Private providers are the first source of care for the majority of the poor in sub-Saharan Africa. However, the private provider system is not optimally structured to provide equitable, high-quality coverage of critical health interventions for the poorest people. The African Health Markets for Equity (AHME) partnership is a $60 million investment by the Bill and Melinda Gates Foundation and the UK Department for International Development to increase coverage of quality care within the private provider system and address priority health issues that most affect the poor. Operating in Nigeria, Kenya and Ghana, the five year investment will increase the scale and scope of franchised health care, expanding from reproductive health to also address malaria, acute respiratory infections, diarrhea, nutrition, maternal care, HIV and TB. Growth will be enabled by simultaneous and coordinated work in policy reform, technology for health communication, systematic quality improvement, strengthening patients' ability to pay and improving provider access to capital. The program expects to include 2,734 provider outlets and avert 2.9 million DALYs, at $46 per DALY. The project will be subject to an external impact evaluation led by Paul Gertler.

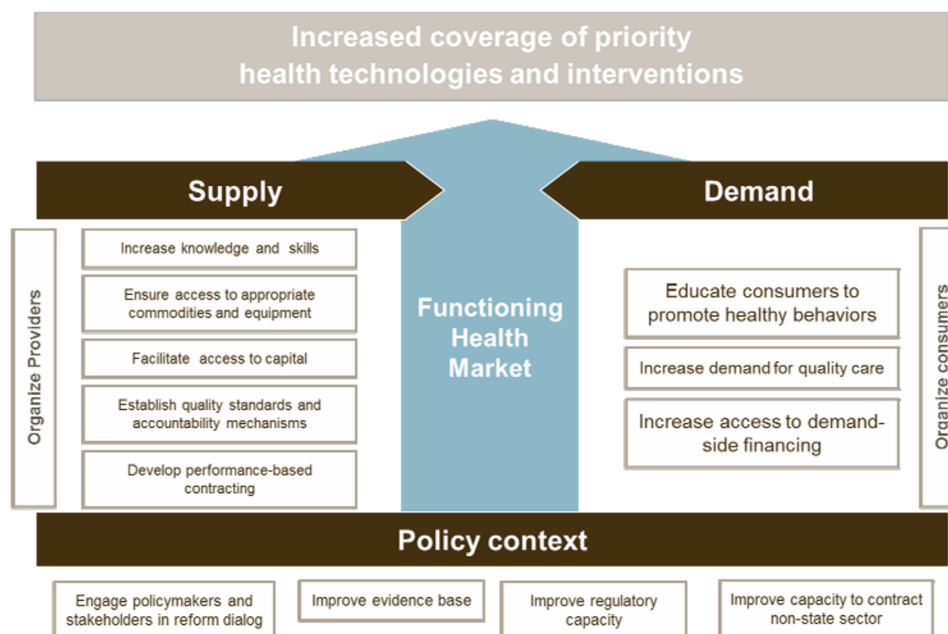
Issue

Private markets for health delivery are critical for achieving coverage of priority technologies and expanding access to care for the poor. In sub-Saharan Africa, private providers typically outnumber public providers many fold, and often deliver the majority of care for priority diseases. As a result, private health expenditures, most of which are to private providers, represent 50% of total resources for health in Africa.[1]

However, private players are motivated by a diverse set of incentives that don't always drive toward achieving the greatest health impact. Constraints on the demand side, supply side and in the underlying policy context, inhibit optimal functioning of the delivery channel. Numerous interventions have addressed this issue, examples of which can be seen in Figure 1 below. Investments in improving private delivery of care often target one specific issue in the framework; for example the IFC Health in Africa program seeks to facilitate access to capital for providers, while the Accredited Drug Dispensing Outlets establish quality standards and accountability mechanisms. While these approaches are likely to bring about incremental improvements in health, significant improvements in equitable coverage are likely to require complex, multi-faceted interventions.

Figure 1. Framework for engaging the private provider delivery channel: improvements require multi-faceted interventions addressing demand, supply and policy issues.[2]

[1] WHO 2010 World Health Statistics
2 Bill and Melinda Gates Foundation Private Provider Engagement Strategy working paper, 2012.



Underpinning AHME is a two-fold hypothesis:

- first, a belief that **each type of intervention in the framework has the potential to increase coverage of priority health technologies and interventions;**
- second, an expectation that **the greater the interaction, synergy, and integration between the solutions, the greater their individual and aggregate impact on access to better health care for the poorest people.**

Building on what works

Social franchising has applied the principles of commercial franchising to promote social benefits rather than financial profit. By bringing together small independent providers, social franchises can leverage returns to support franchisees by facilitating investment in physical capital, improving supply chains, increasing advertising, and strengthening worker training and supervision. Additionally, social franchises can aid rapid scale up of programmes, decrease transaction costs, standardise services in a market, collectively negotiate financial reimbursement mechanisms, and replicate best practices among a large group. Franchisees can cross-subsidize less profitable services with more profitable ones supported by the franchisor. Brand advertising and education programs help promote franchise products and strengthen critical links to low-income consumers through community health workers.

Quality improvement and accreditation are largely lacking in sub-Saharan Africa, making it difficult for clients to identify sources of quality care. In addition, providers are not held accountable for supplying a high standard of care. An objective, step-wise quality assessment and improvement system tailored to small providers in resource-poor settings would allow providers to obtain independent accreditation and enable consumers to identify providers that offer appropriate, quality services.

Increasing private providers' **business acumen** and **ability to access capital** is likely to enable both growth and sustainability within the franchise. **Information communication technology (ICT) systems** facilitate franchise management and integration of programs that improve access to care for the poorest people.

Demand-side financing interventions, such as vouchers for health services and insurance programmes, transfer purchasing power to the poor to enable them access to quality private providers. Demand-side financing strategies must be targeted to those most in need of services, typically poor women and children.

Effective **policy engagement** can strengthen health markets by supporting Ministries of Health and health professional organisations to establish and implement regulatory frameworks, policies, and standards. Policy engagement also includes ensuring high quality and equitable health care by working with the private sector to align market incentives.

To improve access to high-quality private care for the poor, constraints on both the supply and demand-side must be tackled together. Supply-side interventions should improve the quality, scale, and scope of health services available, while demand-side interventions provide purchasing power to poor clients, enabling them to pay for needed services. Policy intervention, alongside ICT and improvements in the evidence base, should create a more supportive environment for achieving significant increases in scale and scope.

AHME Programmatic Design

AHME builds on successful investments in the private sector that strengthen the supply-side, demand-side and policy context by **integrating these interventions in a single, well-coordinated program**. The partnership is comprised of the most capable organizations in each of these technical realms:

- **Social franchising:** Marie Stopes International (prime), Population Services International, Society for Family Health
- **ICT development:** Grameen Foundation
- **Policy:** International Finance Corporation
- **Demand-side financing:** International Finance Corporation, PharmAccess
- **Access to capital:** Medical Credit Fund (MCF)
- **Quality improvement and Certification:** SafeCare

The partnership will increase the scale and scope of franchised health care for the poor in Nigeria, Ghana and Kenya over a five year period. Growth will be enabled by simultaneous and coordinated work in policy reform, technology for health communication, systematic quality improvement, strengthening patients' ability to pay and improving provider access to capital. This not only represents a step forward in integration of market-based approaches to improve delivery, it also expands services provided across disease groups. Currently, the franchises are highly focused on the delivery of family planning services. The program will generate large increases in coverage for malaria, acute respiratory infections, nutrition, diarrhea, HIV and TB, alongside increases in the scale of maternal health and family planning (Table 1). **Over five years, the program expects to include 2,734 provider outlets and avert 2.9 million DALYs, at cost-effectiveness ratio of $46 per DALY** (Table 2).

Table 1. DALYs averted by disease group per year.

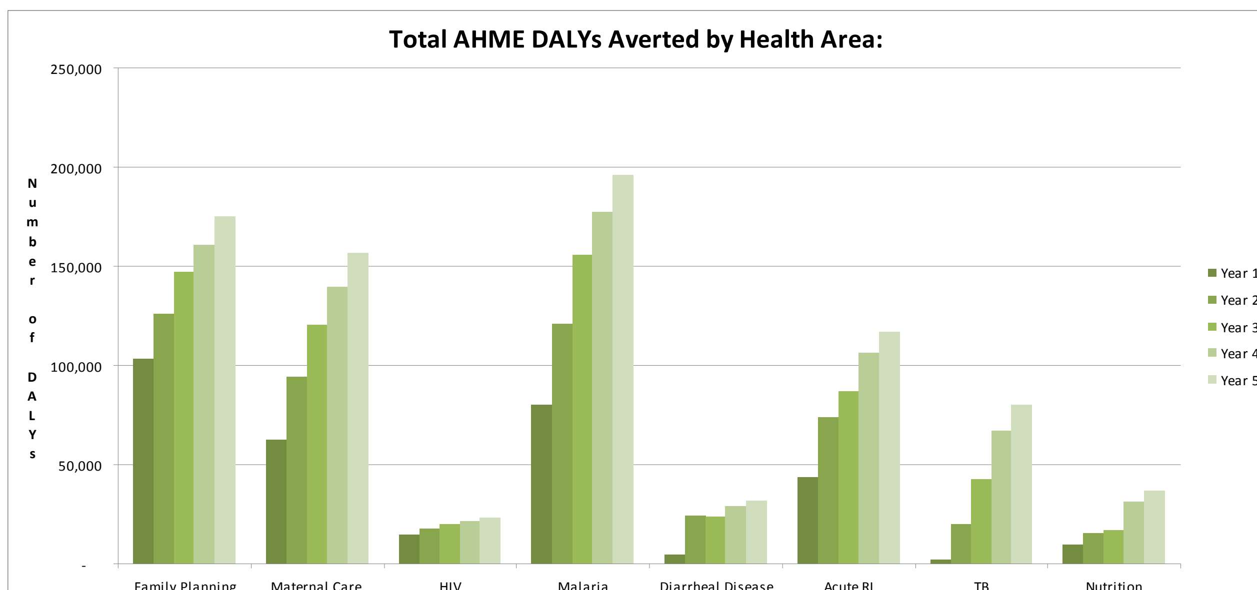


Table 2. Expected results at endline, by country.

	Nigeria	Kenya	Ghana	Total
Provider Networks	1,094 outlets 215 Providers with SafeCare Certificates of Improvement 451 Providers approved for MCF loan	1,340 outlets 204 Providers with SafeCare Certificates of Improvement 290 Providers approved for MCF loan	300 outlets 72 Providers with SafeCare Certificates of Improvement 130 Providers approved for MCF loan	**2,734 Total Outlets** **491 Providers with SafeCare Certificates of Improvement** **871 Providers approved for MCF loan**
Index of Increased Network Scope and Scale (Growth from Yr 1 Index to Yr 5 Index)	132% Growth	196% Growth	273% Growth	**N/A**
DALYs Averted over 5-Years of AHME	873,313	1,746,989	238,500	**2,858,802 Total DALYs Averted**
Average Cost Per DALY Averted	$89 USD	$21 USD	$97 USD	**$46 USD**

Understanding impact

The partnership's success will be judged by its ability to significantly improve the health status of the poor and very poor in a cost-effective manner. The outcome of interest will be cost per DALY averted as a result of the program's integrated effort; a metric that has not previously been used to judge the success of a franchised health care delivery program. Progress will be monitored by the partnership and evaluated through an independent effort led by Dr. Paul Gertler. The results of the evaluation will not only measure the program's success but will also shed light on how closely a model-based estimate of impact can approximate measured results.

Investment details

AHME partnership is co-funded by the UK Department for International Development and the Bill and Melinda Gates Foundation. Both funders plan to commit $30 million over five years, which directly leverages an additional $114 million of current investments in the partner's activities in these countries, and indirectly leverages approximately $344 million. In addition, the donors have each planned investments of 3.5 million USD to support the impact evaluation.