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RESEARCH INSIGHTS

Reaching the Urban Poor and Middle Class in Kenya with Quality Care

Providing high quality, affordable care to the poor is a common challenge for private providers. A process evaluation of LiveWell Health Clinics in Kenya found that the network serves as a sustainable model that addresses this challenge.

Private facilities provide over 40 percent of the health services in Kenya. One in three family planning users obtains her method of choice from a private provider. In urban areas, 25 percent of women who seek antenatal care choose the private sector (40 percent in Nairobi) and 23 percent of deliveries take place at a private health facility (44 percent in Nairobi). However, the private health sector in Kenya is plagued by problems with quality of care, including unlicensed providers and counterfeit drugs. High quality private health services, when available, are not affordable for many. Private facilities that offer these services to lower-income clients are usually subsidized nonprofit providers. Reliance on subsidies makes such providers unsustainable in the long run.

LiveWell Health Clinics* was founded in 2009 to provide essential health care services to the poor in Kenya's urban areas, including preventive care. By mid-2012, LiveWell had three clinics in low- to middle-income areas in Nairobi and two in urban areas in the Central Province. The SHOPS project conducted a process evaluation of the LiveWell model in 2012 to assess whether it could provide affordable quality health services to the urban poor and be financially self-sustainable.

Methods

The process evaluation used data on LiveWell's client volumes, costs, and revenues to assess the financial sustainability of the venture. Researchers interviewed staff and visited the clinics to assess the operational processes. They also surveyed 600 households in the clinics' catchment areas and 200 clients to gather data

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Nurses at LiveWell Health Clinics provided well-baby care and family planning services, referring cases with side effects or complications to the clinical officer.

Key Findings

- LiveWell's model focused on quality and efficiency.
- LiveWell attracted primarily middle-income households, but served many poorer clients.
- Client volume grew steadily, leading to increased cost recovery in the clinics.

*Seeing LiveWell's potential, the Richard Chandler Corporation acquired LiveWell Health Clinics in 2012. The new management incorporated LiveWell into the Viva Healthcare Group network of health clinics and rebranded it as Viva Afya.

SHOPS
Strengthening Health Outcomes *through* the Private Sector

on socioeconomic status. This helped them assess whether LiveWell serves relatively poor clients and explore perceptions of the network's services.

The study measured poverty using a wealth index that combined various household assets and quality of housing measures. Each household was placed in a wealth tercile (poorest, middle, or richest), according to its index score. The index ranges of each tercile matched those in the 2008–2009 Kenya Demographic and Health Survey for a comparable geographic area.

Findings

LiveWell's model focused on quality and efficiency. Each clinic offered consultation services, a laboratory, and a pharmacy. Providing all three services under one roof improves efficiency and quality. Clients could get all services in one visit and LiveWell's providers had access to a unified patient record, which ensured continuity of care.

The staff at each clinic included a clinical officer,* lab technician, nurse, pharmacist, and receptionist. Some clinics had visiting specialists such as a gynecologist or a dentist. Nurses provided well-baby care and family planning services, referring cases with side effects or complications to the clinical officer. An experienced pharmacist purchased drugs for all clinics from reputable suppliers in Nairobi (to reduce the risk of stocking counterfeit drugs) and monitored weekly supplies and restocking. Most clinics used an electronic records system with individual patient records and a monthly reporting feature that showed the number and type of visits. LiveWell management used this data for routine decisionmaking. Formal professional development, quality assurance, and supportive supervision practices (including weekly visits to clinics) fostered staff retention and helped motivate staff.

*A clinical officer is qualified and licensed to perform general medical duties such as diagnosing and treating a disease and injury, ordering and interpreting medical tests, performing routine medical and surgical procedures, and referring patients to other practitioners.

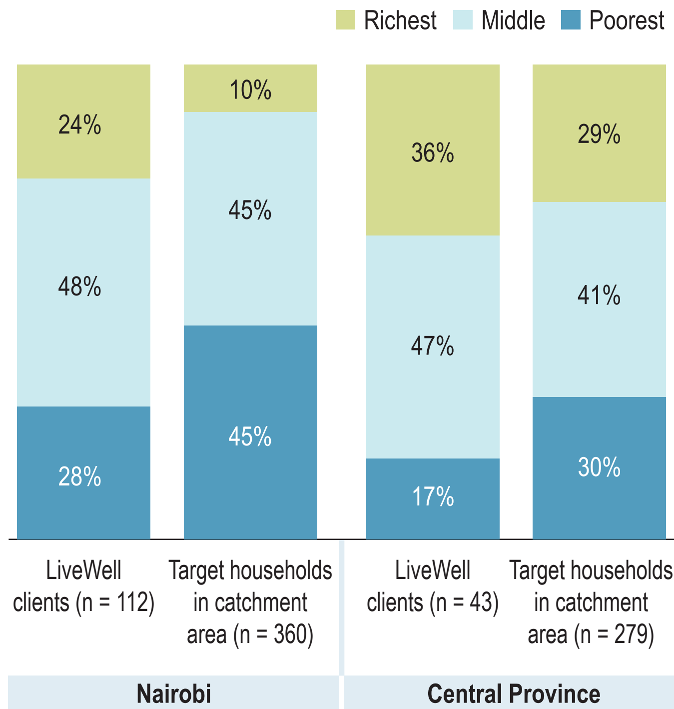
The LiveWell Model

The LiveWell model ensures quality of care by offering comprehensive services under one roof, including consultation, laboratory, and pharmacy services. When a client visits a clinic, she can get lab tests and fill prescriptions in the same place, which is efficient for the client. For LiveWell, the shared facility maintenance and management costs help keep costs down. LiveWell management can easily monitor the quality of the services and outcomes for clients. Clinical officers have timely and easy access to lab results, medical history, and medications, rather than relying on tests from outside labs, or diagnoses from outside practitioners or clients.

LiveWell attracted primarily middle-income households, but served many poorer clients. Just under half of the households in Nairobi where LiveWell operated were in the poorest wealth tercile and the same proportion were in the middle tercile; only 10 percent were in the richest tercile (see Figure 1). In LiveWell's catchment areas in the Central Province, nearly a third of households were from the poorest tercile.

About half of LiveWell's clients in each province were from the middle wealth tercile, while 28 percent in Nairobi and 17 percent in Central Province were from the poorest tercile. By operating in low- to middle-income urban areas, this clinic model may initially attract primarily middle-income households, but may also serve many poorer clients.

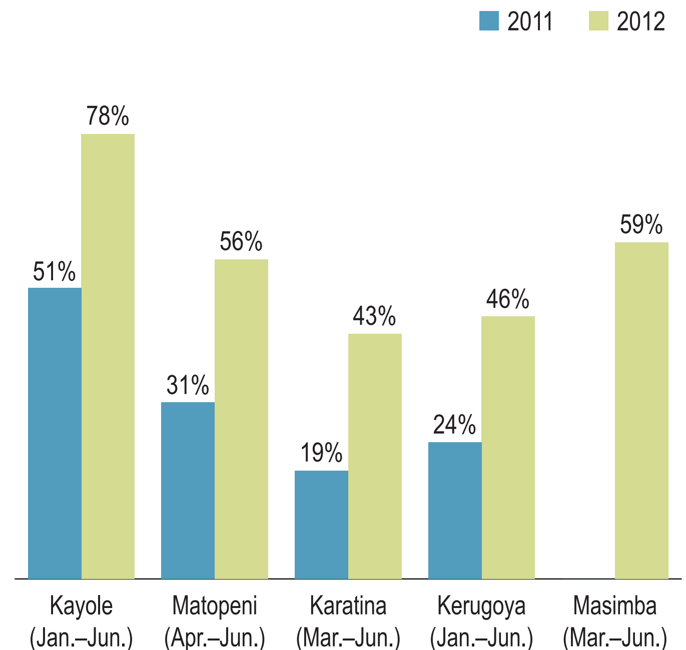
Figure 1. Wealth distribution of LiveWell clients and target households (% that belong to each wealth tercile)



LiveWell's consultation fees were $1.20 to $1.75 for adults and $0.60 to $0.80 for children. Among the clients surveyed at each clinic, 25 to 32 percent said LiveWell's prices were lower than what other private providers in the area charged; the remainder thought prices were about average. While one in five clients cited lower prices as the reason for choosing LiveWell over other private providers, the reasons that clients cited most often were a good quality of services and friendly staff.

Client volume grew steadily, leading to increased cost recovery in the clinics.
LiveWell clinics served about 2,600 clients per month, with most using only the clinics' pharmacies. More than half were repeat clients. In the 12 months prior to this evaluation (July 2011 to June 2012), LiveWell provided more than twice the number of services than it had in the previous 12 months. Between comparable time periods in 2011 and 2012, the number of services provided by each clinic grew between 69 percent and 279 percent. Two and a half years after it was established, LiveWell reached an annual cost recovery rate of 49 percent, with the first and largest Nairobi clinic achieving 79 percent. Cost recovery in each clinic increased remarkably from 2011 to 2012, nearly doubling in some locations and more than doubling in one (see Figure 2). However, in anticipation of expanding the number of facilities, LiveWell's headquarters costs increased, driving down the overall cost recovery of the organization.

Figure 2. Cost recovery in each clinic increased remarkably from 2011 to 2012*



*Costs only included clinic-specific expenditures and excluded headquarters costs.

Note: The Masimba clinic opened in 2012.

Program Implications

The LiveWell model demonstrates that a private clinic can provide high quality services that are affordable to low- and middle-income urban households by focusing on efficient operations. Managers aimed for cost recovery through increased volumes rather than through cheaper services of a lesser quality. LiveWell focused on identifying effective demand generation strategies and efficiency gains, while maintaining quality of care.

While the clinics demonstrate impressive and rapid increases in cost recovery, to reach full cost recovery, this model requires the dedication of owners and investors over several years while client volume and revenue increase. The LiveWell clinics that were located where people had a preference for private sector services experienced greater increases in client volumes than the clinics located in areas where public providers were preferred. This suggests that the achievements of LiveWell may be context-specific and that the replication of the model may work best in similar sociodemographic settings.

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The LiveWell model ensures quality of care by offering comprehensive services under one roof, including consultation, laboratory, and pharmacy services.

Full Report

Hathi, Payal, Slavea Chankova, and Anthony Leegwater. 2014. *LiveWell Private Health Clinics in Kenya: Results from a Process Evaluation of the Model*. Bethesda, MD: Strengthening Health Outcomes through the Private Sector Project, Abt Associates Inc.

Download this report at www.shopsproject.org.

This summary is based on research conducted by the SHOPS project. For more information, contact info@shopsproject.org.

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For more information about the SHOPS project, visit: www.shopsproject.org

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