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Financial sustainability in social franchising:
Promising approaches and emerging questions



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# Executive summary

Social franchising for health is increasingly used as a strategy to increase access to high quality health services in low- and middle-income countries. In 2013, social franchises operated in over 40 countries. Given the growth of social franchises and their contribution to health service delivery, donors and franchisors are focusing their attention on ensuring program longevity. The financial sustainability of these programs is a key area of interest, seen as essential to the success of social franchises in a changing donor climate, as well as with the emergence of new global health financing schemes such as the expansion of national health insurance.

Despite the growing interest, little is known about the best approaches to reaching financial sustainability. There are also questions about the impact financing strategies may have on the ability of franchises to reach low-income populations and provide high quality services. In this report, case studies of eight social franchises in Africa and Asia describe different financing strategies, assess key considerations for balancing the health, equity, and business goals of social franchising, and provide lessons learned to inform donor and program decision-making as social franchises develop sustainability plans.

The case studies highlight four main strategies social franchises are using to improve their financial sustainability:

- 1. Building the business capacity and strength of franchisees: Franchisors are expanding business training, access to capital, and scope of services in order to meet the business needs of franchisees and improve their profitability.
- 2. Linking with national health insurance programs: Franchisors are assisting franchisees in receiving health insurance reimbursements. This can expand the franchisees customer base, and often provides higher and more reliable payments than out of pocket payments.
- 3. Increasing franchisor cost recovery from franchises: Franchisors are implementing more traditional commercial models to increase fees and royalties charged to member facilities to support program operations.
- **4. Focusing on product sales**: Franchisors are offering more products in addition to clinical services. This reduces operating costs and helps increase sales.

Across the programs, several key lessons emerged about how social franchises can structure their organizational and financial models to increase their financial sustainability.

- Franchisors need to better articulate their 'value proposition' to their franchisees and to external partners; this will enable franchises to recover more costs from their members, as well as benefit from domestic sources of financing such as contracting with national health insurance programs. To do this effectively, franchises must better align their programs with the national context and priorities.
- Innovation and adaptability will be essential; franchisors that are able to adapt their structure and function to meet the needs of their members, clients, and national contexts are better able to diversify their funding sources, another central component of sustainability.
- Finally, franchisors and donors need to plan for sustainability. Organizational capacity, management and financial systems, and partnerships with national programs are all important components of sustainability that take time and resources to develop. Early planning, and realistic timelines, will make transitions towards financial sustainability more successful.

As social franchises work towards financial sustainability, they face the central challenge of how to balance their business needs with the health impact, quality, and equity goals of social franchising for health. Franchises face trade-offs as they select financing strategies: increasing cost recovery from franchisees may impact the program's ability to serve the poor; focusing on high margin products rather than service delivery may reduce health impact; and programs often struggle to find a balance between prioritizing cost savings and training or quality assurance activities. Franchisors and donors will need to identify new financing strategies and take advantage of emerging opportunities—such as partnering with national health insurance programs to serve low-income populations that allow franchises to achieve their dual business and health objectives.

In terms of finances, franchisors and donors prioritized the need to be cost-effective, have strong business and finance plans and systems in place, and have diverse sources of revenue (that include donors) to ensure the program can operate in changing economic and national contexts. While the programs highlighted in this report are working to increase the financial stability of their operations, all programs recognize the important role donors have, and will continue to play, in ensuring their organizations' success. Broadly speaking, franchises do not define sustainability as independence from donor funding, but rather focus on their ability to have long-term health impacts.

These case studies highlight the need to transform how donor funds are used-from subsidizing operation costs for service provision to providing much needed investment in scaling up networks and developing organizational and business capacity. Donors can also play a role in

subsidizing services for low-income clients as well as supporting complementary programs and efforts at the national level that create enabling environments for franchise success. All of these strategies will require re-structuring the current incentives created by donor funding structures in order to encourage greater cost-effectiveness.

As more programs in low- and middle-income countries turn to clinical social franchising as a delivery model for health services, the strategies, lessons learned, and considerations for an appropriate role of donor funding outlined in this report can help guide the development of sustainability plans for social franchises.

# Background

#### Introduction

Social franchises for health are an increasingly popular approach used to increase access to high quality health services in low- and middle-income countries. Social franchises link a network of private healthcare providers together through a contract with a franchisor, to provide standardized health services under a common brand. In 2013, franchise programs operated in over 40 countries, and provided services for maternal and child health, reproductive health, malaria, and tuberculosis among other health services. <sup>2</sup>

The growth of social franchises, and their contributions to health services provision globally, has raised questions for donors and implementers about how to ensure the longevity of these programs. Historically, donor funding has covered the majority of franchise programs' start-up and operation costs. Although a few programs are able to raise some revenue through the franchise business model, often this is insufficient to cover operating costs, and today the vast majority of programs continue to rely on donor funds to maintain their organization and franchise clinic viability. In a climate where donor funds for middle-income countries are decreasing, donors and program implementers are exploring strategies to improve the financial sustainability of social franchises.

Financial sustainability is of interest to donors who are concerned about ensuring the long-term value of their investments and the effective allocation of limited resources. For franchise programs, sustainability is essential to achieve impact, both in terms of ensuring the on-going provision of services to clients and achieving long-term impacts on population health. Program sustainability is also essential to maintain community trust in health programs.<sup>3, 4</sup> Despite the interest in sustainability, however, there is limited knowledge on the best approaches to reaching financial sustainability in social franchises. Further, a number of questions have been raised about the implications of cost-recovery strategies on service quality and the ability of franchise programs to serve low-income populations.

In this report we present comparative case studies of eight social franchise programs in Africa and Asia to highlight potential financing strategies for social franchise programs in order to understand the key considerations for balancing the health, equity, and business goals of social franchises, and to provide lessons learned to inform donor and program decision-makers as social franchise programs strive to improve their sustainability.

#### **Methods**

We conducted case studies of eight social franchise networks in Africa and Asia, selected based on their reported progress towards reaching financial sustainability, and on the diversity of their approaches used in doing so. As the large majority of social franchises rely almost exclusively on donor funding, we included programs in the early stages of planning for sustainability, even when donors continue to fund the program's operations. Case study programs include: Blue Star Pilipinas; CFW Shops Kenya; Living Goods Uganda and Kenya; Smiling Sun Bangladesh; the Tunza and Amua networks in Kenya (under the African Health Markets for Equity Program); Unjani Clinics South Africa; and Well Family Midwife Clinics in the Philippines.

To complete the case studies, we conducted interviews with key staff of the selected social franchise programs, representatives from public agencies (e.g. national health insurance programs) in those countries where programs are linking with public financing systems, private sector partners, representatives from donor agencies, and experts in the fields of social franchising and health systems and finance. We completed 47 interviews from June to October 2014. The study received exempt Institutional Review Board approval from the University of California, San Francisco.

# Defining sustainability

Within the public health field, sustainability has been broadly defined as sustaining impact over time. Within this definition, sustainability is conceptualized to include multiple levels of sustainability, including the individual (e.g. health benefits are maintained over time), organizational (e.g. programs continue to provide essential services), and community (e.g. community capacity, norm changes).<sup>5,6,7</sup>

At the level of a program or organization, sustainability has been defined as the ability of the program to fulfill its mission and serve its target stakeholders over time. Researchers and program implementers have identified a number of elements that contribute to the sustainability of a program, which can be categorized as programmatic, institutional, and environmental.<sup>8, 9, 10, 11</sup>

- Programmatic: This includes program design and scale, the "fit" of the program with local needs, and the ability of the program to adapt to changing contexts.
- Institutional: This includes the organization's managerial and administrative capacity, program leadership, financial stability, and partnerships with key stakeholders.
- Environmental: This includes the political and economic context within which an organization operates, including the regulatory and policy environment, resource availability, and the competitive advantage of the program.

A final element of sustainability, the effectiveness of the program in achieving its aims, is widely considered to be essential for the longevity of a program.

#### Sustainability in social franchise programs

Social franchise programs, donors, and experts in the field take a similarly broad view of sustainability, rather than viewing it as exclusively financial. Within the social franchise community, impact—or program effectiveness—is considered an essential aspect of sustainability, which includes the ability of the program to continue delivering high quality services and contribute to community-wide health service provision. Despite this broader view, donors and franchisors recognize the importance of financial sustainability to the growth and success of social franchises, and prioritize sustainability as a long-term goal for social franchising. Financial sustainability will facilitate the success of programs under changing economic conditions,

#### **Measuring sustainability**

Several tools exist to support programs in measuring their level of sustainability. Having good program and financial data not only helps programs track progress towards sustainability, but also provides guidance to programs—and their donors—on how to increase cost-effectiveness and efficiency. While no tools are available specifically to measure financial sustainability in social franchises, there are several indexes that can be informative for programs and funders.

The **ProCap Index** includes 27 sustainability indicators that measure three elements of sustainability: financial strength, programmatic performance, and organizational development. Abt Associates and the USAID-SHOPS project developed this index.

The <u>Program Sustainability Assessment Tool</u> includes a 40-item survey programs can use to measure eight elements of sustainability across programmatic, institutional, and environmental levels.

Population Services International uses the **Social Enterprise Sustainability Index** (SESI) to track sustainability in some of its programs. The SESI allows programs to assess how much of a program's core operating costs are supported by revenue from product sales and to compare sustainability across program areas.

while the pathways to sustainability are seen to create greater accountability within programs for franchisors and franchisees to meet their service goals, and greater adaptability of programs to meet the needs of local markets.

While there is consensus that sustainability extends beyond finances, questions remain about the definition and importance of financial sustainability within the social franchising context. Some franchisors and donors feel that a focus on financial sustainability will limit programs' ability to serve low-income clients. For others, focusing on financial sustainability is the only way for programs to become cost-effective, reach an impactful scale, and ensure program longevity. There are also conflicting views on the importance and role of donor funding in social franchise programs. Few franchisors define financial sustainability as becoming independent from donor funds. Rather, most suggest that the goal for sustainability should be a 'financially sturdy' program with diverse funding sources, including the strategic use of donor funding.

To reach the longer-term goal of sustainability, programs are exploring new strategies for increasing the financial strength of franchises. These case studies provide tangible strategies social franchises can pursue to increase their cost-effectiveness and cost-recovery, as well as useful insights into key questions donors and program implementers should consider as they develop plans for financial sustainability.

#### Social franchise approaches to sustainability

#### Strategies for sustainability

To increase the financial success of their programs, social franchises are using two main approaches: 1) changes to their organizational model, such as offering an expanded set of services; and 2) changes to their financial model, such as modifying the financial arrangements between franchisors and franchisees. These strategies have the potential to increase the financial sustainability of the franchisor and the franchisees.

The primary interest of this report is the financial sustainability of the franchisor organization. This is because, in general, franchisees operate financially viable businesses, while franchisors continue to rely overwhelmingly on donor funding. Currently, the majority of programs are pursuing a set of strategies that rely on increased revenue from product sales, service delivery, and franchisee fees and royalties as the central source of non-donor funding. In these models, the improved profitability and sustainability of the franchisees is essential for the sustainability

of franchisors, and require franchisors to support their members in earning enough profit to pay these fees. At present, few franchisors have been able to capture growth in franchisee income to improve the financial sustainability of the overall organization.

These commercial models for sustainability have limitations, however, because they are ultimately driven by out of pocket payments from franchise clients. Thus, some franchisors are using strategies to directly cover their operating costs such as through contracting with public and private entities for health services provision or attracting private investment capital.

To build the financial strength of their franchised clinics, and develop more significant sources of non-donor revenue, the social franchise organizations highlighted in this report are using four primary strategies:

- 1. Building the business capacity and strength of franchisees: Franchisors are working to meet the business needs of franchisees and improve their profitability by expanding business training, access to capital, and scope of services.
- 2. Linking with national health insurance programs: Franchisors are assisting franchisees in receiving health insurance reimbursements, opening up an expanded customer base with higher and more assured payments.
- Increasing franchisor cost recovery from franchisees: Franchisors are implementing more traditional commercial models to increase payment of fees and royalties that can support program operation.
- 4. Focusing on product sales: Franchisors are offering more products in addition to clinical services, benefiting from the lower operating costs.

These four primary strategies to financial sustainability are discussed in greater detail in the following case studies. Although in this report we explore these approaches as separate, standalone strategies, they can be used together as part of a comprehensive sustainability plan.

## Strategy #1: Build franchisee business capacity and strength

The private healthcare providers engaged in social franchise networks are also small businesses, and franchisors increasingly recognize the need to address franchisees' business success. These approaches focus primarily on increasing franchisee business skills and increasing the number of services offered by franchisees.

Franchisors have come to recognize that business skills are greatly needed and highly valued by their franchisees. Although franchisors that recruit existing providers are working with businesses that have thus far been successful, the majority of these providers come from a clinical background and lack formal business training. For full franchise models, ensuring that providers can run a business is essential to the success of the model. Basic business skills, such as the separation of

business and personal finances, bookkeeping, patient record management, stock management, and human resource systems, have the potential to significantly improve how these providers run their practices and thereby increase their profits.

Many franchise programs operate as fractional franchises in which they support and assure the quality of a limited package of services, often family planning and reproductive health, even as their franchisees offer a much wider range of services outside the franchise brand. A number of franchise organizations have tried expanding their coverage to additional franchised services in order to improve the sustainability of the network. Scope expansion can increase clinic profits and contribute to franchisor cost-efficiency.

#### Case Study: Unjani Clinics, South Africa

#### Program history and structure

Unjani Clinics is an enterprise development initiative in South Africa that aims to empower professional black, female nurses by creating a sustainable model of primary healthcare delivery. The motivation behind the creation of Unjani was to relieve some of the overcrowding burden on state health facilities by creating a high-quality, affordable source of community-based private primary healthcare. Unjani was started in 2010 by Imperial Health Sciences, a division of the Imperial Group, Ltd. Seven pilot clinics opened from 2010 to 2014 in Gauteng, Mpumalanga, and Western Cape provinces, and Unjani is planning to expand to additional provinces with the establishment of 40 clinics over the next two years.

Unjani Clinics, the franchisor, is a registered non-profit company (NPC) managed by Imperial Group members. The NPC structure allows Unjani Clinics to receive donations from corporations in South Africa that fulfill those corporations' requirements under the Broad Based Black Economic Empowerment (BBBEE) legislation in South Africa, which requires companies of a certain size to dedicate a percentage of their profit towards enterprise development activities. At the present time, Unjani's only donor is the Imperial Group, although Unjani Clinics is considering accepting donations from other corporations in the future.



#### **Definition of sustainability**

Unjani defines sustainability from the perspective of the franchisee; a sustainable clinic is one that is commercially viable. Unjani aims to establish a lasting business opportunity: well-functioning clinics that make financial sense to the nurse-owner, allowing her to grow her family's assets and business.

#### Financial model and goals

Unjani operates a full-franchise model in which a nurse is the owner and operator of a newly established clinic. Unjani contracts out the construction of the clinics, which are made from a shipping container that is re-kitted as a primary care clinic and branded for Unjani. Nurses sign an initial 5-year enterprise development agreement.

The core set of services offered by each clinic includes the treatment of minor and chronic ailments, general wellness, family planning, postnatal care, HIV counseling and testing, and treatment of TB and STIs. Franchisees may provide additional services if they have the requisite certificates. Unjani sets the price list for all services. A consultation, together with all related medications, costs 150 Rand (\$14); additional services are charged separately. The business model for the clinic is built on this consultation charge; Unjani estimates that the business costs (including nurse salary) will be covered when a clinic serves 250 patients per month, and the clinic infrastructure has capacity for 450 patients per month (see Strategy #4 for more details on Unjani's financial model).

#### Approaches to reaching sustainability

Several components of the Unjani clinic model and the operation of the franchise are designed to support the sustainability of the clinics as small businesses.

- 1. Nurse selection: Unjani undertakes an intensive selection process for the nurses who become its entrepreneurs. To be considered, nurses must have a minimum of 5–8 years of experience in primary health care and must hold a dispensing certificate. The program seeks to hire candidates who are "entrepreneurs at heart" who will be able to market their facility, and understand the challenges and opportunities of owning and running their own business.
- 2. Site selection: Unjani requires that the nurse be from, or have lived or worked in, the community where she proposes to locate the clinic. Prior to approving the site, Unjani requires that the nurse survey 200 people in the community to find out more about the health-care challenges the community faces, the facilities

they access, and their willingness to pay for services. Unjani targets the segment of the population that cannot afford health insurance but that has some ability to pay for health services. Because the surrounding community's ability to pay is critical to the commercial viability of the clinics, Unjani looks for areas in which a substantial portion of the residences are permanent structures and in which at least 50% of the population is employed, based on the nurse's community survey.

**3. Business training:** Nurses participate in a 5-day training that focuses on business operations. The training covers Unjani's standard operating procedures, documentation processes such as patient

registration and record keeping, stock management, balancing books, petty cash management, health and safety requirements, and use of the clinic management software. A day of the training is devoted to financial management, including separating personal and business finances, and understanding the price list and clinic financial model. Although Unjani does not provide franchisees with any clinical training, Unjani staff provide extensive on-the-job support when nurses first join the franchise network. Unjani staff assist with setting up the clinic and stay with the nurse in the clinic every day or two for the first several months of operation.

# Case Study: The African Health Markets for Equity program, Kenya

#### Program history and structure

The African Health Markets for Equity (AHME) program is a 5-year, \$60 million initiative funded by the Bill and Melinda Gates Foundation and the Department for International Development in Kenya, Ghana, and Nigeria. The aim of AHME is to improve access to quality health services for the bottom two wealth quintiles through an approach that integrates demand- and supply-side interventions. In this section we focus on the supply-side (health facility level) interventions implemented through AHME in Kenya. <sup>12</sup>

In Kenya, AHME works through two social franchise networks: **Amua**, operated by Marie Stopes Kenya (MSK), and **Tunza**, operated by Population Services Kenya (PSK). Through AHME, MSK and PSK are expanding the scale and scope of their networks by franchising additional providers and services. The franchisors are also linking their franchisees to two programs run by the PharmAccess Foundation: the SafeCare quality improvement program, and the Medical Credit Fund (MCF), which partners with commercial banks to offer the clinics, which are often not considered credit-worthy by the financial sector, access to loans.

#### **Definition of sustainability**

AHME as a program does not have a definition of sustainability. PSK and MSK each have their own organizational definitions of sustainability, as well as their own financial models and goals for Tunza and Amua, respectively. At this time, both organizations' franchising operations are donor funded.

#### Approaches to reaching sustainability

Amua and Tunza are using business training and scope expansion activities to increase the financial strength of their franchisees.

1. Business training: Through their partnership with PharmAccess, the Amua and Tunza networks link franchisees with services that the franchisors do not offer. Through the SafeCare facility improvement program, franchisees receive business-related support in areas such as human resources, information, and risk management. PharmAccess' Medical Credit Fund (MCF) program provides business training to health facilities that take a loan through the program to improve their facilities. Under AHME, MCF can also offer business training to franchisees that are not yet able or willing to take a loan, helping them to improve their systems to the point where a loan may be more attractive and feasible.



- 2. Access to credit: The MCF program facilitates access to credit for the franchisees by linking them to commercial banks while undertaking some of the risk of the loan. MCF works with the franchisees to make a plan for the use of the loan, which may be for equipment purchase, renovations, or other needs, some of which may contribute to their quality improvement plans under SafeCare. MCF is structured so that franchisees can step up to larger loans once their first loan has been successfully repaid, shifting more of the lending risk onto the bank and gradually transitioning the franchisee into the regular credit market.
- 3. Scope expansion: Under AHME, the Amua and Tunza networks are expanding the scope of their franchised services to include Integrated Management of Child Illness, and Tunza has begun to work on franchising malaria and Safe Motherhood services. By the time AHME ends in 2017, the networks are also expected to franchise services for STIs, HIV, and TB. Adding additional franchised services develops the financial strength of clinics by enabling them to offer more and higher value services. This will further strengthen the franchisees' financial viability by opening new revenue streams for them.

#### **Smiling Sun Franchise Program, Bangladesh**



Smiling Sun Franchise Program was started in 2007 with funding from USAID. The franchise built on an existing network of over 300 clinics and 8000 satellite clinics by bringing 26 NGOs into a single franchise brand. Smiling Sun's mission was to increase access to health services in a sustainable way; the program's five-year goals were to reach 70% cost recovery and to ensure that 30% of all services were provided to the

poor. Smiling Sun franchise clinics provided a wide range of health services, focusing on reproductive, maternal, and child health.

To achieve their financial goals, Smiling Sun franchise pursued a number of strategies, such as expanding the range of services offered, improving the cost effectiveness of program operations, and increasing cost recovery through client payments. The program also partnered with government and private sector partners. For example, Smiling Sun developed partnerships with companies such as H & M and British American Tobacco Bangladesh to provide health care for their employees. Smiling Sun also worked with the government to receive subsidized family planning products. To reach the poor, Smiling Sun instituted strategies such as providing vouchers for services, and the Health Benefit Card Program, which enabled poor households to access free services.

The program was able to quickly improve its financial and service performance. From 2007 to 2010, the program increased its cost recovery to 43%; and at the end of the five-year program, Smiling Sun reached its target for 30% of services to be provided to poor clients.<sup>14</sup>

# Advantages and challenges of focusing on franchisee business models

These approaches increase franchisee profitability and improve the quality of services offered. Many aspects of clinic functioning that fall under business and entrepreneurship skills, such as patient record keeping and the ability to manage investments to improve the facility, are also essential for quality improvement. The same is true of access to credit, which may allow providers to purchase equipment that expands or improves their services. Importantly, by franchising the full range of services that a franchisee might provide in their clinic, franchisors are also able to offer training and quality assurance activities for these health areas, ensuring higher quality across the full range of clinical services.

These approaches also increase the 'value proposition' of the franchisor. The Amua. Tunza. and Uniani networks all said that their value added depends on the services that they provide to their franchisees and the franchisees' perception that those services are improving their businesses. Entrepreneurship skills, access to credit facilities, linkages to national health insurance systems, and other such services offer franchisees a tangible benefit that increases the value of the franchise network to franchisees, particularly when the end result is increased profits. Franchising a wider range of services can also make participation in the network more attractive to potential franchisees, and the progressive addition of services means that the value of the network to providers is not limited to a set of up-front trainings. Franchisors stressed that increasing their value proposition reduces attrition and increases their ability to enforce quality and other standards.

These approaches can also contribute to the financial sustainability of the franchisor. First, the increased profitability at the franchisee level can enable franchisors to recover more costs from their members. For example, Tunza and Amua noted that many of their franchisees operated with small profit margins, and felt that increasing franchise fees would be unsustainable without first increasing franchisee profitability. Second, scope expansion can improve the

cost-efficiency of the overall network. The marginal cost to support additional services is relatively small compared to the fixed costs of quality assurance and other regular activities. Other franchise networks have used scope expansion as a means to advance cost-recovery. The Smiling Sun franchise in Bangladesh expanded their program to include services that were important for health and that generated more revenue, such as maternity and lab services, and bundled services in a way that increased revenue, for example by selling child health packages, or lab and consultation packages.

However, there are challenges in pursuing these strategies; in particular, business support and scope expansion activities can be costly for a franchisor to provide without any immediate guarantee of increasing financial returns to the franchisor. For example, the extensive business support provided by Unjani, and the quality improvement provided through the SafeCare program under AHME are very expensive activities. In all three franchises, these costs are fully covered through donor funding, and as of now no programs have been able to increase their cost recovery from franchisees. The continuation of such services will require either continued donor funding or substantially increased cost recovery.

Scope expansion can also be expensive and risky. To be successful, franchises need to ensure they select the right package of services, one that meets the needs of both the target population and the franchisees. Scope expansion may also entail a degree of risk depending on the nature of the service; maternity services, for example, are often profitable but are complicated to provide. When a franchise adds services, they also assume liability should the quality of these services not be maintained. Finally, adding services can impact the mission and brand recognition of some franchises. For example, MSK has a core mission to provide reproductive health services. In franchising services outside this scope under the Amua network, MSK is adopting a strategy of using these additional services to cross-sell their core services, but also must maintain their brand.

## Strategy #2: Link with health insurance

Linking with third-party payers, and particularly national health insurance systems, has generated considerable interest as a promising strategy for financial sustainability within social franchising. Interest in national health insurance is strong because of the potential to support both the financial sustainability and equity goals of social franchises By reducing client reliance on out of pocket payments, as well as offering clinics a steady source

of income, third party payment systems can help to overcome the tensions between serving lowincome communities and the business needs of franchisees. Linking clinics with health insurance programs also increases the value added of the franchisor, and a number of networks are interested in how they might recover costs by intermediating in the claims reimbursement process.

# Case study: Well Family Midwife Clinics and BlueStar Pilipinas

Two franchisors in the Philippines, Well Family Midwife Clinics and BlueStar Pilipinas, are working with the national health insurance program, managed by the Philippine Health Insurance Corporation (PhilHealth), to facilitate accreditation for their franchisees. Both organizations franchise midwives operating birthing homes and offering women's health services, including family planning, antenatal and postnatal care, and basic maternal and child health care. Once accredited, franchisees are eligible for reimbursement for services under the Maternity Care and Newborn Care Packages. Reimbursement through PhilHealth has proven very profitable for the franchisees: many midwives have not only recovered operating costs for their clinics, but have made significant profits. While these reimbursement enable franchisees to become financial sustainable, franchisors have not been successful in recovering costs from franchisee fees or other activities, and largely remain dependent on donor funding.

#### Franchisor history and structure

Well Family Midwife Clinics (WFMC) grew out of a USAIDfunded program. Between 1993 and 1995, USAID provided funding to John Snow, Inc. (JSI) to convert two non-governmental organizations (NGOs) into commercial franchisors with the goal of expanding family planning. Under this project, WFMC was created with the NGOs serving as local franchisors and JSI serving as the national franchisor. In 2002 the WMFC Partnership, Inc. (WPFI) was formed, taking over from JSI as the national franchisor to oversee the operations of NGO area franchisors. WPFI sets and enforces franchise policies, links area franchisors with government agencies, and arranges trainings, while area franchisors recruit and train midwives, collect franchise payments, and assist with quality monitoring. Area franchisors also support midwives with PhilHealth accreditation and reimbursement. Currently 11 area franchisors manage 132 franchisees in 20 provinces.<sup>15</sup>

The BlueStar Pilipinas (BSP) franchise was started in 2008, under the direction of Population Services, Pilipinas, Incorporated (PSPI), a non-profit organization functioning as the primary Marie Stopes International (MSI) partner in the Philippines. The BSP franchise is a fractional franchise. PSPI provides training and technical assistance, subsidized supplies and commodities, and quality oversight, as well as support with accreditation. Currently there are 266 franchisees nationwide, of which 185 are accredited by PhilHealth.<sup>16</sup>

WFMC and BSP franchisees primarily target their services to middle-income clients who are able to pay for services.



#### Collaboration with national health insurance

In order for private providers to participate in the national health insurance program, they must meet the licensing and accreditation standards or the insurer, and feel that the reimbursement rates make participation beneficial. WFMC and PSPI worked directly with PhilHealth to ensure that accreditation standards, services packages, and reimbursement rates were set in a way that enabled franchised midwives to participate in the PhilHealth program.

WFMC began working with PhilHealth in 2001, and played a significant role in guiding the development of accreditation standards, benefits packages, and training topics. PSPI started engaging with PhilHealth in 2009 when they expanded their services to include maternal health. Both franchisors continue to collaborate and engage in advocacy with PhilHealth, as well as the Department of Health (DOH), particularly at the regional level; for instance to provide feedback on the expanding service packages PhilHealth is reimbursing and the new birthing home licensing standards that will be rolled out by the DOH in 2015.

#### Definition of sustainability

For the franchisor organizations, sustainability means being able to operate, either at current or increased capacity, without relying entirely on donors; for PSPI, it additionally means longevity of impact. For these organizations, linking with national health insurance has been a key strategy to increase the financial sustainability for their members. As a result of accreditation with PhilHealth, these franchises also report improved clinic quality and stronger patient-provider relationships.

#### Financial model and goals

Both organizations are funded primarily by donors with very minimal cost-recovery from franchisees. Franchisees in these networks are required to pay a one-time franchise fee and monthly network fees. In the PSPI network, franchisees pay an annual fee of 1,000 PHP and a monthly fee of 1,000 PHP for equipment and supplies, for a total of 13,000 PHP annually (US \$261). These fees cover less than 5% of PSPIs operating costs, and MSI International funds the majority of operating costs.

In WFMC, franchisees pay a 30,000 PHP (US \$670) franchise fee, payable over five years, and a monthly fee ranging from 1000 PHP/month (US \$22) for clinics in rural regions to 3,000 PHP/month (US \$67) for urban clinics. WFMC provides minimal financial support to franchisees for clinic infrastructure and commodities. WFMC has a dual franchisor model with area and national franchisors. Area franchisors receive 90% of the franchisee fees, and WPFI receives 10%. The franchise fees do not cover the full operation costs of area franchisors, many of whom operate primarily with revenue from other grants and programs run by the NGOs. At the national level, the franchisee fees cover an insignificant amount of WPFI's operation costs, which are funded primarily by a trust fund left by JSI.

# Approaches for reaching financial sustainability

WFMC and PSPI have engaged with PhilHealth in a number of ways to help their members become and remain accredited, both during the early development of maternal and child health packages and through the expansion and modification of the PhilHealth program today.

1. Advocate with PhilHealth and Department of Health: Both organizations, especially WFMC, have invested significant time and resources into working with PhilHealth to ensure their members could become accredited, and that accreditation would be beneficial for the midwives. Key components of this engagement include:

- Negotiate feasible accreditation requirements: Health insurance requirements can prohibit entry for small private clinics. WFMC and PSPI were strong advocates for requirements that made participation in PhilHealth realistic for franchised birthing homes (e.g. size and training requirements, and referral mechanisms).
- Advocate for beneficial service packages:
   To benefit from health insurance programs, franchises need to align their services with reimbursable services. PSPI successfully advocated for reimbursement of an extended package of family planning services in line with those provided by their midwives.
- Advocate for better pricing: Reimbursement rates need to reflect the full cost of services in order to encourage private sector provision. WFMC conducted studies to assess the cost of providing delivery services, and successfully advocated for these costs to be adopted for the reimbursement rates for the Maternal Care Package, making accreditation attractive to franchised midwives.

WFMC and PSPI continue to represent the interests of their members at PhilHealth and DOH, particularly at the regional level. There is a need to maintain these relationships with the national policy bodies; the DOH is currently enforcing licensing requirements for birthing homes, and there are concerns that the licensing requirements will pose significant barriers for franchised clinics. On-going advocacy and partnership will be needed to make sure that franchises meet licensing requirements in order to continue operating.

- 2. Support franchisee accreditation and reimbursement. WFMC and PSPI provide direct support to franchisees to enable them to benefit financially from the PhilHealth program. Key components of this support include:
  - Help midwives meet accreditation requirements: Franchisors assist midwives to secure business permits and licenses, establish partnerships with referral facilities, and facilitate access to required trainings. Initially, WFMC and PSPI offered franchisees low-interest loans for clinic renovations and upgrades, though these programs have ended due to lack of funding.
  - Support accreditation and reimbursement processes: Franchisors assist midwives to process and submit accreditation and claims paperwork, as well as facilitate the re-accreditation process.

Maintain relationships with regional PhilHealth and DOH offices: To facilitate accreditation and reimbursement, and to manage challenges franchisees face in working with the PhilHealth program, the franchisors established close relationships with the regional offices of PhilHealth and the DOH.

Given the high cost of these activities, both franchisors face challenges in continuing to provide these support activities. For instance, while WFMC and PSPI initially supported midwives with loans for infrastructure and equipment to meet accreditation requirements, the franchises have ended these programs due to financial constraints, which in turn has slowed accreditation for midwives in the networks.

For more information about WFMC's and PSPI's work to ensure a successful link between franchisees and the national health insurance program, see the Global Health Group case study Social health insurance: an approach to long-term viability for social franchise programs? Lessons from the Philippines.



#### Financial opportunities for franchisors working with health insurance

Many experts in the field of franchising consider third party payment systems—such as national health insurance programs—as the most promising opportunity for financial sustainability, if franchisors can position themselves between the payer and the franchisees, for instance through contracts for service delivery and quality assurance. Social franchises in the Philippines could position themselves to receive direct financial benefit from their partnership with the DOH and PhilHealth through contracts for accreditation and monitoring of private providers. Both the DOH and PhilHealth recognize the role of the private sector in providing services, particularly in rural areas where there are fewer public facilities. However, from the perspective of PhilHealth, there is currently no difference between working with a franchisor and working with independent private clinics; PhilHealth still has to visit each clinic and process all paperwork individually. This is in part because there remain quality and compliance concerns regarding private clinics, such as midwives failing to refer cases or billing for services they do not provide. However, it is difficult for PhilHealth to accredit and monitor the large volumes of private clinics in the system, and the process is longer than for public facilities. Therefore, if a franchisor could guarantee compliance with accreditation standards for all its members, it could contract from government services for accreditation, along with monitoring and training. Representatives from PhilHealth and the franchisors suggested opportunities such as this for stronger partnership, though these direct contracting relationships have not yet been established.

#### The AHME experience with health insurance

The AHME partnership is engaged in several activities to support Amua and Tunza franchisees to become accredited with the National Health Insurance Fund (NHIF) in Kenya. As the NHIF undertakes new initiatives to increase its population coverage, AHME implementers believe that NHIF accreditation will be an increasingly important means of securing a sustainable revenue stream for franchisees while enabling them to reach poorer clients.

NHIF accreditation, eligibility, and reimbursement requirements are poorly understood by some franchisees. To help address this, AHME funds will be used to 'hand-hold' Amua and Tunza clinics through empanelment, the process by which NHIF accepts facilities into their system and allows them to claim reimbursement. AHME is also facilitating their franchisees' participation in SafeCare's quality improvement program. Separately, PharmAccess is working with NHIF

to recognize SafeCare's quality assessment process as an accreditation tool. Under this system, different levels of SafeCare accreditation will correspond to different levels of NHIF reimbursement, and thus only the facilities accredited at the highest SafeCare level would receive 100% of the maximum NHIF reimbursement rate. This link between SafeCare and NHIF will benefit the Amua and Tunza franchised clinics, whose participation in the SafeCare quality improvement and accreditation process is already supported by AHME.

On the policy level, several of the AHME partner organizations are engaged in discussions with NHIF and other organizations on the development of a new Joint Inspection Tool for the empanelment process. As part of the new tool, NHIF is developing a portal that is designed to allow providers greater access to information about NHIF rules and regulations, as well as improve transparency around the empanelment process.

# Advantages and challenges of linking franchising and health insurance

Participation in national health insurance programs is a successful strategy to increase the profitability and financial sustainability of franchised private providers. PSPI and WFMC franchisees have reported increased profitability due to PhilHealth reimbursements. National health insurance can enable franchises to increase profits without compromising their ability to serve low-income populations or increase out of pocket payments; though this is only true where these insurance programs enroll low-income clients. Historically, WFMC and PSPI franchisees focused on providing services for middle-income clients who were able to pay for services. PhilHealth is continually expanding coverage to low-income communities, and the reimbursement rates enable franchisees to expand their services to these populations.

WFMC and PSPI have benefited from the Philippines context, where roughly half of all health services are provided in the private sector, and the majority of maternity care providers are private providers. Given the role of the private sector, PhilHealth actively engaged with private sector partners in the roll out of the national health insurance program, and the franchisors were therefore able to advocate for policies that facilitated franchisee participation. The licensing and accreditation process

are undergoing significant changes; in 2015 the DOH is introducing new mandatory licensing guidelines and Phil-Health accreditation will move to the DOH. To ensure that new and evolving policies continue to benefit franchisees, WFMC and PSPI will need to invest continued energy in their relationship with PhilHealth and DOH.

Building and maintaining strong relationships with government agencies, and facilitating the accreditation process for franchisees, are resource and time intensive processes for the franchisors. At the same time, the franchisors have been unsuccessful in leveraging the financial benefits received by franchisees to also support the operations and financial stability of the franchisor organization. Neither WFMC or PSPI have increased franchise and royalty fees, even as member clinics have dramatically increased profits; often these organizations struggle to have members pay on time, and in some cases WFMC area franchisors have had to lower their fees to prevent attrition. The financial success members have had as a result of accreditation has also reduced the reliance members have on their affiliation with the franchisor, particularly once the franchisor has trained members in the accreditation process. Franchisors will need to identify additional, on-going, value that they bring to their members to ensure that franchisees remain in the network even as they participate in health insurance programs.

# Strategy #3: Recover costs from franchisees

In the traditional commercial franchising model, franchisors benefit financially both from efficiencies in operation (e.g. economies of scale in purchasing and advertising) and from financial returns from franchisees (e.g. fees, royalties, and investment capital contributions).<sup>17</sup> In social franchising, few programs have successfully benefited from the range of financial opportunities presented in the commercial model, and instead frequently

support franchisees through subsidies for clinic infrastructure, products, training, and quality assurance. Recognizing that franchisees themselves could be a potentially significant source of revenue, two franchises—the Child and Family Wellness clinics in Kenya and Unjani Clinics in South Africa—are developing franchise models that recover more costs from their member clinics as a strategy to achieve financial sustainability.

#### **Case Study: Child and Family Wellness** Clinics, Kenya

#### Program history and structure

The Child and Family Wellness (CFW) franchise was established in 2000, and is jointly run by US and Kenyan organizations. The HealthStore Foundation, a US-based non-profit, oversees the franchise program and is responsible for strategic direction and fundraising. The Sustainable Healthcare Foundation, a Kenya-based NGO, is currently responsible for managing the operations of the franchise program.

The HealthStore Foundation created CFW shops with the mission of expanding access to essential medicines in rural Kenya. To achieve this, the early CFW franchisees were retail drug outlets operated by community health workers selling over-the-counter medicines and hygiene products. In 2004, the program transitioned to nurse-owned clinics, enabling the franchise to provide an expanded set of products and medical services, including maternal and child health care, basic preventive services, and simple acute care services such as wound care and malaria treatment. CFW is a full-format business franchise, requiring franchisees to offer a defined set of outpatient services and health products; a CFW franchisee is a licensee of the CFW system, brand, and business format. There are currently 56 CFW clinics and 9 CFW shops.

#### **Definition of sustainability**

The HealthStore Foundation seeks to build a fully profitable commercial franchise, in which all of the operating expenses are recovered from franchise fees and sales. Serving low-income clients is a central goal of the CFW franchise, and a measure of its sustainability. To this end, the program is working to develop complementary programs (e.g. health savings schemes) that will enable commercial growth without losing this second goal of sustainability.



#### Financial model and goals

The HealthStore Foundation and CFW franchise was initiated with funding from the founder. The program later attracted grant funding, and the franchisor organization continues to be primarily donor-funded. At the franchisee level, CFW clinics are financed primarily through out of pocket payments for products and services. Franchisees cover the majority of their direct operating costs through this source of revenue, while SHF subsidizes less than 10% of the clinics' operating costs through supporting some of franchisees core costs such as annual clinic licenses. At the franchisor level, over 95% of franchisor costs in Kenya (and 100% outside of Africa) are paid by grants and donations.

To pursue its goal of becoming a successful commercial franchise company, the organization is transitioning from a non-profit to a for-profit model. A for-profit holding company was created in the US, and a for-profit company, HealthStore East Africa, was incorporated in Kenya. The HealthStore Foundation remains a non-profit organization. and continues to govern the program direction, as well as receive donor funding to support operations or invest in HealthStore East Africa. The US-based holding company can also receive investment funds directly, and invest these in HealthStore East Africa.

The for-profit HealthStore East Africa will serve as the franchisor for all new franchise outlets, which will operate under a restructured model. HealthStore East Africa has opened the first four of the new for-profit clinics. The 65 existing 'legacy' facilities will continue to operate under their current franchising agreement with the non-profit SHF, and SHF will pay a management fee to HealthStore East Africa for its role in running the network. It is possible that some successful existing franchisees will be given the option to switch to the new model and sign a new franchise agreement with HealthStore East Africa; otherwise, they will remain in operation under the current non-profit system. No new clinics will be opened by SHF.

In restructuring the program to a more traditional commercial franchise model, the franchise seeks to generate greater revenue from franchisees, enabling the new for-profit franchisor to pursue profitability based on royalties and fees collected from franchisees. The ability to generate a return on capital will help attract a new form of investor to the franchise program, which will make it possible to scale similarly to other commercial franchise companies.

#### Approaches to reaching sustainability

Within this new for-profit model there are three main strategies the organization is using to reach sustainability:

- 1. Attract investment funding: The CFW franchise will continue to seek non-franchisee funding in the form of investment capital rather than traditional donor funding. Investment funders are seen as beneficial because they will invest in the growth of the network, where many of the existing donors show more interest in subsidizing small pieces of the operations such as product purchase. The formation of a private holding company in the US will enable investors to receive a return on their investments in the franchise.'
  - However, to date the program has not received any investors. In part, this is due to the high returns requested and the risk-aversion of some social investors; for example many social investors require double-digit returns, while the presently projected rate of return is lower and the risks arguably higher. For this reason, the franchise is targeting only specific types of social investors. Other types of funders, such as those in microfinance, are also hard to attract to the model because the goals of those donors, and the milestones for success (e.g. rate of loan repayment), are poorly aligned to the indicators of success used by CFW. Therefore, as the program makes the transition to a for-profit model, and scales to the size required for larger returns, traditional donors will continue to be a primary source of revenue.
- 2. Recover costs from franchisees: To sustain a viable franchisor organization, CFW is designing strategies to increase the cost-recovery from franchise fees. Initially, franchisees paid a start-up franchise fee of US \$250, 5% royalties on sales, and repaid a US \$2,500 loan for start-up at an interest rate of ~18%. The program ended royalty payments in 2008. CFW initially charged a mark-up on products, but ended these payments as the organization felt this was counter to the goal of expanding access to essential medicines. Currently, products are sold to franchisees at the wholesale price, and CFW charges a small monthly franchisee fee of US \$16 for clinics and US \$11 for shops. These fees cover less.

In the new financial model, HealthStore East Africa will recover more costs from franchisees. Franchisees will pay a US \$500 franchise fee for a five-year contract,

- 8% royalties on product sales, a 2% advertising fee, and a 5% distribution offset. To increase cost recovery from franchisees, HealthStore East Africa is re-designing the program to raise franchisees' profits. On average, CFW clinics earn US \$5,000 annually, roughly half of which is profit. This is significantly lower than an estimated average income of US \$500/month for nurses in Kenya. To increase clinic profits, Health-Stores East Africa is pursuing three main strategies: 1) adding higher value services (e.g. laboratory services) to the franchise offerings, along with other changes to the clinic business model; 2) focusing on clients with higher purchasing power; and 3) integrating subsidized third party payments into franchisee revenue streams (see below). Using existing high-performing clinics to make projections, the program estimates that franchisee profits will reach approximately US \$6,000 a year in this new model.
- 3. Increase client purchasing power: The CFW franchise seeks to serve low-income populations, and initially targeted rural villages with limited access to health services. This rural focus impacted the profitability of franchisees, which frequently served clients with limited ability to pay. To increase business viability of franchisees, the program is shifting to locate clinics in rural towns and low-income urban communities with larger, denser, and wealthier populations. It is estimated that in the rural communities where CFW previously operated, average household income was \$2.50/day, while the target communities in the new model have an average household income of \$6/day.<sup>18</sup>

The program views third-party payments as essential for achieving their business sustainability goals while serving the poor. To this end, CFW is changing the way it uses subsidies in its network, transitioning from subsidizing inputs (e.g. franchisee nursing licenses, field support) to a situation where any subsidies will target low-income patients through third party payment mechanisms. The HealthStore Foundation is pursuing partnerships with third-party payers, including private micro-insurance schemes, large employers, health savings schemes, and the National Health Insurance Fund, in an effort to become preferred providers for these networks. The program has not established any form of third-party payment to date, and in order to maintain services for the poor, is currently trying other strategies, such as subsidizing services through coupons and local health savings schemes.

#### **Case Study: Unjani Clinics, South Africa**

The **Unjani Clinics** in South Africa (see Strategy #1 above for program description), is also implementing a number of more traditional commercial franchising elements to increase the percentage of operation costs recovered directly from franchisees. Under the franchise's financial model, in the first year of the scale-up, Unajni will recover 4% of its costs from the member clinics. This is in large part because 50% of Unjani's expenses for the first year of each clinic's operation are attributable to infrastructure investments. By year 4 of the expansion, once most of the initial infrastructure costs have been covered, Unjani projects that it will recover 25% of the NPC's annual operating costs from clinics.



#### Cost recovery model

Unjani spends approximately 540,000 Rand (US \$49,000) to support the start-up of each clinic. This includes the cost of clinic infrastructure and clinic equipment, an initial stock of clinical and medicinal supplies, furniture and computer equipment, and 192,000 Rand in operational cash donations to assist with working capital needs. Unjani recovers 30% of this start-up cost (160,000 Rand/US \$14,500) through a monthly infrastructure recovery fee of 2,667 Rand (US \$242) that nurses pay over the duration of their five-year contract. If nurses renew their contract, they will continue to pay this as a network fee that will offset the costs of Unjani's operations. Nurses also pay monthly fees for marketing (1000 Rand/US \$90), business systems (450 Rand/US \$40), and ordering systems (250 Rand/US \$22). The business and ordering systems fees cover the full costs of these activities, while the marketing fee offsets the cost of marketing the Unjani brand. Each nurse pays a 10,500 Rand (US \$954) fee to join the network. This joining fee covers the cost of the 5-day training nurses receive.

Unjani provides operational support to nurses for the first two years of operation, beginning at 12,000 Rand (US \$1,090) for the first eight months, dropping to 8,000 Rand (US \$727) for the next eight months and 4,000 Rand (US \$364) for the final eight months. The expectation is that by the end of two years, nurses will have built a client base that can support the clinic operations and her salary. The break-even point, including salary, is 250 clients per month; Unjani encourages nurses to reach 180 clients monthly in the first year of business, growing to the break-even point by the second year. Unjani clinics charge a standard consultation fee of 150 Rand (US \$13), including medications. Unjani has raised the consultation fees over time (from 60 to 150 Rand) to ensure the financial sustainability of the clinics.

# Advantages and challenges of cost recovery models

In a financial model based on cost-recovery from franchisees, franchisors may have greater accountability to franchisees. In many programs, there is a perceived misalignment between the financial needs of the franchisor and franchisees: since the financial success of the franchisor—in a fully donor-dependent model—does not depend on the financial success of the franchisees, there is little incentive of the franchisor to pursue an operational model that maximizes the business success of franchisees. By transitioning to a full cost recovery model, franchisors will be pushed to support the financial viability of clinics to ensure a level of profitability that can also generate income for the franchisor.

Moving in a direction of traditional commercial franchises is also seen as a strategy to attract non-donor funding. For example, CFW believes that transitioning to a for-profit model will allow them to attract investment capital that will facilitate program expansion, as well as ease partnerships with banks to increase franchisee access to capital, since banks currently hesitate to offer loans to franchisees without formal credit history and to those whose financial needs are larger than microfinance loans and smaller than traditional bank loans. Unjani is considering investments from other businesses looking to fulfill their BBBEE requirements. However, there are also concerns that transitioning to a for-profit model may make it more difficult for programs to continue receiving funds from longstanding donors in the health community.

The primary challenge social franchises pursuing cost recovery strategies face is ensuring that franchisees can serve poor and rural clients, as cost recovery necessitates

charging clients a rate that will cover operating costs both for the franchisee and franchisor. CFW's rural franchisees could not sustain sales volumes and prices of sales that enabled them to make significant contributions to the franchisor's operating costs, leading CFW to move clinics away from rural areas. For this reason, CFW is seeking to partner with health insurance or other third-party payers, though it has not been able to do so yet. Unjani has doubled the consultation fee over time in order to reach a sustainable level, and also targets clinic placement in peri-urban areas where the population has the ability to pay for services. Accordingly, Unjani does not aim to target the poorest segments of the population.

Franchises also face tensions in the organizational culture as they transition to more commercial, for-profit models. CFW experienced challenges among its staff, with some viewing the for-profit model as a move away from the organization's core mission of providing needed health services, as well as among its franchisees—nurses who have worked with the organization for many years expressed doubt about the move to increase fees.

A second major challenge is reaching scale; Unjani and CFW recognize that they will have to significantly scale-up their networks for the organization to reach full cost recovery. For example, HealthStores estimates that they will need to expand to roughly 200 clinics to generate sufficient revenues for the franchisor to become financially self-sustaining under the new model. However, growing the network to this scale will take several years; one business projection estimated the program would require a \$2.5 million investment over a 7-year period to reach a break-even point.<sup>19</sup>

# Strategy #4: Focus on a product-driven model

Commodity social marketing is a financially sustainable approach used to expand access to health products globally. Social marketing organizations like DKT International have become profitable and independent of donor support by focusing on product sales rather than health services provision. Other organizations, such as INPARRES in Peru, have used the profits from product sales to support clinical services provision at existing clinics.<sup>20</sup> The product-focused model is financially successful because of the large volume of sales

and the low operation costs, as compared to managing and maintaining brick-and-mortar clinics, or to providing training and quality assurance support for services. Several social franchising organizations are pursuing similar product-driven models to reach greater levels of financial sustainability. Living Goods is as an example of a program that aims to use a product sales model to provide an impactful, and financially strong, product delivery model.

# Case Study: Living Goods, Uganda and Kenya

#### Program history and structure

Living Goods was founded in 2007, with the mission of bringing essential health commodities to underserved communities through an "Avon-style" micro-franchise in which mobile sales agents provide a package of basic health services and commodities. The program started in Uganda, in partnership with BRAC, a Bangladesh-based development organization, and expanded to Kenya in 2012. Living Goods Uganda is an entrepreneurial community health worker model which focuses on non-clinical maternal and child health services, including pregnancy registration, ante-natal care counseling and commodities, and post-natal visits; diagnosis and treatment for malaria, pneumonia, and diarrhea; and hygiene products and overthe-counter drugs. Living Goods Kenya is a livelihoods model that includes only the sale of hygiene products, nutritional supplements, and durable consumer goods. Both programs target lower-middle income clients, primarily in urban and peri-urban areas.



#### **Definition of sustainability**

Living Goods defines sustainability as achieving "high impact at scale at a low cost." Living Goods Uganda, with its focus on maternal and child health services, seeks to maximize and expand its maternal and child health impact, while Living Goods Kenya defines sustainability in more economic terms—supporting economic livelihoods development for agents (income generation) and helping clients save money with high quality products.

#### Financial model and goals

Living Goods is financed by a combination of donor funding and profits from product sales. Donors currently fund over 90% of Living Goods' operating costs. Profits from product sales contribute only a percentage of in-country expenses, covering 80% of agent level costs (recruitment, training, and agent equipment) and 60% of distribution level costs (branch rental, branch manager and assistant salaries, equipment, and marketing and branding) in Uganda. Both country offices are working to increase the financial strength of their programs; however given the different models and goals in Uganda and Kenya, each program has unique financial targets. In Uganda, the high operating costs associated with training, monitoring and supervision, and quality assurance activities required to run a community health worker program, together with the emphasis on low cost, low margin medicines, makes reaching cost recovery challenging. The program has a goal of cost-effectiveness, and will continue to rely on external funding to support operations. In Kenya, Living Goods is able to pursue a goal of financial sustainability given the limited operational costs of a delivery model that does not include health services and focuses on high value products such as cook stoves. The program intends to reach country-level financial sustainability in the next three to five years, with the in-country operating costs fully covered through profits on sales.

#### Approaches to reaching financial sustainability

The profitability of Living Goods' model relies on the performance of sales agents and, more specifically, on the volume and margin of product sales, as agents do not pay franchise fees. The two program offices are pursuing similar strategies to strengthen the size and performance of the sales agent network in order to improve cost-effectiveness and reach greater cost recovery. Living Goods is using three main strategies to reach these financial goals.

- 1. Focus on a high value basket of products: In determining the product basket offered by Living Goods agents, the organization assesses the products' health impact and margin, and customer demand. Initially, agents sold a large variety of products under the assumption that having more products would facilitate more sales. However, there are limitations to this model: it makes branding agents more difficult and can lead to agents selling easier—rather than more impactful or profitable—products; additionally, managing the supply chain for a wide variety of products is costly. Living Goods is currently modifying its product basket to:
  - Narrow the number of products sold. Living Goods is reducing the number of products within each product category to focus on higher-margin

- varieties and removing products with low demand or low margins.
- Focus on products sold for their business value. Living Goods is offering more products that are not widely available in the market and can therefore be sold at a higher margin.
- 2. Increase sales margin: Living Goods currently earns an average 15–20% margin on product sales, while agents earn an average 10–15% margin. In order to reach a level of cost-recovery that will sustain in-country program operations, Living Goods estimates that they will need to increase the sales margins to 25–40%. To increase the margins they receive on sales, Living Goods is pursuing the following strategies:
  - Partner with manufacturers. Living Goods
    works closely with manufacturers and wholesalers
    to negotiate discounted prices through bulk purchases and long-term fixed price sales contracts;
    and is focusing on working with local manufacturers to reduce shipping costs. Living Goods works
    with some manufacturers to procure raw materials
    and receive products at a discounted price.
  - Offer private label products. Living Goods recently created its first private label product, a fortified porridge for children aged six to nine months, and is exploring additional products to develop. Living Goods is also working with manufacturers to place their label on existing products, or to manufacture lower cost models specifically for their agents (e.g. low cost cook stoves). This strategy can be risky if the product does not sell well or the program does not reach the scale needed for cost recovery.
  - Increase product prices. Living Goods is exploring opportunities to price products more competitively with the market. Essential medicines are sold at 20–40% below market rate, while durable goods are sold at 5–10% below the market price. Essential medicines will continue to be sold at discounted rates, whereas the price of other products may increase. Living Goods believes that clients are willing to pay competitive prices for the quality and convenience of their products, and will pay marginal interest to be able to buy products on credit they would otherwise be unable to afford. Currently, 28% of all sales in Kenya are on credit, and the program is working to expand their credit options.

- 3. Improve sales agent retention and performance:
  - The performance of sales agents is essential to the financial success of the program. As the costs to recruit and train sales agents are high, particularly in the Uganda program, it is important for agents to remain active enough to recover these initial costs. Increasing the sales performance of low-volume agents is also important for cost-recovery; currently, just 20% of agents account for 80% of sales. Living Goods is using several strategies to improve agent retention and performance:
  - Support sales agents. Living Goods supports agents through training, monthly meetings, and field agent visits, and provides coaching for inactive agents.
  - **Expand access to capital**. Living Goods offers agents the opportunity to buy products on credit, allowing them to stock larger volumes of high value products.
  - Facilitate re-stocking. To limit the transportation and cost barriers agents faced in reaching the branch offices for product re-supply, Living Goods introduced a hub-and-spoke delivery system to deliver products to agents' homes.
  - Engage agents in recruitment and management. Living Goods Kenya is piloting two incentive programs to engage existing agents in recruiting and supporting new agents. In the first, agents are paid for each new agent they recruit. In the second, agents are offered a percentage of the sales profit from each agent they recruit. In this model, based on other door-to-door sales programs (e.g. Avon and Mary Kay), agents participate in managing and encouraging other agents, as they are invested in their performance.
  - Modify voluntary sales agent model. Living Goods is considering modifications to the current agent-based model to increase cost-effectiveness, for example hiring full-time sales agents or sales representatives. Full-time sales force models may be more cost-effective, require less management and training, and have higher sales volumes.

#### Advantages and challenges of a productdriven strategy

Living Goods has successfully used a product-focused model to increase cost-effectiveness and improve the financial sustainability of in-country operations. Their experience also offers insight into the benefits and limitations of this model. The reliance on mobile agents and product sales is highly cost-effective and scalable; Living Goods has rapidly expanded its network and has plans to significantly continue this growth. However, there are tensions between health impact and financial sustainability goals; the more profitable model in Kenya does not seek to have health impact in the same way as the Uganda program, focusing instead on livelihoods of sales agents. This leads the organization to have two different program models in the two countries.

Whether or not financial sustainability should be a goal of Living Goods remains up for debate in the organization, and each program is seeking different impacts with different financial goals A rigorous evaluation documented impressive health impacts of Living Goods Uganda, which achieved a 26% reduction in under-5 mortality in areas where Living Goods was in operation.<sup>21</sup> However, in Kenya's more business-oriented model the program does not seek to achieve health impact. In Uganda, results of the evaluation have "reinvigorated" the prioritization of health impact over financial return—two of Uganda's seven branches were previously operating similarly to Kenya's model, but are now in the process of converting back to a community health worker model more typical of Uganda's other branches. With this emphasis on health impact, transitioning away from donor funding is no longer a priority for Living Goods Uganda.



# Lessons learned across programs

The programs highlighted in the case studies offer useful insights for programs seeking to increase their financial sustainability, including important questions to consider regarding program design and implementation, the position of social franchises within the health system, and the relationship between franchises and donors. From the case studies, several key lessons emerge which may benefit programs and donors alike as they consider options for increasing financial sustainability.

#### **Increase program cost-effectiveness**

Cost-effectiveness is a core goal of social franchising, and yet many programs and donors report they have not yet reached a high level of cost-effectiveness. For the programs highlighted in this report, cost-effectiveness was viewed as an essential step in reaching a greater level of financial sustainability. Having a cost-effective operations model enables the program to scale-up, to more successfully contract with partners, and to maintain donors.

Establishing strong financial management and data systems, and building staff capacity in business and finance, is needed to increase cost-effectiveness. These steps not only ensure that resources are well spent, but also are needed to understand program costs and set the right fee and price structures. Living Goods is training program managers on finances, increasing financial controls to ensure departments spend within their budgets, and improving financial reporting. CFW shops is expanding their financial data collection, using this to guide their program design and scale-up plans, as well as pairing this data with impact data to demonstrate the return on investment for program funders.

Program operations can also be modified to increase cost-effectiveness, such as by improving management structures or increasing franchisee performance. Smiling Sun introduced cost-savings mechanisms such as reducing staff size, and added additional services that could be provided within the existing infrastructure and staff capacity at clinics to increase efficiency. The program was able to reach 70% cost recovery within 5 years. In the WFMC network, many of the NGO area franchisors operate programs in addition to the WFMC franchise. By diversifying the programs and funding sources within the organization, these NGOs cross-subsidize some of the operational expenses of running the franchise, albeit still using donor funds.

Programs still find it challenging to reduce costs, particularly while maintaining the quality and impact of franchise programs. Some programs feel that more significant changes to the franchise model will be needed to become truly cost-effective. Many raise the concern that franchise networks may be "over-built", providing services for franchisees that might be better done through contracting outside parties. Others feel that alternative forms of provider networks, such as network-owned clinics, may be more cost-effective models. Finally, concerns about cost-effectiveness raise questions about the fractional franchising model that predominates the field, with many experts suggesting that full franchises may be more cost-effective, as well as more impactful in the communities they serve.

#### **Diversify funding sources**

To be financially sustainable, facilitate growth, and reduce risk, franchises need to diversify their funding sources. There is wide agreement that donors can play a part in a strong financial model as long as a single donor is not the sole source of funding, though most social franchises continue to rely on a small number of core donors. Having diverse funding, and diverse donors, is crucial for programs to weather various financial challenges (e.g. market or donor "storms"). Reliance on a single donor can narrow the program mission and direction based on the donor's interests, particularly because many donors are interested in specific health areas. Diversifying the franchise's services can help to diversify the donor base for funding core franchise operations and reduce vulnerability to donor priority shifts.

Some franchises are looking at non-health donors, such as attracting livelihoods or economic development donors. However, this transition can be difficult; Living Goods has been unsuccessful to date at attracting this type of funder because their sales agents do not generate significant income through product sales when compared to programs focused purely on livelihoods. It can be difficult to attract donors as programs transition to full cost recovery models; Well Family Midwife Clinics has struggled to attract the donor funding they need to support the franchisor operations and scale-up because many donors focused on health impact are skeptical of funding programs that charge for services. Unjani Clinics, in contrast, has focused on corporate donations for livelihood generation from the beginning of the program, and has thus attracted a funder that is primarily interested in seeing the clinics perform as viable businesses.

More recently, social franchises have been exploring the possibility of attracting social impact investment. CFW, for example, is transitioning to a for-profit model in which they hope to be able to provide a return on investment that will attract new forms of financing to the franchise. However, no programs have yet been able to attract this kind of investment. In addition, this model, with its need to generate large profits, raises significant challenges for maintaining service affordability.

#### Scale-up the program

Reaching a larger scale is important for the sustainability goals of most social franchises. Scaling is not only essential for most franchise models to reach cost-effectiveness, but can also increase the impact a program has on community health. Despite this, the majority of franchises working towards sustainability operate at a scale smaller than required to be cost-effective. For instance, Living Goods estimates that its distribution branches and existing management structure could support two to three times as many sales agents; and CFW estimates it will have to grow its network by three to five times in order to reach cost-recovery. Unjani estimates it will need 300 clinics to reach full cost-recovery, but is concerned that a rapid scale-up will strain program resources and lead to a higher clinic failure rate. The high start-up and fixed costs to build up clinic and distribution networks is a significant barrier programs face in trying to reach scale.

Finding partners who can support or share some of these costs is a key strategy for reaching greater financial sustainability. In Uganda, Living Goods is working on partnerships with the government to leverage the existing village health worker program by recruiting trained health workers as sales agents and exploring possibilities to link with government-run training programs or scale the model in the public sector. In addition, Living Goods partners with organizations such as BRAC, who also have product distribution sites, and social franchises such as Population Services International, who have clinics that could function as distribution and referral centers. Programs such as Smiling Sun and Well Family Midwife Clinics were able to reach a large scale quickly by incorporating NGO's together with their existing clinics—into the franchise network. CFW shops is exploring the possibility to have multi-unit franchisees, reducing the cost of going to scale by requiring training for fewer franchisees, each operating multiple clinics.

# Define and capitalize on the franchisor value proposition

Across social franchise programs, there is a sense that franchise organizations need to better articulate, expand, and capitalize on the value franchisors bring to franchisees and external partners.

Franchisors can be of great value to external partners such as national or private health insurance by providing much of the training, technical assistance, and monitoring and quality assurance activities that health insurance programs require to manage their providers. However, few franchisors have been able to capitalize on this value to date. For example, although the franchises in the Philippines have ensured that their members receive reimbursements from PhilHealth, the franchisors themselves receive no financial benefit from their work with the insurance program. Although Tunza and Amua are working to fast-track the National Health Insurance Fund accreditation of their clinics through partnership with SafeCare, there is also no plan for the franchisors to receive any financial benefit from this relationship.

There are a few examples of franchisors benefiting financially from formal relationships with insurance programs. For instance, many of the International Planned Parenthood Federation affiliates in Latin America have negotiated contracts directly with public and private health insurance programs, therefore enabling them to cover operational costs while supporting clinics providing services. Similarly, Smiling Sun Franchise in Bangladesh developed contracts directly with large private employers, such as H&M, for their employees to receive services at Smiling Sun clinics. In order to identify opportunities for capturing some of this revenue at an organizational level, franchisors will need to better articulate the value they can bring to health insurance programs, employers, and other partners.

Similarly, franchisors need to better frame and sell their value proposition to franchisees, which in turn may increase member willingness to pay franchise fees and remain in the network over time. In addition to supporting franchisees in generating greater profits, franchisors can expand the business and capacity-building support they provide, and link their members to external partners that provide additional services (such as PharmAccess) or to third-party payers. Some franchisors have been able to expand their offerings to franchisees and use this to increase the payments from their members; for example PSI Tanzania piloted a successful tiered membership option in which franchisees paid more for extra training. It is important for franchisors to continually assess the value they bring to members, and ensure that this extends beyond

initial training and start-up support; some franchises have seen members leave the network as their financial success grows and they no longer need or receive much support. If the value franchisors offer to members is not significant enough and sustained over time, increasing franchise fees may also limit the growth of the network by disincentivizing membership.

Some franchisors feel that by increasing the value they bring to their members, they will also have greater leverage to ensure that members are compliant with quality and equity standards, by having a higher incentive to maintain membership and therefore making compliance "worth it". However, others feel that repositioning franchisors in order to increase franchise fees could reduce the ability of programs to serve the poor if franchisees pass these costs on to clients.

# Align the franchise with the national context

The health system context within which programs operate—including the health financing options available. the national regulatory system, the strength of alternative healthcare options, and the health and wealth status of the population—significantly impacts the financing strategies available to social franchise programs. The alignment of a franchise's operational model and goals with the priorities and regulations of the national government is essential for the program's success, and impacts the program's ability to meet health and financial sustainability targets. For example, Living Goods Uganda has aligned the work of its sales agents very closely to that of the public sector community health workers, and has close relationships with local and national health departments. facilitating program expansion in Uganda. In contrast regulatory restrictions on community health worker scope of practice in Kenya has led to a business, rather than health, focus.

Franchises need to understand the health system and financing within the country, in order to identify what sources of domestic financing may be available and the best role for the franchise to play within the health system in order to capture these resources. The BlueStar and Well Family Midwife Clinic programs in the Phillippines have expanded their services to align with the PhilHealth reimbursement packages, and were able to use their strong relationships with PhilHealth and the Department of Health to effectively advocate for packages and reimbursement

rates that benefit their member clinics. In Bangladesh, the Smiling Sun franchise worked with the national and local government to support program operations; the Government of Bangladesh provided the program's contraceptives, amounting to US \$18 million over the course of the project, and at the local level Smiling Sun signed contracts with local health departments to participate in national immunization days and other health programs. In South Africa, Unjani has been able to take advantage of the BBBEE act, and as the network seeks to expand they may look for funding from other businesses to generate more domestic investments rather than turning to traditional donors.

#### Innovate and adapt

To best capture the value franchises can bring to their members and partners, successful franchises are flexible and innovative, and able to adapt to the context in which they operate. Smiling Sun, Well Family Midwife Clinics, and the AHME participating networks (Tunza and Amua) have each adapted the services they offer to meet the needs of the populations they serve and better partner with external agencies. Living Goods continually pilots new programs to improve various elements of their operation—from product distribution to agent recruitment. Programs that are able to respond to changes and opportunities within their local health context are better positioned to capitalize on new sources of financing and expand their role in health services provision.



#### Plan for sustainability

Improving the financial strength of a social franchise program requires planning. Often, programs run for years without much attention given to the cost-effectiveness or financial stability of their operations. Making this transition—from a non-profit or NGO model, in which an organization is driven purely by its health and social objectives, to a business model, in which financial objectives are prioritized—is challenging. Many franchises spoke to the difficulties of developing new organizational models to generate revenue and building systems to capture and analyze financial information. For many, the biggest challenge was addressing the huge shift in organizational culture and capacity that is required to transition to a business-minded model. This is particularly true among franchises that have emerged from within existing NGOs, where staff expressed concerns about the ethics of the new business focus. A focus on financial sustainability also requires a level of business training that few leaders and staff within these organizations had prior to entering franchising. Strong leadership, and extensive business

training for staff at all levels of the organization, is needed to lead to this cultural shift, as well as ensure that the systems and structures are in place to generate income and reach cost-effectiveness.

Planning for and transitioning to a model that focuses on financial sustainability also takes time. The Well Family Midwife Clinics and Smiling Sun Franchise underwent rapid transitions away from donor funding. Smiling Sun was able to reach 70% cost-recovery in just five years; however this transition was difficult, and in the end the focus on sustainability was put aside due to concerns about quality and equity. For Well Family Midwife Clinics, JSI, through USAID funding, supported a transitional period, including establishing the national franchisor organization. However, with the end of donor funding to support program operations at the area franchisor and franchisee level, the program still experienced challenges in growing and maintaining their network. Creating the systems and capacity for sustainability, and building the network to a sustainable scale, requires significant planning and time.

# Integrating financial sustainability with social franchising goals

A global consortium of social franchise programs for health established a set of five programmatic goals for social franchising: quality, health impact, equity, cost-effectiveness, and increased use of franchised services (health market expansion).<sup>22</sup> These goals guide social franchises in developing programs and assessing their performance. Although some organizations are thinking about how to approach the issue of financial sustainability, this has not yet become a central priority within the social franchising community. In part, this is motivated by concerns that a focus on financial sustainability may limit the ability of franchises to reach their core goals. The franchise programs in this report offer important lessons and considerations for how to balance financial sustainability with the social franchising goals of equity, quality, and health impact.

#### **Equity**

In agreeing upon equity as a common goal, social franchises affirmed their intention to serve low-income clients. To ensure that clinics provide affordable services, while enabling franchisees to make a profit, social franchises subsidize the cost of services and products, and set price guidelines for the franchisees. Many franchises locate their clinics in low-income communities; franchises also often use tiered pricing, charging higher prices to wealthier clients or for non-essential services, and using this to cross-subsidize services to the poor.

In order to be profitable, franchises rely on serving clients who are able and willing to pay for services, and therefore depend on serving an economically diverse customer-base that can purchase higher value products and services. Some franchises have been more successful at serving low-income clients. For example Smiling Sun reached a very high level of cost-recovery while growing the share of low income clients from 26% to 33% by adopting a tiered pricing system, partnering with voucher and employer-sponsored insurance programs, and using community outreach providers to reach rural and poor communities. Given the financial limitations franchises face in serving low-income clients, the majority of franchises serve lower-middle and middle-income clients who can afford services, and do not target services to the very poor. In many cases, franchises disproportionately serve the wealthiest demographic, even when clinics are located in low-income areas.

It is also difficult for franchises to serve rural areas, due to the high cost of managing a dispersed rural network. Many franchises have re-structured their programs to

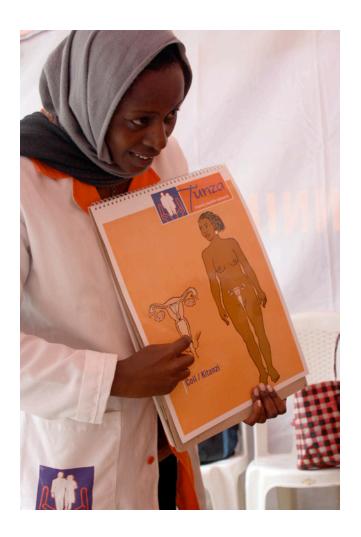
serve urban areas in order to be more cost-effective. CFW initially operated only rural clinics, but in an effort to reach greater cost-recovery, shifted the location of clinics to larger towns and cities that have higher customer traffic and a wealthier client base. Many of the Well Family Midwife Clinic NGOs that previously provided health services in rural areas moved their clinics to more urban settings after joining the franchise network and some WFMC area franchisors with a large rural presence left the network.

There is a clear tension between serving low-income populations and running a sustainable business model. Although some franchise programs stated that poor clients are willing to pay for quality services, the majority expressed concerns that charging out of pocket payments for health services was prohibitive to reaching the poor and that franchising is best suited to serve middle-income clients. To provide services for low-income clients, franchises will need to link with a third-party payment mechanism that covers services for the poor, or continue to work with donors to subsidize these services. Donors and programs seeking to increase financial sustainability must consider the impact this will have on the type of clients franchises can serve, particularly given the concerns many franchisors have that franchisees will pass any increases in fees on to their clients. While partnering with health insurance programs to ensure franchisees can provide affordable services is a promising model, this will continue to be a challenge in the many countries that do not have national health insurance programs, or have health insurance programs that do not achieve wide coverage among the poor.

#### Quality

Social franchises also face challenges in balancing the profitability of their program with the ability to ensure the high quality of services offered. Quality assurance activities (e.g. training, monitoring, and enforcement) are time and resource intensive. In seeking to reduce operation expenses, programs must often make tradeoffs in terms of the level of quality assurance implemented in the program.

For example, Living Goods Uganda provides extensive training and quality assurance monitoring for their agents who are providing diagnosis, treatment, and referral for maternal and child health conditions. This "high-touch" model is expensive to manage, and in an effort to become more cost-effective, the program began to reduce the amount of training and supervision agents received. However, reducing support for agents resulted in poorer agent



performance; as a result, the program determined that the training and quality assurance activities were of greater priority than maximizing cost recovery. The AHME franchises, through partnering with SafeCare, have been able to introduce quality assurance activities at a lower cost to the franchisors. Such partnerships may be one approach to maintaining quality while improving cost-effectiveness. Some franchise programs also identified the value of full franchising all services offered for improving quality and efficiency; full franchising allows franchisors to guarantee the quality of all services offered at franchised outlets, without adding significant additional operating costs.

#### **Health impact**

The ability of a program to serve the community in which it is located and provide high quality services affects the program's health impact. Often, the products and services that are most profitable are not the same as the products and services that have high health impact. In pursuing a path to financial sustainability, a program may risk reducing its health impact. For example, Living Goods Kenya is positioned to be fully sustainable in the coming years; however this is possible given its focus on non-health products such as cook stoves and solar lights. In Uganda, the emphasis on medicine sales—with fixed and low margins—together with the need to conduct expensive training to support community health promoters, prohibits a goal of financial sustainability.

# Role of donors in reaching financial sustainability

Donors have, and will continue to play, an important role for social franchise programs. Donor funding is essential in the start-up and scale-up of social franchises. Significant front-end investments are needed to fund activities such as developing management capacity, establishing data and quality assurance systems, and building supply chains and clinic infrastructure. Scaling up programs also requires significant investment. For example, BlueStar and Well Family Midwife Clinic networks will have to make substantial investments in clinic upgrades and equipment purchase to ensure that their members can be licensed for health insurance reimbursement under the new requirements. Living Goods has made significant investments to develop technologies that support health and financial data collection. The majority of social franchises do not have a level of profitability that enables these types of investment, and donors can play a crucial role in financing these activities.

Many franchises are looking to health insurance programs as key partners in ensuring the business profitability of clinics without losing the capacity to provide affordable services. Donors have a significant role in supporting the development of these complementary programs. For example, some franchisors spoke about the important role donors play in establishing health insurance programs and facilitating the relationship between franchises and government partners. As donors work together with social franchise programs to plan for increasing financial sustainability, donors can think about ways to target their spending that will ensure franchises continue to succeed while facilitating a transition to greater financial stability. Specific considerations for donors include:

- Use donor funds as an investment, not a subsidy:
  Currently donor funding is used most commonly to
  subsidize franchise operation costs. Donors could target their investments to scale-up franchise networks,
  supporting growth and cost-effectiveness. Donors
  could also focus their funding to develop the organizational capacity of franchises. This could include
  funding to: support capacity-building to leverage alternative funding sources such as health insurance or
  contracting; develop new systems or technologies to
  improve operational efficiency; and support business
  and leadership training for staff.
- Change the incentives for donor funding: The current incentives and accountability systems associated with most donors are misaligned with the goal of financial sustainability, because there is very little incentive for programs to be cost-effective. Rather, with donor

#### **USAID** graduation experience

USAID has graduated many of its family planning programs in Latin America and other regions. To facilitate the transition away from donor funding, USAID created a graduation strategy that outlined criteria for initiating graduation and focus areas to ensure a successful transition. With the goal of improving access to family planning, USAID based the initiation of a transition on two core health impact indicators: total fertility rate and contraceptive prevalence. "Readiness" for graduation was then assessed based on a number of organizational and contextual factors such as the political commitment to family planning, the security of contraceptive product supply, and the human resource capacity in the country. US-AID provided technical assistance to programs and worked with national governments to generate commitment for domestic family planning finance. To support transition, USAID reduced direct funding for commodities first, phasing out technical assistance later. The USAID graduation experience may be a useful example for other donors, highlighting the need to set clear criteria for determining if and when to prioritize financial sustainability, and to develop context-specific sustainability plans.<sup>23</sup>

funding, the incentive is to spend money, and there is no accountability for under-delivery. This results in poorly structured programs and does not encourage innovation or cost-effectiveness. It also heightens the disconnect between the financial performance of the franchisor organization and that of its franchisees.

• Increase donor funding to support a strong health system: Donor funds could be used to create a more enabling environment for a strong private sector. Donors could invest in programs that aim to expand access to capital for health providers, support the development of national health insurance programs, or support training and accreditation programs for private providers.

Despite the benefits and rationale outlined in this report for moving towards financial sustainability, there are times when donors and programs may choose not to prioritize financial sustainability, for instance to ensure franchises can provide free or low-cost services for low-income communities or countries, or to support a franchise that is providing essential services where other programs are not meeting that need (e.g. reproductive health services). Many donors and social franchises view their primary goal as ensuring that valuable health services are being provided, and therefore prioritize a cost-effective, rather than fully sustainable, program. For donors seeking to maximize their investments, they may consider continuing to fund franchise programs that have demonstrated the most cost-effective and efficient models for delivering particular services. To facilitate a transition to financial sustainability while best enabling programs to pursue health and equity goals, donors and programs will need to engage in on-going conversation.



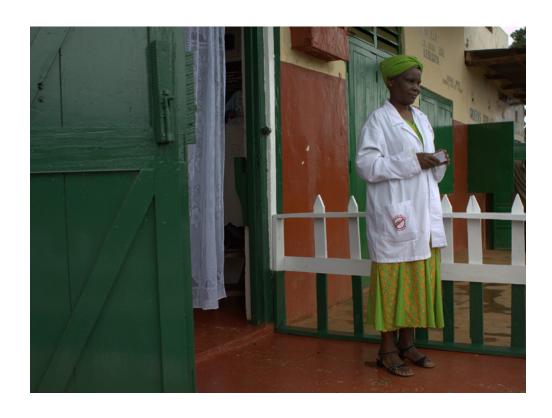
### Conclusion

The programs highlighted here are using diverse strategies to reach financial sustainability, and are at different stages in their process of doing so. These examples provide useful lessons about strategies programs and donors can use to increase the financial strength of social franchise programs. Through changing the service delivery model of the franchised outlets to focus on high impact, high value products and services, to strengthening programs' financial and organizational capacity, and to re-thinking the role and relationship of the franchisor with its franchised members and external partners, some social franchises have been able to make progress towards financial sustainability.

Franchises will inevitably take different approaches to sustainability, depending on the programs' goals, focus health areas, and where they operate. Aligning with the national health context and priorities, articulating the unique value proposition to franchisees and to the health system, and continually adapting to changing economic environments, including donor environments, will enable franchises to be sustainable—not only financially but also to continue providing valuable health services.

The challenge of reaching low-income populations and achieving business success remains a central tension, and one that appears to require on-going donor investment to ensure programs can reach the equity goal central to the mission of social franchising for health. However, as countries develop national health insurance schemes, the opportunity of social franchises to leverage third-party payers to serve low-income clients seems a promising strategy for ensuring franchises can achieve their business and health goals.

Reaching financial independence from donors is challenging. Donors continue to fund the majority of programs—in a review of social franchises, fewer than ten of 74 programs globally reported reaching any level of cost-recovery. According to one franchisor, reaching sustainability will require "transformative breakthroughs on multiple fronts" in order to generate the profits needed to recover operation costs. Among franchisors and donors, there remain debates about the need for donor independence. Donors can have an essential role not only in franchise start-up costs but in supporting franchises reaching scale, becoming more cost-effective, and providing the subsidized services that enable them to achieve their equity and health impact goals. Donors can also play an essential role in supporting enabling environments for the private sector.



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## The Global Health Group

The Global Health Gorup (GHG) at the University of California, San Francisco (UCSF) is an "action tank" dedicated to translating major new paradigms and approaches into large-scale action to positively impact the lives of millions of people. Led by Sir Richard Feachem, the founding and former executive director of the Global Fund to Fight AIDS, Tuberculosis and Malaria, the GHG works across the spectrum—from analysis, through policy formulation and consensus building, to comprehensive implementation of programs in collaborating low- and middle-income countries.

One of GHG's programmatic focuses is documentation and analysis of the private sector components of health systems. The GHG studies a variety of innovative delivery platforms that leverage the strengths of the private sector to achieve public health goals. More information about this case study and social franchising in general can be found at sf4health.org.

globalhealthsciences.ucsf.edu, global-health-group