Snapshot 11 | Social Franchising and Equity

AHME is a partnership focused on equity, committed to helping private providers deliver quality health services to poor people. Social franchising is a key AHME intervention, providing an opportunity to measure equity in the private sector. Our data is disappointing – how are we using this knowledge?

Summary

This snapshot outlines AHME's approach to measure equity in social franchising, and considers how findings have informed social franchising models used by AHME partners.

Intervention

AHME works in Nigeria, Ghana and Kenya, and represents more than 1,500 clinics in five franchises. To assess if the franchises were reaching the poor, MSI's client exit interviews were modified to gather data on relative poverty measures across the networks, in addition to standard practice of measuring absolute poverty (e.g. US$ 1.25/day).

Comparison was made between clients who used franchised clinics with national wealth quintiles (using DHS data, and following methodology developed by the social franchising metrics working group).

Findings from this analysis were surprising, and disappointing. Very few clients came from the lowest two wealth quintiles, and many came from the wealthiest quintile. This was counter-intuitive as 'no AHME franchisors work with up market clinics'.

In response, AHME looked carefully at the data and compared client populations to sub-national quintiles (given the uneven spread of the private sector and geographic concentrations of poverty, which do not always overlap.)

Each analysis shifted the results a little, particularly by reducing the proportion of clients in the wealthiest quintile. But there was no radical change; the overall picture remains the same – few clients are amongst the poorest, even when we consider regions in which we franchise.

AHME came to the conclusion that:

1. We were not serving the poorest through social franchising
2. We were not even serving the poorest people from the areas in which social franchise facilities are located.

AHME partners responded by reviewing the social franchising models they were using to make markets work for the poor.

In response to the equity analysis, AHME partners reviewed the theory of change underpinning the programme and made adjustments to their approach. A decision was taken to reduce emphasis on scale and scope and focus on provider location and subsidization of services for the poor in order to facilitate access to quality primary health care in social franchised facilities.

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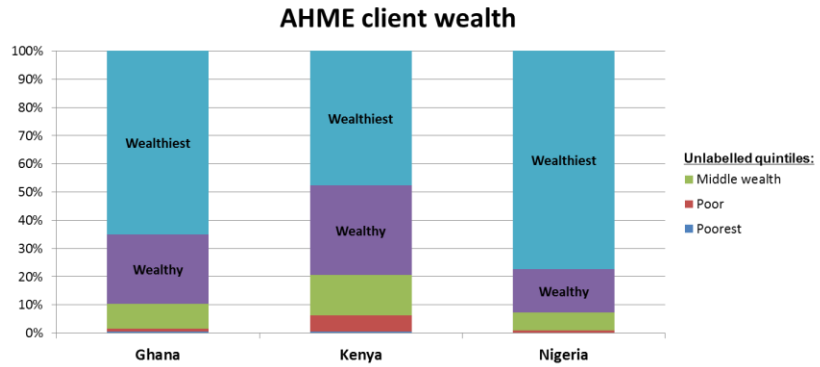
Evidence

AHME exit interviews demonstrated that, absent interventions targeting the poor, franchisees rarely serve those in the lowest wealth quintiles. Follow-up data in the Social Franchising Compendium confirmed this mediocre reach to the poor is common across franchisors and countries.



Result

Following the insights on equity, AHME franchisors have focused increasingly on midlevel providers in an effort to ensure facilities are co-located with the poor. These characteristics have been included in revised guidelines for franchisee selection.

AHME franchise networks have focused on the empanelment of their providers in national health insurance (NHI) programmes. AHME is also working to support the enrollment of poor households into NHI schemes, including Kenya's Health Insurance Subsidy Programme (HISP).

Lessons Learned

In order to reach the poor through private sector providers, it is imperative to work with those in poorer, more rural areas, and to incorporate financing of services for poor clients.

Providers who serve poor communities are likely to be less well qualified and run smaller, simpler clinics. This potentially has implications for quality and cost per DALY.

Political considerations can often factor in how the poor are identified and where they are supported to enrol in NHI. There is need to ensure:

- Areas with enrolment activities contain a significant proportion of poor households;
- Tools validated to identify the poor are utilized; and
- Provider empanelment activities are overlaid with enrolment areas to link pieces critical to make markets work for the poor.

Outlook

We believe that ultimately, franchising the right providers, and linking them to government strategic purchasing to remove financial barriers, is the way that Social Franchised will fulfil its promise of providing quality services to the poor. More than that, adding value to both providers and governments will ultimately ensure the sustainability of franchising, and this success will catalyse market change, as others crowd in to follow where social franchising organizations have led. AHME will continue to push this agenda and to carefully and honestly evaluate what works, and what doesn't .