those working at WHMC, were trained in family planning. WHMC is staffed and equipped to deliver all contraceptive methods except sterilization, IUD, and Norplant.

For more invasive family planning services, including surgical contraception, IUD, and Norplant, patients are referred to Odyssey Plaza. These services are considered part of the basic package of services for all members and require no additional service fees. Odyssey Plaza is equipped with a small surgical theater for surgical procedures and has a gynecologist who is responsible for providing these services.

B. PROFITS's Role and Participation

PROFIT provided a loan to AAR of Ksh. 23 million, or approximately $414,000. The loan was denominated in Kenyan shillings, with a term of six years. The interest rate is adjusted biannually, based on prevailing commercial interest rates in Kenya.

Most of the proceeds of the loan were used for building and medical equipment related to development of the outpatient clinic system that includes the Odyssey Plaza Medical Center in the Nairobi industrial area. With AAR's existing WHMC clinic in Nairobi near capacity, the new Odyssey Plaza facility was necessary to meet the new demand created by the growth in membership. This loan specifically aimed to increase the availability of high-quality family planning services in Kenya and to increase awareness of family planning methods and sexually transmitted diseases (STDs) and/or AIDS IEC campaigns.

In conjunction with this loan, PROFIT provided training and technical assistance to AAR in three main areas:

family planning methods
marketing/promotion
IEC activities.

PROFIT and AAR shared all costs for these activities, provided by the Association for Voluntary Surgical Contraception (AVSC), Management Sciences for Health (MSH), and other organizations.

PROFIT support was conditional on AAR delivering high-quality family planning services without an increase in costs. PROFIT anticipated that the proposed family planning activities would have enough impact on the target population to increase contraceptive prevalence. To become institutionalized within AAR, however, it was important that family planning services did not increase AAR's overall cost structure. This subproject was designed to introduce family planning service provision along with cost-saving measures through opening the outreach clinics. The outreach clinics have a lower cost per visit than the Odyssey Plaza Medical Center, and members are encouraged to visit the outreach clinics for family planning and minor curative services. Thus, while AAR is including an additional service, its total cost per member should not increase because it is lowering costs in other ways.

C. Summary of Baseline Information

Despite an increase in the availability of contraceptives and family planning services, the 1993 Kenya Demographic and Health Survey (KDHS) indicated significant unmet need for family planning. The Government of Kenya (GOK) has set ambitious goals for reducing the population growth rate from 3.6 percent to 2.5 percent and for increasing contraceptive prevalence from 27.0 percent to 40.0 percent by 2000. There is a strain on public resources available for family planning promotion and service delivery, and only 50 percent of public sector health facilities are now able to provide family planning services adequately. Thus, the GOK recognizes that there is a need to involve the private sector in family planning service provision.

In 1994, PROFIT and Management Sciences for Health (MSH) sponsored a workshop in Kenya for commercial sector providers and/or financers of health care services. AAR was identified as the health care company best positioned to evolve into a managed care organization, given that it owned and operated its own outpatient clinics and had experience in financing inpatient health care. Because AAR's existing clinic in Nairobi was near capacity, AAR proposed to expand its services to new members by establishing a new medical center.

AAR commissioned a market study of the Nairobi industrial area to evaluate the feasibility of establishing a medical center in the area. This study provided basic information on the health care and family planning services provided by employers. The industrial area encompasses 384,000 residents and 674 companies employing 42,000 workers. Only 12 percent of the companies interviewed provided some form of family planning services to their employees. Although approximately 75 percent of companies provide general health care services, they expressed dissatisfaction with their health plans. Thus, AAR and PROFIT

concluded that there was an opportunity to market a new health care plan that included family planning services.

D. Evolution of the Subproject

The Odyssey Plaza Medical Center was opened in September 1995, two months after USAID's approval of the subproject. The GOK accredited it as a family planning provider, entitling it to free commodities. AAR was able to open Odyssey Plaza so rapidly because it had located a good facility and began construction on the facility even before USAID's approval so as not to lose the site. AAR demonstrated its commitment to this subproject by taking the risk of investing funds obtained through bank overdrafts at very high interest rates.

In conjunction with its loan to AAR, PROFIT funded and, by December 1995, completed a first phase of technical assistance (TA) activities, providing training to staff members in family planning delivery and counseling and in managed care principles. AAR began offering family planning services in January 1996. AAR discusses managed care topics in its weekly staff members and in its quarterly meetings with the sales force.

PROFIT also funded a second phase of TA activities focused on marketing and promoting AAR's services, including family planning services. The second phase of TA comprised six activities:

- development of a corporate video
- Odyseey Plaza Medical Center launch event
- development of a corporate information/HMO information kit
- development of a family planning brochure
- preparation of two newsletters
- qualitative and quantitative market research.

AAR undertook a significant public relations campaign in conjunction with the official launch of the Odyssey Plaza Medical Center in December 1996. The U.S. Ambassador to Kenya, Prudence Bushnell, was the keynote speaker at the ceremonies. PROFIT funded costs related to the launch ceremony, including invitations, posters, and displays. AAR sponsored an extensive promotion campaign to coincide with the event, including TV and radio advertisements. AAR created a media event around the launch, generating both print and broadcast news coverage for the company overall. Attendance at the Odyssey Plaza Medical Center more than doubled since the launch. The medical center was also featured in AAR's newsletter to members and in a corporate video used at sales events and exhibitions.

There was a delay in the development of an HMO kit and a family planning brochure, but these products should be completed by the beginning of October 1997. This delay was due in large part to turnover in the position of Marketing and Communications Director.

Due to the limitations of the local real estate market, AAR was unable to meet its target date of March 31, 1996, for the opening of three outreach clinics. In low- and middle-income residential areas, there are few sites with the necessary facilities for a clinic—the most important of which are proper plumbing and electricity—and AAR also faced difficulties in negotiating with landlords due to inaccurate perceptions of AAR's willingness and ability to pay high rents. As a result, AAR's first outreach clinic, in Kariobangi, did not open until December 1996, many months behind schedule. Despite the delay, attendance at the Kariobangi clinic steadily increased during the first few months and has reached a level of approximately 200 attendances per month.

A second site for an outreach clinic had been identified in Dagoretti but was later deemed to be inappropriate for use as a health facility. AAR has since located another site in Kangemi, which would be part of a facility owned by the Ministry of Health. Lease negotiations between the Ministry of Health and AAR were in progress during September 1997. The opening of the Kangemi outreach clinic is scheduled for the first quarter of 1998.

ACHIEVEMENT OF SUBPROJECT GOALS

II.

A. Summary of Goals and Data Collection Methods

The major input goals to this subproject were to provide:

managed care training to all employees and salespeople

family planning training

IEC campaign implementation training on topics such as family planning and STDs/AIDS awareness, and child nutrition, among others.

The short-term goals of this subproject were to:

expand availability of health care services

increase knowledge of family planning delivery

increase knowledge of IEC implementation

ensure that the premium for AAR health care plan does not increase above the rate of inflation

increase the number of enrollees

increase the number of lower-income enrollees.

The longer-term goals of this subproject were to:

collect data on employer participation in the provision of family planning services

assess the financial sustainability of a managed care clinic network that provided family planning and primary health services

shift family planning service provision from the public to the private sector

increase the number of new family planning acceptors

have AAR provide a full range of family planning services, including pills, barrier methods, spermicides, IUDs, female sterilization, and vasectomy.

The main data collection methods of the subproject were as follows.

Baseline data. There were three sources of baseline information for this subproject.

- A *market survey* was conducted prior to implementation of the subproject. While this survey was conducted primarily to assess employer's interest in AAR's services, it included information on the characteristics of employers and the percentage of employers that provided health and family planning benefits for employees.
- *AAR management indicators* were part of the baseline data against which future results were compared. These indicators included AAR profits, premiums, membership, and member characteristics prior to the initiation of this subproject.
- *AAR's Quarterly Reports* also contained additional baseline information, such as members' previous source of family planning services and employer participation in provision of family planning services prior to enrolling in AAR.

Quarterly Report. AAR prepared a Quarterly Report which includes information on service statistics, new employer and member profiles, and training activities. This report was submitted to PROFIT within 30 days after the end of each quarter. The report on training activities included information on the content of training, the number and cadre of staff members trained, and the results of the pre- and post-training tests.

Financial Monitoring Data. AAR also submitted its income and loss statement at the end of each quarter.

B. Inputs

Table II-1 shows the goals, indicators, data sources and results of the subproject at the input level.

Table II-1
Input Results

Goal/Objective	Measurable Indicator	Source of Information	Status
Provide managed care training to all AAR employees and salespeople	Number of trainees by cadre	AAR Quarterly Report	Managed care training provided to: C Agents/brokers (121) C Managers (5) C Accountants (3) C Secretaries/Clerks (13) C Medical Staff (29) C Computer Staff (9) C Drivers/Messengers/ Others (17)
Provide family planning training to 4 doctors and 10–30 nurses on AAR staff	C Number of trainees by cadre C Number and subject matter of training sessions	AAR Quarterly Report	Completed courses: C 10-day course for 2 doctors and 2 nurses in minilap C 5-day course for 2 doctors on vasectomy C 5-day course for 2 doctors on Norplant C 10-day course for 10 nurses on family planning dispensing C 6-day course for 8 nurses in family planning and HIV counseling C 1-day update for all AAR clinical staff on infection prevention
Provide training to 15 nurses on implementation of IEC campaigns on topics such as family planning, STDs/AIDS awareness, and child nutrition, among others.	Number of trainees by cadre	AAR Quarterly Report	10 nurses completed 10-day course on implementation of IEC campaigns on family planning, STDs/AIDS awareness, and child nutrition, among other topics.

Overall, this subproject achieved all of its input objectives during the first year of operation. All of AAR's employees were trained in managed care principles through three training sessions conducted in October and November 1995. Dr. Dan Kraushaar of MSH participated in development of the training curriculum and in conducting the training.

All family planning training was completed as scheduled through six courses that took place between November 1995 and January 1996. In addition to the scheduled family planning training for nurses and doctors, all clinical staff underwent a one-day refresher course on infection prevention. All training related to clinical family planning methods and family planning dispensing and counseling were conducted by AVSC International. Additionally, Family Planning Private Sector (FPPS) provided training to nurses on implementation of IEC campaigns on topics such as family planning and STDs/AIDS awareness, child nutrition, etc. Although the goal was to train 15 nurses, only 10 nurses participated in this course. The burden on AAR operations was too great to have any more nurses away from work for a two-week period.

C. Short-Term Outcomes

Table II-2 shows the goals, indicators, data sources, and results related to short-term outcomes.

Table II-2
Short-Term Outcomes

Goal/Objective	Measurable Indicator	Source of Information	Results
Expand the availability of health care services	Opening of Odyssey Plaza Medical Center and three outreach clinics	AAR correspondence and field visits	Odyssey Plaza Medical Center opened Sept. 1995; Kariobangi outreach clinic opened Dec. 1996; Kangemi outreach clinic due to open first quarter 1998.
Increase knowledge of family planning delivery for AAR doctors and nurses	Pre-training and post-training tests	AAR Quarterly Report	Pre-training mean test score: 70.3% Post-training mean test score: 91.1% Post-training test increase: 20.8%
Increase knowledge of IEC implementation	Pre-training and post-training tests	AAR Quarterly Report	Pre-training mean test score: 42.4% Post-training mean test score: 82.2% Post-training test increase: 39.8%
Ensure that the premium for AAR health care plan does not increase above the rate of inflation	Premium for AAR Health Care Plan	AAR Quarterly Report	Premiums have not increased above the rate of inflation.
Increase the number of enrollees	Total enrollees after inception of new clinic network is greater than 9,616	AAR Quarterly Report	Membership as of July 31, 1997: 16,130
Increase the number of lower-income enrollees	Breakdown of new enrollees by job categories	AAR Quarterly Report	AAR is enrolling more higher-income members and is not reaching lower-income members as intended.

AAR achieved an important goal of expanding health care services with the opening of the Odyssey Plaza Medical Center in Nairobi's industrial area in September 1995. This medical center has the capacity to serve over 20,000 members. Odyssey Plaza is open 12 hours a day, seven days a week, and provides a full range of outpatient services, as well as laboratory services and a pharmaceuticals dispensary.

Although there were delays in the opening of the outreach clinics, one clinic in Kariobangi opened December 1996. The Kariobangi clinic provides minor curative services, family planning services and products, immunizations and vaccinations, maternal and child health care, diagnosis and treatment of sexually transmitted diseases including HIV/AIDS, and health education. The Kariobangi clinic is open Monday through Friday from 8:00am to 4:30pm, and on Saturday from 8:00am to 12:30pm. AAR also expects to open a second outreach clinic, in Kangemi, by the first quarter of 1998.

The objectives of increasing the knowledge of AAR staff in family planning delivery and IEC were met. Comparison of pre-training and post-training test results show that participants' knowledge of family planning delivery increased 31 percent and their knowledge of IEC techniques increased 40 percent after training. These results were provided by AVSC and FPPS, which conducted the training.

AAR has been able to limit its premium increases to well below the rate of inflation. In July 1995, AAR's overall annual premium for new members was Ksh. 5,500, and renewing members were entitled to a discounted premium of Ksh. 5,000. Since then, AAR eliminated the discount for renewing members, resulting in a flat premium of Ksh. 6,150 for all members as of July 1997. The premium for new members increased 12 percent since the inception of the subproject, while the premium for renewing members increased 23 percent. By comparison, the Kenyan inflation rate over this period was 26 percent. AAR is planning a premium increase in the fourth quarter of 1997, which will be the first increase in two years.

The subproject successfully increased the number of enrollees from a baseline figure of 9,616 in July 1995 to approximately 16,130 in July 1997. This represents an increase of 68 percent over two years. While this increase has been impressive, it is still somewhat below AAR's ambitious targets. In order to increase its membership, AAR has expanded and reorganized its sales and marketing staff and has conducted an intensive marketing campaign.

This subproject has not yet met its goal of increasing the number of lower-income members. ***Table II-3*** compares the breakdown of AAR members by job category, a measure agreed upon as a simple indication of a member's income.

Table II-3
Comparison of Changes in AAR Members' Profile by Job Category (percent of all members)

Job Category	Baseline: Members as of July 1995	New Members for Quarter ending July 1997
Senior Management	12	23
Middle Management	15	21
Supervisory	21	22
Clerical/Junior	52	34

Of the members who enrolled since the inception of this subproject, the largest percentage consists of clerical and junior staff, rather than managers. While AAR never specifically sought out lower-income members, the rationale was that as AAR was better able to control its costs using managed care concepts, it would be able to offer a lower premium, thereby encouraging employers to enroll lower-level employees as well as managers. Data from employers shows that newly enrolling employers cover approximately 93 percent of their workers on average, so that the decline in junior workers is not because employers are excluding them. One potential explanation is that AAR is enrolling more service organizations, which tend to have fewer junior-level workers than manufacturing companies.

D. Longer-Term Outcomes

Table II-4 shows the goals, indicators, data sources, and results related to long-term outcomes.

Table II-4
Longer-Term Outcomes

Goal/Objective	Measurable Indicator	Source of Information	Results
Collect data on employer participation in providing family planning services	Receipt of data on characteristics of new enrolling employers	AAR Quarterly Report	AAR is providing some data on newly enrolling employers.
Assess the financial sustainability of a managed care clinic network that provides family planning and primary health services	Total profits remain above their pre-project levels	AAR Financial Statement	C Profits for year ending April 1997: Ksh. 55 million C Profits for year end-ing April 1995: Ksh. 18 million
Shift family planning service provision from public to private sector	Percent of family planning clients formerly using public services	AAR Quarterly Report	60 clients had used public sector family planning services
Increase the number of new family planning acceptors	Number of new acceptors	AAR Quarterly Report	103 new acceptors out of 469 family planning clients
AAR provides a full range of family planning services including pills, barrier methods, spermicides, IUD, female contraception (Minilap), and vasectomy.	C Provision of pills C Provision of barrier methods C Provision of spermicides C Provision of IUD insertion C Provision of minilap C Provision of vasectomy	AAR Quarterly Report	Pills: Yes Barrier methods: Yes Spermicides: No IUD: Yes Minilap: Yes Vasectomy: Yes

This subproject has shown mixed results in achieving its long-term objectives. Given that it has been operational only two years, it is difficult to draw conclusions about whether the subproject will achieve its intended outcomes over the long term.

This subproject met its objective of collecting data on employer provision of family planning and health services. AAR submitted data on the characteristics of newly enrolling employers as part of its Quarterly Report. The goal of the data collection was to gather information on the type of employers that provide health and family planning services for their employees. Such information may provide insight into the design of future subprojects. One of the difficulties, however, was the quality of data from AAR: some

of the information collected was incomplete or unclear. It took a great deal of time to research and ensure quality data.

AAR was very successful at maintaining its profitability while offering new services and investing in training its medical staff. PROFIT chose to use a bottom-line approach, only because of its interest in learning whether the package of managed health care including family planning services can be profitable. AAR used various internal cost-efficiency indicators to determine how the managed care approach affects different types of costs. AAR's profits for the year ending April 1997 were Ksh. 55 million, well above its profits for any 12-month period in its history. For comparison, its total profits for the year ending April 1995, the year before the initiation of this subproject, were Ksh. 18 million. Because usage of family planning services has been low, it is too early to draw conclusions about the long-term effect on profits of adding family planning services.

This subproject has successfully established a new source of family planning services through the private sector. AAR currently provides the full range of family planning services, with the exception of spermicides. AAR does not offer spermicides because of difficulty obtaining supplies through the GOK. Prior to this subproject, condoms were the only method of family planning available through AAR. This subproject promoted the full range of contraceptives and provided trained counselors to help clients choose the most appropriate method.

While there are clearly some successes, it is unclear whether AAR will be able to achieve the objectives of shifting users from the public to the private sector or increasing the number of new acceptors. In its first two years of operation, AAR served 60 clients who had previously obtained family planning from the public sector, and 103 new acceptors. Before these objectives can be achieved, the number of family planning clients served by AAR would need to increase. Over the two years of operation, AAR had 470 family planning visits out of a total of approximately 120,000 medical center visits from among about -16,130 current members. There should be opportunities to increase AAR's provision of family planning services.

One of the main reasons for the low usage of family planning services was the delay in opening outreach centers. The outreach centers were designed to be located in residential areas and were aimed to serve mostly women and children dependents of enrolled employees. Since the first outreach center opened only in December 1996, this avenue for reaching potential family planning has not been fully utilized. The scheduled opening of the Kangemi outreach clinic should help fulfill this goal.

There was not a focused effort to promote usage of family planning services from the outset of the subproject, although AAR designed an intensive communications and marketing plan to increase its membership. As part of the PROFIT-funded second phase of technical assistance activities to support

AAR's communications and marketing strategy, AAR is developing a family planning brochure and has included family planning information in other promotional materials. Given the opening of additional outreach clinics and the additional promotion activities, it is anticipated that usage of AAR's family planning services will increase, which is the first step toward achieving the two most challenging long-term objectives set for this subproject.

CONCLUSIONS

III.

A. Conclusions

Target Market and Demand

In its first two years of operation, this subproject confirmed that there is a demand for high-quality health services in Nairobi. The fact that AAR was able to increase its membership by 68 percent over two years demonstrates that employers are willing to pay for quality health care for their employees. AAR had even more ambitious targets, and thus it is undertaking an intensive communications and promotion campaign to increase its membership.

Implementation Process

Overall, the implementation of this subproject proceeded smoothly. AAR proved to be a very capable partner, and it had a strong interest in having the medical center operational as soon as possible. The most significant unforeseen obstacle was the lack of appropriate space for the outreach clinics in residential areas: there were few facilities available that had adequate plumbing and electricity. Thus, the first outreach clinic opened nearly nine months after the initial target date.

PROFIT believed that AAR made good faith efforts to identify outreach clinic sites. Nonetheless, it must be noted that AAR gains little benefit from opening the outreach clinics until the medical center reaches a certain utilization level. As the medical center becomes more fully utilized, it will be to AAR's advantage for members to go to outreach clinics, as the outreach clinics have a lower cost structure per visit. Because the outreach clinics play such an important role in providing family planning services—PROFIT's main objective—it might have been helpful to provide an incentive for AAR to ensure their timely opening. Greater efforts to increase membership quickly also would have pressured AAR to open outreach clinics sooner in order to lower its costs.

Commitment to Managed Care

AAR was selected as a partner because it had a genuine interest in managed health care. Since the inception of the subproject, AAR demonstrated its commitment through efforts to educate staff and members. AAR clearly stands to benefit if it can lower its cost structure and thereby increase its profit margin or lower premiums to attract more members. It was helpful to have a managed care expert, Dr. Kraushaar, available in Nairobi to provide assistance as needed. Despite a firm commitment from AAR management to managed care, more time is needed to draw conclusions regarding the acceptance by members and staff of this approach and its effectiveness in managing cost. Although the top managers are extremely capable and committed, none had direct experience in a managed care organization.

Commitment to Family Planning

While AAR's commitment to managed care stems from a basic profit motive, its motives for providing family planning services are less obvious. The inclusion of family planning in its package of covered services gives AAR a competitive advantage over other health care providers. It is a useful sales feature to employers, who may see children as additional burdens for their employees and for themselves, if they cover health care for all dependents. Providing family planning services, however, is distinct from promoting family planning usage. AAR does not have a financial incentive to promote family planning usage among its members. AAR did realize that PROFIT was most concerned with family planning outcomes, and it made some effort to promote the availability of services. As part of the second phase of its technical assistance, PROFIT supported AAR in efforts to educate members about family planning and managed care.

B. Lessons Learned

- Employers are increasingly willing to pay for high-quality health care services for their employees.
- A private, well-managed, and entrepreneurial company has the ability to take risks, to act quickly, and to produce quick results.
- Even if a health care plan offers family planning services, there must be specific incentives in place to ensure that it is financially advantageous to promote family planning usage.