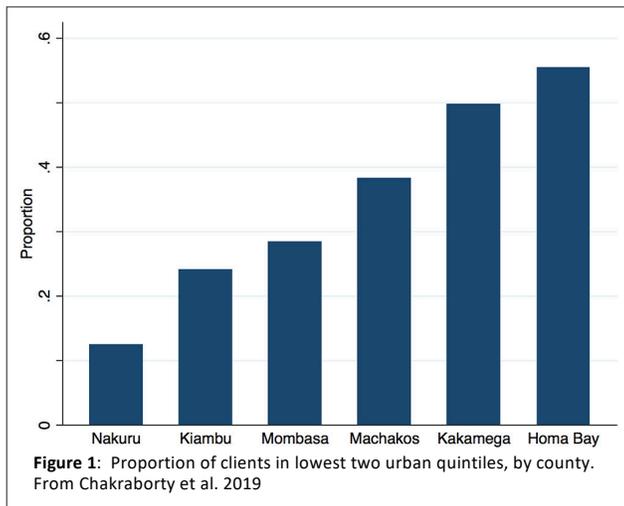


Two recent studies<sup>1,2</sup> have examined the wealth of clientele in social franchise programs in Kenya and Ghana, looking at the programs’ effectiveness as a vehicle to reach the poor with subsidized, quality assured services linked to social health insurance.

Part of the goal of AHME has been to shift the gap in what care is provided to whom: to increase the quality and quantity of family planning (FP) and maternal, neonatal and child health (MNCH) services accessible to the poorest 40% of the population. AHME’s intent has been to accomplish this through expanding the number and financial accessibility of quality-assured private providers offering these services.

Some recent Kenya data highlights a challenge to accomplishing this. Few very poor people live in cities. As a result in urban settings few poor patients are seen in any clinic. In small towns and rural settings, where the population is more likely to be poor, patients are more likely to be poor as well. (Figure 1)



**Franchised Services and the Poor**

Chakraborty et al. (2019) assessed the wealth of clients seeking care for FP and child health services from a representative sample of 96 health facilities in urban Kenya. A few key findings with implications for AHME resulted: the poor (defined as the lowest two wealth quintiles) seek care less often than the wealthy, in all settings. Among facilities where these patients seek out care, public facilities have a higher proportion of poor clients than do faith-based facilities, which in turn have a higher percentage of poor clients than for-profit or franchised facilities.

Notably, for-profit and franchised clinics serve quite similar client wealth distributions, understandable given that franchise clinics are for-profit clinics that have been recruited into a franchise network.

Importantly for AHME, the Chakraborty study also found that poor clients had a theoretical preference for private providers, but went to public facilities and faith-based clinics because of lower costs.

**The AHME experience**

Money matters. Distance matters more.

The findings from Kenya suggest that linking private facilities to public or social-health-insurance funding should have an effect on use by the poor. However, analysis of 4,500 client exit interviews from MSI Ghana (MSIG) didn’t find this: poor clients were no more likely to visit a clinic empaneled with the National Health Insurance Scheme (NHIS) than clinics not empaneled.

Undoubtedly, part of the reason for this is that even with NHI coverage, out-of-pocket costs remain. Insurance matters a lot for hospital care.

*Now that I have NHIF I find it easier to come here. And then when you have NHIF you can decide to go to (child coughs) expensive hospital and you are treated and NHIF pays.*

*Client at a franchised facility in Kenya*

It matters less for outpatient clinic services because premiums are high, and so many respondents prefer to gamble on not falling ill.

*Interviewer: So what has hindered you that until now you have not registered [with the NHIF]?*

*Respondent: It's money... You see if a month can end and I don't have money or I don't have that five hundred. Ehh.  
Client at a franchised facility in Kenya*

What did make a difference in Ghana was whether the clinic was in a rural or poor area, and specifically if it was geographically near to the poorer clients. (forthcoming analysis). This finding aligns with past research which has shown that transportation costs – both direct expenses and the time away from work – deeply impact the ability of the poor to access care; often more significantly than any direct costs of services.

### The AHME problem

Analysis of client data from the early years of AHME showed that the program was falling short in its efforts to reach the poor. In the first year of full operation, (Y2 of the project), less than 2% of all clients in MSK and MSIG came from the poorest two quintiles, and less than 7% of PSK clients.

Given that AHME specifically aims to improve healthcare access for poor populations, this shortcoming was a shock to the partners. The roots of the challenge can be found in the studies above: (1) insurance is limited, particularly for the poor; (2) even when families are covered, not all AHME member clinics were accredited to receive insured patients; (3) and even when clinics were accredited, proximity matters more than insurance. Further, AHME partners had been recruiting franchises from the areas where private providers were most common: large towns and cities. However, as the Kenya evidence shows, large cities have wealthier-than-average populations, and so new franchise members in large cities add few poor clients. In keeping with the MSIG findings that proximity is what drives client-mix, the Chakraborty study further suggests that even after joining a franchise, a clinic's client mix looks almost the same as the client mix of its un-franchised private for-profit competitors.

Interviews with officials from the Qualitative Study highlight the insurance programs' recognition of the need to align covered patients and accredited facilities:

*What we have also discovered is that ... when the healthcare providers are far from the people enrolment of our members there is low. ... Because you see when the facilities here people will see that value proposition they know I stand to benefit I don't have to travel far, I know the doctors there, they do a good job so there is that urge to demand for insurance.*

*NHIF official*

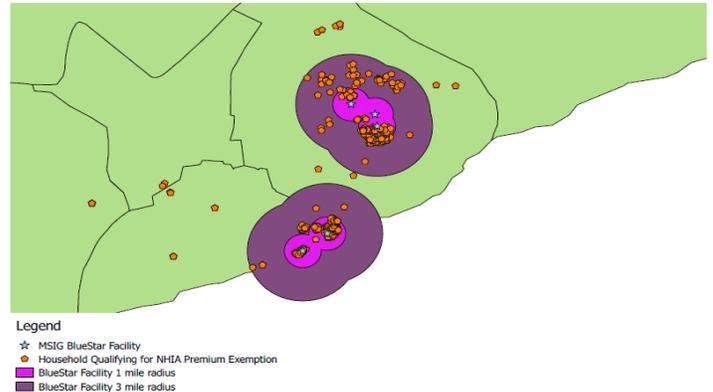


Figure 2: An example of good facility / client proximity in Ghana

### The AHME response

Beginning in Y3 the AHME partners focused on a two-pronged approach. First, they worked to actively support National Health Insurance initiatives in both Ghana and Kenya that piloted extending insurance to the poor (Kenya) or actively supported accrediting more providers in poor regions (Ghana). Second, and more importantly, the franchise providers within AHME ramped up both recruitment of providers from smaller, more rural towns, and active outreach to clients to be sure they are aware of the AHME services nearby. In Kenya MSK and PSK used community volunteers to reach, and promote free services, to needy households identified by the government. In Ghana, MSIG expanded into Northern, Upper East, and Volta regions.

The results of this work can be seen in partner data shown in Table 1: the percent of Q1 and Q1+2 clients in all programs has increased significantly from the Y2 low. By Y5 20% of MSK clients and 11% of PSK clients were from the lowest 2 wealth quintiles. This matches the rates found by Chakraborty et al. for government facilities and FBOs respectively, and is significantly better than the 7.5% poor clients that study found among private for-profit sites. In Ghana, MSIG showed even more significant improvement, with 33% of clients coming from the lowest 2 wealth quintiles.

**TABLE 1:** AHME franchise programs reaching the very poor (Q1) and poor (Q1-2)

%Q1 Clients by Year						
	Y2	Y3	Y4	Y5	Y6	Y7
<b>MSK</b>	0.0%	3.4%	3.5%	7.9%	4.5%	5.6%
<b>PSK</b>	0.5%	1.6%	1.5%	2.5%	3.0%	2.8%
<b>MSIG</b>	0.6%	3.4%	2.8%	21.4%	9.5%	5.2%

%Q1-2 Clients by Year						
	Y2	Y3	Y4	Y5	Y6	Y7
<b>MSK</b>	1.8%	8.7%	10.9%	20.1%	15.4%	15.3%
<b>PSK</b>	6.3%	7.5%	5.5%	10.9%	9.5%	8.1%
<b>MSIG</b>	1.5%	7.3%	10.6%	33.1%	17.9%	TBA17.1%

*Data collected and shared by AHME implementing partners*

But even these efforts at outreach had challenges. The Kenyan government program didn't identify 'poor' households, they identified households with orphans and vulnerable children. In Ghana, the challenges of assuring NHIS annual re-registration were greater in remote areas as internet connectivity went down for days at a time.

#### Current data:

2019 analysis of client wealth data from the franchised and 'control' clinics identified at the start of AHME have confirmed the challenges above: the wealth of clients looks largely identical between the two study arms, unchanged after years of AHME support.<sup>3</sup>

One bright note from this analysis is that the cost of care was statistically lower for the AHME-facility clients fortunate enough to have NHIF coverage. As only 500 households per district were included in the HISP pilot to reach the poor with insurance, this naturally doesn't effect the overall client population average.

#### Conclusion

Reaching the poor with quality franchised services has proven to be more difficult than making quality health services financially accessible; services must be geographically accessible as well, and coverage of both patients and facilities must overlap. This has not been easy to learn, or to address, but over the course of the past 6 years AHME partners in both Kenya and Ghana have shown that with focus and investment it is possible – with concerted effort – to reach this population. In the future we hope to learn if franchised programs could do even better, if pro-poor initiatives can be sustained and how, and whether new facilities or expanded NHI accreditation and coverage of the poor as part of Universal Health Coverage efforts provides the most effective way to build a lasting bridge between low-income clients and nearby private services.

<sup>1</sup> Chakraborty et al. *Who Serves the Poor? An Equity Analysis of Public and Private Providers of Family Planning and Child Health Services in Kenya.* *Frontiers in Public Health* 6:374, 2019.

<sup>2</sup> *Factors associated with Social Franchising reaching the poor – the experience of Ghana's BlueStar Healthcare Network.* Internal analysis report MSI, 2019.

<sup>3</sup> Gertler et al. *AHME Impact Evaluation Preliminary Findings.* Presentation, Nairobi, Kenya. March 19, 2019

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

To learn more about the AHME Qualitative Evaluation:  
[www.globalhealthsciences.ucsf.edu](http://www.globalhealthsciences.ucsf.edu)