Report on a Multi-Country Social Franchise Meeting

November 20, 2008
Washington, DC

This report summarizes the outcomes of a planning meeting for research and collaboration on Social Franchising which took place on November 20, 2008 at the Center for Global Development in Washington DC. The meeting was a spontaneous collaboration between a number of interested academics, implementers, donors, and franchise managers. We are optimistic that the outcomes noted below, will form the basis for future collaboration among this group and beyond.

Background

The field of social franchising and provision of clinical services is both growing and changing dramatically, as noted by:

- **Significant expansion and initiation of franchise network**s: In 2002, there were 4 well-run health franchises in the world. There are now almost 30.

- **Integration of services**: Franchise operations are increasingly offering new services such as STI management and TB treatment to the range of products and services offered by the outlets.

- **New financing initiatives**: Insurance-based initiatives, the use of vouchers, and other third-party subsidies for services are likely to increase demand for organized, distributed networks of private providers.

With this rapid expansion in networks, services offered, and financing mechanisms, implementers and funders need more information to promote best practices, make evidence-based decisions, advocate for support at the national and international level, and better understand the strengths and limitations of franchising compared to other platforms for provider organization. The need for study, and for policy-level follow up, has been highlighted by a 2007 review (Koehlmoos et al.) that found no franchises studies that met Cochrane inclusion criteria.

Meeting summary

A small number of representatives from organizations currently operating franchise programs, foundations supporting ongoing franchise operations or with an interest in health service delivery, and other experts in social franchising participated in a daylong meeting on November 20, 2008, at the Center for Global Development (see attached participant list and agenda). All participants had prior direct experience in franchise program support, management and operation, or evaluation. The meetings goals were to:

1. Prioritize research to better evaluate and improve franchise operations
2. Commit to collaborate across programs to answer these questions
3. Begin to define how collaborations will be put into operation

Five implementing partners — PSI, MSI, Chemonics/Smiling Sun, Janani, and WHP — provided brief overviews of their franchise programs, which highlighted the tremendous

diversity in structure, size, and services offered. Of the 28 country programs represented, the most common services offered were family planning and HIV/AIDS voluntary testing and counseling (VCT). A limited number of franchises provided more comprehensive services including obstetrics and delivery, tuberculosis treatment, and pediatric care.

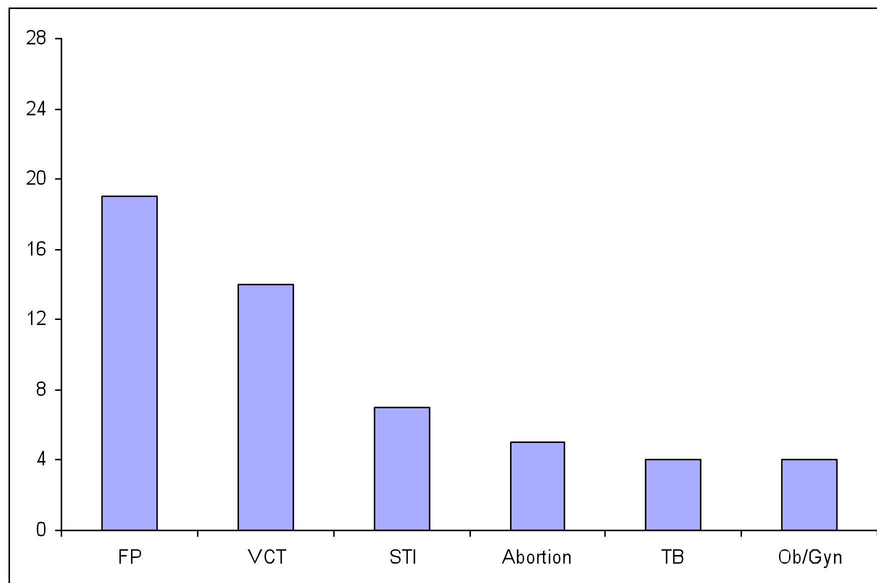

Figure 1: Services offered by country programs

The majority of the country programs currently have 40 or fewer outlets, which may be due in part to the fact that many of the programs began within the past few years and have yet to fully go to scale. While most of the franchises accept only out-of-pocket payments for their services, a smaller number have incorporated payment via voucher and insurance schemes. Three franchises also receive government reimbursement for specific services such as TB treatment and sterilizations.

PSI, MSI, and WHO also presented information on current and planned research and evaluation activities. These included an MSI study to assess vouchers and output-based aid as well as the franchise model in Pakistan; an impact evaluation of Sun Quality Health Franchise in Myanmar by WHO/PSI; and ongoing internal evaluation practices including MIS data collection, market research, and provider interviews.

The afternoon was spent reviewing common terminology, identifying existing gaps in knowledge, prioritizing study questions, and discussing possible research options and measurements. Key discussion themes are discussed in further detail in the following section. All present committed to collaborate on future research, to open program books, share data, and move toward the standardization of methods for case studies, research protocols, and output metrics.

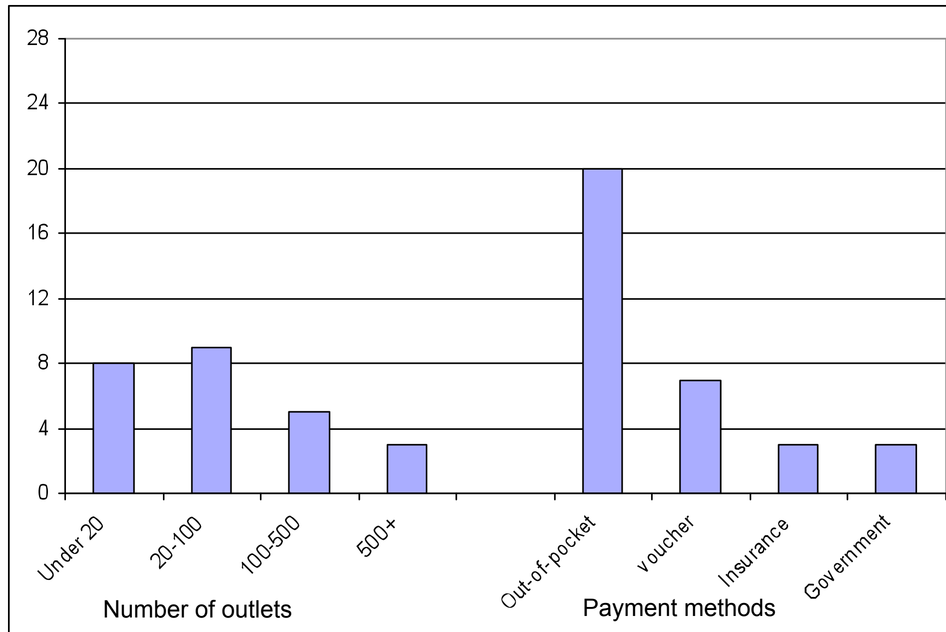

Figure 2: Number of outlets and payment methods by country programs

Discussion

Participants recognized a significant need for more evidence to support decision making and for the standardization of definitions and measurements. Major themes that emerged during discussion included:

Agreement on definition of social franchise

To be considered a social franchise, a network of providers should have the following characteristics:

- Outlets are operator-owned
- Payments to outlets are based on services provided, but the mechanism of payment may vary (client out-of-pocket, voucher, third party insurance, fee linked to service)
- Services are standardized

This would therefore exclude networks in which all of the operators are paid employees of a sponsoring non-profit or other organization as well as networks where all services are provided free of charge. For the purpose of this meeting and future research, we also restrict the franchises to those offering clinical services (eg: TB treatment, STI testing and treatment, sterilization), along or together with commodities, as opposed to those offering *only* commodities (eg: toiletries, bednets, condoms, vitamins), although it was noted that some commodites could be delivered with a service component (eg counseling) in specific instances. It was agreed that the particular complexities of franchising clinical services carry a set of concerns that should be examined independently.

There was a shared assessment that much standardizing of terms is needed to move forward social franchising thinking.

Agreement on goals of social franchise

Social franchising programs should be measured based on the following:

- ***Volume and Access*** (referred to as "Effectiveness" in the recent Bishai paper)
- ***Cost-effectiveness***
- ***Equity***
- ***Quality***

Participants noted that any program and research must find a balance between these four goals and that the four must be viewed jointly. For example, a social franchise would not be considered successful if it were able to provide high-quality services, but only at a high cost or to a small number of clients.

Participants also argued for a focus on the "value added" of franchising. For example, if a program converts a pre-existing network which had a client base of 5000 patients/year and increases the volume to 6000 the following year, the franchise program can only be credited for an increased volume, or value added, of 1000 new clients. (Although other changes – to quality or equity or cost-effectiveness – might add value to the services provided to the pre-existing 5000 patients.)

There was a strongly felt consensus that all measures of franchise achievement of the goals above should include comparison with alternative providers in government, NGO, and non-franchised for-profits.

Volume and Access: Participants agreed on the importance of measuring franchise effectiveness in a number of dimensions, including the number of franchise outlets, the number of clients seen in each franchisee clinic, and the overall volume of services provided. In discussions it was broadly agreed that a principal motivation to using franchising as a method to delivery care was the system's potential to rapidly scale up access by using existing providers. Important outstanding questions regarding access include:

- Is the total market growing?
- Are subsidized franchisees cannibalizing the clients of non-subsidized providers?
- Has the franchise increased access to services?
- Are service volumes reflective of need?

Cost-effectiveness: Franchise programs should be measured by the cost of services as well as the cost-effectiveness of this mechanism of service delivery compared to others. Services delivered through franchised systems should be compared both in terms of subsidy required as well as the overall societal cost incorporating both subsidy cost and patient cost. In both instances, cost-effectiveness should be compared to other delivery options: government, NGO, and non-franchised private providers. Measures of cost-effectiveness need to be developed. Questions for future research include:

- Are there economies of scale for franchises?
- Are there economies of scope for franchises?

- Are franchise platforms a more efficient way to delivery subsidized services than alternatives (eg: government health services)?
- Are there specific situations in which franchises are most cost-effective?
- What are the differences in cost and impact of demand-side and supply-side approaches to financing?

Equity: Equity can be measured by the proportion of clients in the lower socioeconomic quintiles compared to the general population. A franchise goal may be either to increase specific services to the poor or to provide a broad range of services to the poor. It was noted that serving rural poor populations is likely to be both more difficult and more expensive than serving urban poor populations, but that it may have more of an impact on health where there are fewer alterative sources of care in rural areas. Potential research questions include:

- Does the introduction of a franchise into a market result in a net benefit to the population?
- Are certain delivery mechanisms more effective at reaching the poor?
- What is the socioeconomic profile of a franchise clientele compared to the general population, and compared to clientele of other providers?
- What levers, such as the use of a sliding scale, increase access to the poor?
- Can free or very low-margin services be delivered through franchise systems, and if so under what circumstances (eg: as an add-on to an existing profit-generating franchise system)?

Quality: Participants debated the relative importance of quality in the franchise model, with some feeling that quality was a poorly understood, and perhaps largely subjective, attribute above a minimum safety threshold, and that an overemphasis on quality in a franchise risked diverting attention from more important goals of volume and equity.

Quality was defined as having both an objective (clinical) element as well as having a more subjective (client satisfaction) aspect. Examples of clinical quality include correct lab testing and diagnosis, proper insertion and removal of an IUD, and using the appropriate protocol for the treatment of diseases such as TB or malaria. Participants recommended using pre-existing measurements of clinical quality based on WHO standards or country-specific guidelines. Participants discussed identifying key quality indicators by service type, and possibly, creating an overall quality index to be used across program. Questions to be answered regarding quality include:

- Can franchising improve a clinic's quality of care?
- Does improved franchise quality result in increased use?
- Is perceived quality a reason that clients give for choosing a franchise? Is perceived poor quality a reason given for not attending or returning to a franchise?

Participants also noted that social franchises (as opposed, perhaps, to for-profit franchises) were not intended to provide a "boutique" experience but rather to help local

service providers attain an appropriate standard of quality. There was general agreement that quality is important, but must be evaluated in balance to the other three goals.

Value added was highlighted with regards to quality by noting that there should be appreciation of franchises that move providers from ‘D’ to ‘B-’ range as well as of those that move providers from ‘A-’ to ‘A’.

Purpose of social franchising

Several participants discussed the potential benefit of the franchise model as compared to other service delivery mechanisms. These included the possibility of rapidly scaling up the number of providers, quickly adding new services or standards to an existing franchise platform, and creating a mechanism for supervision where other systems of accreditation may be substandard, finally the franchise model usually includes communication of these attributes to generate awareness and demand. All of these merit further research to determine if franchises in fact produce these benefits, how to maximize these objectives, and how franchising compares with other mechanisms. There was agreement that current franchises must be measured against these goals.

The questions about franchise networks are becoming more sophisticated and increasingly focus on measures beyond outlet numbers and service volume.

Additional research questions

A number of additional questions were raised, many most appropriate to exploration through operations research. These included:

- Relative health outcomes of patients in franchised clinics
- Comparison of systems for maximizing beneficiary targeting and equity
- Testing modalities of multi-service integration
- Determining the effectiveness and optimizing factors for multi-tiered networks
- Documenting innovation in the use of mobile and other information/communication technologies
- Considering the role of consumers in the accountability and governance of franchises
- Evaluating the applicability of franchising in differing situations
- Testing the effectiveness of links to demand-side financing such as vouchers and health insurance

Agreement on use of a Total Market Approach

As noted before, there was strongly voiced agreement that franchises should be evaluated in the context of, and in comparison with:

- Private for-profit providers
- NGO/FBOs
- Government clinics
- Networked clinics

A number of issues were highlighted in relation to this; first that by providing benchmarks, franchises could improve quality even anong non-franchised clinics, and second that a measure of poor quality among rural franchised clinics might not reflect the quality relative to other alternatives available which is a more appropriate metric.

In considering the Total Market Approach participants also highlighted the importance of considering a/ population based measures to know whether franchises have increased service quantity, quality, equity, or effectiveness, or simply displaced alternative sources of care, and b/ market-wide ramifications of subsidized franchised providers, and how those might be addressed over time.

Agreement on need for more documentation and dissemination

Three distinct types of documentation are needed:

- Advocacy materials and brochure summarizing current programs, franchise purpose and impact of existing social franchises.
- MIS analysis, an annual Social Franchising Statistics summary (similar to the Social Marketing document produced by DKT), a newsletter and website to disseminate lessons learned and provide a forum for discussion for practitioners.
- Studies and analysis of existing data, operations research studies, and population based studies to both provide new information for program planners and managers and to add to the existing knowledge base on social franchising.

Next steps

Participants agreed on four priorities for future work:

- ***Begin with easy metrics***: Due to the need to quickly expand the evidence base, future work should begin with research that can be quickly implemented, especially case studies, analyzing existing MIS information, qualitative studies, and targeted operations research.
- ***Plan next meeting***: A follow-up meeting should be arranged for 2009 with an objective of disseminating the results of rapidly produced case studies and other quickly developed data.
- ***Document and share information***: A report similar to DKT's Annual Social Marketing Statistics Report should be produced for social franchising.
- ***Study integration of social franchising with health financing***: conduct operations research study on the integration of social franchising delivery platform and third-party financing mechanisms such as vouchers or insurance programs.

Short term

In the next several months, participants committed to accomplish the following:

- Case studies
  - Results for Development is developing a template for case studies, which they will share so that others can use the same framework for their own case studies.

  - MSI is planning a case study in Malawi with support from a doctoral student work with Amy Tsui of Johns Hopkins University. They have agreed to use the standardized template if provided.
  - Chemonics has budgeted for a case study starting in early 2009. They will also follow the standardized template if provided.

- Existing in-house data
  - All partners will work to collect, analyze, and summarize available MIS data. GHG will seek funding to support this.

- Documentation, dissemination, and advocacy
  - GHG will create web-based format for sharing updates, and launch a discussion forum for social franchising issues by December 15th and moderate for at least one year.
  - MSI and Chemonics both have program newsletters which they will share regularly.

- Standardize metrics
  - PSI and MSI will work to standardize calculations used for DALYs across their systems, beginning with PSI sharing its calculator on the GHG discussion platform.

Mid term

In 2009, participants agreed to the need for the following:

- Documentation
  - Document and share case studies.
  - Create summary materials for advocacy and introduction of concept.
  - Prepare periodic newsletters to disseminate lessons learned.
  - Publish existing information in peer-reviewed journal.

- Share preliminary results
  - Hold a follow-up meeting to build on the November 20 discussion and share the results from the MIS data and initial case studies. This will be open to a larger audience to enable field-based managers to learn best practices and share lessons learned.
  - Work to include additional franchises who will be encouraged to take up standards (case studies, MIS data, open dissemination) adopted by the group.

- Standardization
  - PSI and MSI agree to work to standardize DALY calculations over the next 12 months.
  - Determine key MIS indicators to collect across program.

- Operations research

  - Work to develop and initiate franchise-specific operations research initiatives with support from diverse funding sources. Topics to include:
    - Voucher / insurance payment for franchised services
    - Effectiveness of marketing and referrals for franchise clients
    - Drivers of demand among clients of franchise and non-franchise sites
    - Geographic access success and challenges
    - Provider attitudes toward expanded service mix
    - Client profiles among franchises

Long term

- Multi-country research
  - Measure impact according to effectiveness, cost-effectiveness, access, and quality
  - Evaluate franchises according to the Total Market Approach to determine value added to a population.
  - Pilot research linking social franchising and third party financing systems
    - OBA and voucher programs
    - Insurance programs

- Documentation, dissemination, and advocacy
  - Write findings of multi-country study

Acknowledgements

We thank the Center for Global Development for hosting this meeting as well as the Bill and Melinda Gates Foundation and the World Health Organization for supporting the travel of some participants.

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Agenda

Multi-Site Franchise Study
Thursday, November 20, 2008
Center for Global Development
1776 Mass Ave
Washington DC

Preceded by reception and light dinner 6-9pm on November 19th at
Restaurant Nora
2132 Florida Avenue N.W.
Washington, D.C. 20008

Time	*Topic*	
8:30 – 9:00 a.m.	**Arrival and coffee**	
9:00 – 9:30 a.m.	**WELCOME** o Introduction o Goals for the meeting	 April Harding Dominic Montagu
9:30 – 11:00 a.m.	**SESSION A: Franchise program overviews** o DKT –Janani o PSI o Chemonics SSFP o WHP o MSI BlueStar	 Nita Jha Smith / Honeyman James Griffin Gopi Gopalkrishnan Cynthia Eldridge
11:00 – 11:15 a.m.	**BREAK**	
11:15 – 12:30 p.m.	**SESSION B: Current and Planned Studies / Evaluations** o WHO/PSI Myanmar Sun Quality Health o MSI in-house studies o PSI in-house o Summation and discussion	 Dale Huntington Dhaval Patel Steven Chapman Guy Stallworthy
12:30 – 1:30 p.m.	**LUNCH**	
1:30 – 3:00 p.m.	**Research Topics: Prioritization and Methodologies** o Introduction o Group A: Operations, Finance and Economics o Group B: Quality, Equity, Access	 Mara Decker Lead: David Bishai Lead: Roger England
3:00 – 3:15 p.m.	**BREAK**	
3:15 - 5:00 p.m.	**Discussion on Study Structure** o Group A: Operations, Finance and Economics o Group B: Quality, Equity, Access o Summation and next steps	 Dominic Montagu

List of participants

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