

private sector

Franchising in Health

Emerging Models, Experiences, and Challenges in Primary Care

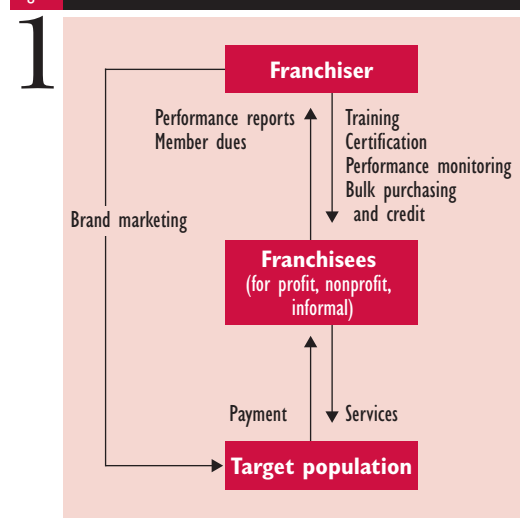
In the past decade a growing number of health franchising schemes have emerged in developing countries. Often reaching tens of thousands of poor households, these private schemes currently provide logistical, managerial, and sometimes financial support to small-scale providers (franchisees) of preventive care, such as family planning and maternal and child health services. While franchising has attracted growing interest among governments and donors as a possible way to achieve health objectives, there is some debate about the ability of the model to reach the poorest people and the ability of franchisers to sustain themselves financially.

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A franchise is a type of business model in which a firm (the franchiser) licenses independent businesses (franchisees) to operate under its brand name. A firm might choose to expand its business through franchising because the arrangement shifts capital investment and day-to-day managerial responsibilities to independent businesses, overcoming two major constraints to rapid growth. The franchiser typically has established a successful product line and so is able to provide specialized business strategies to franchisees in exchange for a fixed fee or royalty payment. Franchisers in the health sector, often supported by international donors and nongovernmental organizations (NGOs), establish protocols, provide training for health workers, certify those who qualify, monitor the performance of franchisees, and

Figure 1 Typical franchising structure in the health sector



provide bulk procurement and brand marketing (figure 1).

Potential benefits

Franchising offers potential benefits:

- *Quality control.* To protect the brand reputation, the franchiser typically trains its franchisees in technical and business administration skills and monitors their performance to ensure that they conform to its standards. The monitoring built into franchising may be attractive to a government that is interested in establishing partnerships with small-scale providers close to communities but lacks the capacity or resources to oversee their operations.
- *Bulk supply of goods and services.* The franchiser may identify qualified suppliers and negotiate long-term bulk prices for goods (drugs, contraceptives, equipment, office supplies) and services (finance, insurance). A franchiser of primary health care might also develop a referral network of qualified secondary care providers, creating opportunities for referrals and professional networking and exchange.
- *Mass marketing.* The franchiser markets its brand name—through billboards, mass media, and personal contacts (such as local meetings organized by community health workers)—informing potential clients about the availability of services and enhancing the reputation of clinics by allying them with the brand name.
- *Incentives for care providers.* Because franchised providers bear the financial risks associated with their success or failure (with ejection from the franchise meaning the loss of the caseload associated with membership), they have a strong incentive to maintain the quality of their service. As a result, franchised providers need less supervision than a network of providers employed by a single entity. A franchising effort in India uses competition to strengthen incentives to perform well. After training a provider in a rural area, the franchiser maintains contact with a potential replacement and encourages the alternative provider to give feedback on the quality of care by the franchisee.

Potential issues

While the general concept of franchising is applicable to the health sector, the highly technical nature of health care provision and the externalities associated with it raise issues often quite different from those in commercial franchising. These issues need to be considered when evaluating franchising as an option for health care provision and designing health franchising schemes.

- *Asymmetry of information.* Because judging the appropriateness of clinical services is extremely difficult for patients, they are unlikely to change providers on the basis of service quality. That makes demand shift a poor mechanism for quality assurance. Designed properly, franchising can address this problem. By signaling the quality of providers, franchising helps inform clients about their choices when seeking care. And the franchiser, which is better informed than patients, monitors and controls the quality of service on their behalf.
- *Difficulty and cost of monitoring.* Because a patient's needs and the appropriate care vary significantly from one case to another, monitoring the quality of health services tends to be more difficult and costly than monitoring the quality of other goods and services.
- *Limited possibility for standardization.* A successful franchising scheme requires well-defined products that enable franchisees to mass-produce and the franchiser to monitor quality. In health care the range of services offered is much larger than in other sectors and relatively few "products" can be standardized. This is one reason that franchising in health has focused on preventive care, such as family planning and reproductive health, where standardization, training, and monitoring are relatively straightforward.
- *Difficulty of franchising and training professionals.* Franchising can enable entrepreneurs with little knowledge of an industry to launch a successful business. But this is harder in the health sector, where providing services requires more specialized knowledge. For a health franchise to succeed may therefore require a large number of underemployed private medical practitioners.

Table Three health care franchises in developing countries

| | Kisumu Medical Educational Trust | Greenstar Network | Well-Family Midwife Clinic Network |
|--------------------------------|--|---|--|
| Country | Kenya | Pakistan | Philippines |
| Geographic coverage | Rural | Urban and periurban | Urban |
| Year established | 1995 | 1995 | 1997 |
| Area of practice | Family planning, postabortion care, and sexually transmitted infections | Family planning and reproductive health | Family planning and maternal and child health |
| Franchisees | Nurses, midwives, and clinical and medical officers working with community-based doctors | Mostly obstetrician gynecologists or Bachelor of Medicine and Bachelor of Surgery (MBBS) doctors from disadvantaged neighborhoods | Registered and practicing midwives |
| Scope | 125 providers (in October 2001) | 2,850 female doctors and 11,867 other health care providers (in June 2002) | 205 clinics (in October 2002) |
| Services offered by franchiser | | | |
| Supplies | Free contraceptives; start-up kit for manual vacuum aspiration (MVA) | Subsidized contraceptives and clinical supplies | Lease of clinic equipment and instruments; clinical supplies purchased at bulk rate |
| Technical training | One week's training in family planning and reproductive health, MVA, sexually transmitted infections, HIV/AIDS, and infection prevention | 40 hours' training in managing intrauterine devices, or IUDs (for female providers); 8 hours' training in administering hormones | 35 days for family planning; 4 days for communication skills; 4 days for counseling. Additional continuing training available from the franchise |
| Business training | Use of revolving loan funds; record keeping | .. | Market feasibility assessment; 2 days for business planning; 2 days for reporting and monitoring |
| Advertising | None | Radio, television, and print media advertising; personal contacts | Radio and television advertising |
| Monitoring mechanism | Monthly visits from coordinators | Monthly visits from Greenstar doctor (informal monitoring) and "mystery client" to monitor provider quality; biannual evaluation by qualified doctors | Regular monitoring by regional franchiser ^a |
| Fees paid by franchisee | Token annual membership fee (for eligibility for revolving loan scheme) | None. Fee charged for additional training | 500 pesos (about US\$10) a month and 200 pesos (about US\$4) per delivery. Fee charged for continuing training |

.. Not available.

a. Franchisees that fail to conform to standards receive a written reprimand after the first offense and a one-month suspension after the second, and are ejected after the third.

Source: Interviews with franchisers; <http://www.greenstar.org.pk>; <http://www.wfmc.com.ph>.

Beyond these issues specific to the health sector, social franchising—franchising to achieve social goals—also has unique features. For example, if public subsidy is involved, the potential costs and benefits of a franchising scheme need to be measured against those of alternative subsidy mechanisms, including providing subsidies directly to clinics. Franchised networks are unlikely to use financial subsidies more efficiently unless their networks are large enough to benefit from economies of scale in advertising and monitoring.

Operating models

Kenya, Pakistan, and the Philippines offer examples of schemes ranging from an informal network of providers, which has the potential to evolve into a franchise structure, to a full-blown franchising operation (table 1).

In Kenya a local NGO, Kisumu Medical Educational Trust, provides one-week training in postabortion care to a network of rural health care providers—nurses, midwives, health workers, medical assistants, clinical officers, and community-based doctors. The NGO visits network care providers around once a month to conduct informal monitoring.

In Pakistan the Greenstar Network franchises private doctors, female paramedics, and pharmacists to provide family planning services and reproductive care in urban areas. Clinics receive subsidized supplies from Greenstar as well as initial training and monthly visits from Greenstar doctors. The monthly visits allow both ongoing training and informal monitoring. While most franchisees make little profit from family planning services, participation in the network offers the benefits of more patients and training by Greenstar.

In the Philippines the Well-Family Midwife Clinic Network franchises clinics owned and operated by midwives in selected municipalities to provide family planning and maternal and child health care services, including delivery services. The network has contracts with eight NGOs that act as regional franchisers. Midwives who meet the selection criteria and agree to invest in renovating or constructing their clinics sign an agreement with the regional franchiser to obtain membership in the franchise. The

franchise focuses on urban areas and on clients who are unable to pay the full cost of most privately provided health care services yet can afford to pay reasonable fees.

Challenges and opportunities

Early results from health franchising schemes suggest that the model can rapidly expand the coverage of basic health services to poor people, capture economies of scale, and reduce the information asymmetries that often adversely affect the quality of care. The financial sustainability of health franchising schemes is being debated, however. While franchisees may reach financial sustainability relatively quickly, as has happened in the Well-Family Midwife Clinic Network, franchisers that pursue public policy goals may need to continue to rely on public subsidies.

One proposed strategy is to expand the services provided beyond family planning to include curative care, such as treatment for malaria and tuberculosis, for which the willingness to pay is typically higher. Indeed, donors have begun to develop new funding strategies to assist franchising schemes in expanding their operation to cover these services. These new funding approaches center on tying the payment of subsidies to the outputs and outcomes of franchising schemes, increasing the need for the schemes to develop appropriate, cost-effective monitoring and reporting systems.

viewpoint

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