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PRIVATE PROVIDER NETWORKS:
THE ROLE OF VIABILITY IN EXPANDING THE SUPPLY OF REPRODUCTIVE HEALTH AND FAMILY PLANNING SERVICES

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PRIVATE PROVIDER NETWORKS:
THE ROLE OF VIABILITY IN EXPANDING THE SUPPLY OF REPRODUCTIVE HEALTH AND FAMILY PLANNING SERVICES

CONTENTS

ACRONYMS

BCC	Behavior Change Communication
BFLA	Belize Family Life Association
BLM	Banja La Mtsogolo (Marie Stopes Affiliate - Malawi)
BMC	Bushyeni Medical Center (Uganda)
CA	Cooperating Agency
CMS	Commercial Market Strategies Project
CYP	Couple Years Protection
EMP	Empresas Médicas Previsionales (private medical offices)
FP	Family Planning
HIV	Human Immunodeficiency Virus
HMO	Health Maintenance Organization
INPPARES	Instituto Peruano de Paternidad Responsible (Peru)
INSS	Nicaragua Social Security Institute
IPPF	International Planned Parenthood Federation
IUD	Intrauterine device
LAPM	Long Acting and Permanent Methods
LLC	Limited Liability Corporation
MAPPP-E	Medical Association of Physicians in Private Practice in Ethiopia
MSI	Marie Stopes International
NHIS	National Health Insurance Scheme (Nigeria)
NGO	Non-Governmental Organization
RH	Reproductive Health
RMP	Rural Medical Providers
STI	Sexually Transmitted Infection
TB	Tuberculosis
USAID	United States Agency for International Development
WFMC	Well Family Midwife Clinics (Philippines)

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EXECUTIVE SUMMARY

WHY PRIVATE PROVIDER NETWORKS?

As the private sector plays an increasingly critical role in the delivery of reproductive health/family planning (RH/FP) services, donors and public health ministries are turning their attention to business arrangements that offer the potential to increase access to high-quality priority health services. Private provider networks hold the promise of cost effectively expanding the scale of private practice, and are increasingly being considered as a way to achieve national public health objectives.

Networks are an affiliation of health service providers grouped together under an umbrella structure or organization. They are an attractive mechanism for delivering uniform health services to a broad market, with a structure that lends itself to replication. Networks are able to realize efficiencies in training, capacity building, product distribution, procurement, and the advertising of health services. This paper distinguishes among three types of networks based on their *objectives* (social or commercial) and their *ownership* (individual or integrated). The network types are not-for-profit networks, social franchises, and purely commercial networks.

To date, evidence on the effectiveness of networks in achieving RH/FP objectives is scarce, and even less is known about the factors that contribute to their long-term viability. This review is intended to address this knowledge gap, offering practical guidance to donors and network implementers on how to expand the supply of high-quality priority health services. The paper first assesses whether and how networks achieve viability and, second, distills lessons that have contributed to network viability. The review also examines the extent to which viability goals conflict with or support the delivery of RH/FP services. By drawing from the business practices of both commercial and donor-supported networks and assessing their relative strengths and weaknesses, the paper cross-fertilizes lessons from each and suggests the need for synergies and partnerships across sectors.

The methodology consisted of a literature review of publications and resources on over 50 networks, the development of a framework to assess network viability, followed by in-depth interviews with representatives of 23 networks. All selected networks met the following criteria: they operate through several service delivery points, serve low to middle-income populations, and provide RH/FP services.

A FRAMEWORK TO ASSESS NETWORK VIABILITY

Every network is structured according to a set of benefits and obligations that tie the parent and members together. Benefits to the provider may include training, marketing and promotion, and increased clientele; in return, providers are typically obligated to pay the parent fees or royalties, provide specific services at fixed prices, and adhere to quality standards. The exact structure and design of benefits and obligations stem from a variety of conditions, as noted below, that in turn affect network viability:

- Policy and regulatory environment
- Mission of the network

- Institutional capacity and ability to develop a business plan
- Financing sources
- Revenue and expenses
- Marketing and promotion strategies
- Monitoring and quality assurance systems

The paper assessed networks against this framework to understand the factors and conditions that contribute to network viability.

MAJOR LESSONS ON NETWORK VIABILITY

A *policy environment* conducive to private sector provision of health services is critical to the viability of private provider networks. Policies may relate directly to service provision, governing the range of services private providers are able to offer and their licensing requirements; or they may relate to incentives that spur private sector participation, including opportunities to contract with government or operate within public or private health insurance schemes.

Depending on their *mission,* networks are driven to achieve a combination of health and financial objectives. Most networks must make a trade-off in reaching the poor versus earning a profit. Few networks operate with a "double bottom line," which is the ability to make a profit while achieving public health objectives. Successful strategies to achieve a double bottom line include diversifying clientele, offering a mix of curative and preventive services, and cross-subsidizing service delivery outlets. Effective networks also demonstrate strong *institutional and business planning capacity* and employ staff with a business orientation. Any plan to achieve growth or scale up must be based on a tested model that is built into the business plan. It should also demonstrate an understanding of consumer and provider markets and reflect the network's institutional capacity.

Networks are increasingly diversifying their *financing sources* to achieve viability. More and more, they are negotiating service contracts with the public sector, forming partnerships with pharmaceutical manufacturers, seeking commercial loans and private equity, structuring plural franchise arrangements, or simply diversifying donor funds in order to enhance their financial strength. The ability to generate revenue from the sale of services and products (either directly to consumers or through government contracts) is critical if networks are to achieve viability. Donor-supported networks now recognize the need to expand beyond RH/FP services to curative and ancillary care, which are associated with higher demand and consumers' willingness to pay. Commercial networks, on the other hand, may require incentives to expand the provision of RH/FP services, which are typically less lucrative than curative or ancillary services.

Networks tailor their *marketing and promotion strategies* to consumer and provider markets. The better they respond to changing conditions, the more likely they will anticipate opportunities and constraints in both markets. The ability to serve a diversified clientele with varying abilities to pay and to deliver services through several types of service providers underscores a keen sensitivity to the market.

A long-standing challenge for private provider networks is the cost of quality assurance. Although they continue to struggle with identifying cost-effective *monitoring and quality assurance* approaches that benefit from scale, private provider networks are still testing quality assurance strategies such as peer oversight, partnering with professional associations, and empowering consumers to respond to quality signals.

CONCLUSIONS AND LOOKING FORWARD

Largely owing to their ability to bridge commercial and social objectives, private provider networks represent a compelling business arrangement for scaling up RH/FP services in the private sector. However, donor-supported networks can enhance their viability by looking to the business practices of commercial networks and learning from their lessons. Such lessons focus on an orientation to market opportunities, understanding differentiated consumer preferences, and planning according to a long-term strategic roadmap. Alternatively, incentives for commercial networks to expand the delivery of RH/FP services, possibly in synergy with donor-supported institutions and public health ministries, should be explored.

Ultimately, no one "best" model or approach can ensure an expanded supply of RH/FP services. Networks must make practical trade-offs between serving the poor, offering preventive RH/FP services, and earning a profit. Donors and health practitioners need to realize both the potential and the limitations of the private sector in meeting public health objectives. They must also understand how best to target their own support to maximize social return. As this review underscores, it is essential to draw on the relative strengths of commercial and donor-supported models to optimize health and efficiency objectives.

Looking forward, it is necessary to identify financial incentives that will catalyze *commercial networks* to expand the delivery of preventive RH/FP services by, for example, advocating for capitated health insurance packages or facilitating public-private contracts for defined health services. Approaches to supporting the viability of *donor-supported networks* might include (1) negotiating mutually beneficial corporate partnerships, such as with pharmaceutical firms, (2) shifting networks to looser "centers of influence" by transferring capacity and responsibility to professional associations or educational institutions, and (3) facilitating the graduation of franchisees out of the network to focus on recruiting new members and supporting the overall competitiveness of the provider market.

1. INTRODUCTION

The need for reproductive health and family planning services (RH/FP) in developing countries is high. Although RH/FP services have traditionally been the concern of the public sector, the private sector actually delivers a substantial proportion of such services (Winfrey et al., 2000; Marek et al., 2005). Moreover, with government health budgets failing to keep pace with increasing demand, many countries are recognizing the importance of partnering with the private health sector to meet RH/FP needs. This recognition, coupled with health sector reform and privatization of healthcare services, has positioned private providers to play a larger role in the delivery of healthcare services (Bennett, 1994; Hongoro, 2000; Kumaranayake, 2000; Harding, 2003; Cuellar, 2000).

Several mechanisms have emerged to engage the private sector directly in the delivery of healthcare services, including contracting out, voucher schemes, insurance schemes, provider accreditation, and social marketing (Mills, 2002; Kumaranayake, 2000; Smith, 2001; Stephenson et al., 2004). Private provider networks can and do encompass many of these mechanisms and, as such represent a compelling approach to mobilizing private health practitioners to deliver high-quality health services.

For the purpose of this paper, a network is an affiliation of health service providers (members) grouped together under an umbrella structure or organization (the parent). The types of networks initiated to date include social franchises, not-for-profit networks, and purely commercial businesses. Little evidence exists on the effectiveness of networks in achieving RH/FP objectives, and even less is known about the factors that contribute to networks' long-term viability. Moreover the different types of networks have never been subjected to either a comparative analysis or assessment of their relative advantages and efficiencies in achieving viability and scale.

This technical review is targeted to donors and network implementers and is intended to offer guidance on expanding the supply of high-quality RH/FP services through private health networks. It first assesses whether and how three major network types—social franchises, not-for-profit networks, and commercial networks--achieve viability and then identifies factors that contribute to viability. The assessment considers selected factors, such as the health and financial objectives, institutional capacity, and policy environment in which a network operates, and examines the effect of these factors on network viability and the mix of health services offered by various models. It also examines the extent to which viability goals conflict with or support the delivery of RH/FP services. Finally, the review synthesizes lessons learned about the viability of three major network types and discusses future directions for private health networks.

1.1 WHY FOCUS ON THE PRIVATE SECTOR?

The term *private sector* encompasses all those providers outside government purview. It includes individual health practitioners, commercial clinics and hospitals, nongovernmental organizations (NGOs), and faith-based health organizations. Largely owing to a mistrust of private practitioners and the challenges of ensuring service quality, the public sector has long disregarded the private sector as a source of health service delivery (Bennett, 1994; Hongoro, 2000; Brugha, 1998; Smith, 2001; Smith,

2002; Harding, 2003). Moreover, given that RH/FP care is primarily preventive and thus not lucrative, the public and not-for-profit sectors have been the main providers of RH/FP services while for-profit private providers have concentrated on delivering curative care (Harding, 2003).

However, with many developing countries now implementing broad health sector reforms and shifting the government's function from service delivery to healthcare funding or management, the private commercial sector is playing an increasingly important role in meeting national public health objectives (Cuellar, 2000; Kumaranayake, 2000; Harding, 2003), particularly in light of the ambitious Millennium Development Goals (UN Millennium Project, 2005). While the regulatory and policy environment and the demand for private sector healthcare vary from country to country, it is possible to make a few generalizations about the private health sector in developing countries. First, a significant percentage of women rely on the private sector for reproductive and other healthcare needs. Women report that public health facilities are overcrowded and inaccessible and deliver poor-quality care (Harding, 2003). One study found that a third of women in the developing world obtain their family planning method from a private source (Rosen and Conly, 1999). For women in many Latin American and Asian countries, the private sector provides more than 50 percent of all contraceptives (Family Health International, 2004; Winfrey et al., 2000). Second, in many African countries, out-of-pocket expenditures comprise the majority of health expenses (Marek et al., 2005).

Yet, the fact that private healthcare is largely unregulated raises concerns about the quality of private sector care (Harding, 2003). Lack of regulation opens the door for opportunistic practices on the part of the provider, such as ordering unnecessary treatment or charging exorbitant prices for services or products (Hongoro, 2000; Bennett, 1994; Smith, 2002). With more oversight and enforcement of regulations, many current concerns about the private sector might fade away. In reality, however, public health ministries in many developing countries are not able to provide adequate enforcement of regulations, which is costly both in human resource and financial terms. Nonetheless, private provider networks offer a potential solution to the regulatory challenge, whereby the parent or franchisor takes on the function of oversight and enforcement.

1.2 WHY NETWORKS?

Networks originate in the industrial development field, where they are prominent in the context of small and medium enterprises. Since the 1970s, networks have earned recognition as an effective business arrangement in which groups of small firms cooperate with one another and specialize in order to overcome common problems, achieve collective efficiency, and penetrate markets beyond their individual reach (United Nations Industrial Development Organization, 2001). Through networks, small firms are able to specialize, build technological capability and innovation, and interact with each other to facilitate knowledge flows and learning.

Since the late 1980s, in light of concerns about quality of and access to healthcare, private provider health networks have become increasingly attractive to international donors and health practitioners. Networks are viewed as an effective business model because of their potential to rapidly expand the supply of health services. At the same time, their structure is conducive to combining several interventions that have been shown to improve health outcomes, such as training, oversight, performance-based incentives, accreditation, vouchers and other external payment schemes, ongoing support, and monitoring (Prata, 2005). By organizing heterogeneous private providers, networks

naturally take advantage of operating efficiencies in activities such as training, product procurement and health service advertising. Networks also emulate the best of the public sector in terms of creating a centralized structure and ensuring quality.

Private health networks offer the potential to improve the quality of health services and expand the scale of private practice, thus contributing to broad public health objectives. To the extent that networks are able to deliver on their promise, their viability is critical.

POTENTIAL BENEFITS OF NETWORKS

- Organize heterogeneous group of private practitioners
- Rapidly expand service outlets and thus increase access to health services
- Ensure high-quality services
- Benefit from economies of scale (procurement, promotion, and negotiating financial reimbursement mechanisms)

1.3 IMPACT OF NETWORKS

Although networks offer great potential for rapidly increasing the supply of high-quality healthcare services, the evidence of their health impact is still somewhat limited. Only a few impact evaluations have been conducted, and they have largely focused on provider and client-level effects. Far less documentation is available on the financial aspects of health networks, particularly those factors that contribute to viability, which is a critical precursor to scale-up.

A recent evaluation conducted facility-based interviews with franchised and nonfranchised providers and their clients to measure the effects of franchises in three countries: India, Pakistan, and Ethiopia. Baseline results demonstrated that franchise membership was significantly associated with greater total client volume in each of the three sites and that franchised outlets offered significantly more contraceptive methods than did nonfranchised outlets (Stephenson et al., 2004). Results from the impact evaluation largely validate the baseline findings: franchise membership in each of the three countries significantly influenced client recognition of service quality as measured by client willingness to return to the clinic for RH services. The likelihood of returning was 43 percent higher for franchised versus nonfranchised clinic clients in Ethiopia, 71 percent in Bihar, and 63 percent in urban Pakistan (Tsui, 2006). In all three countries, franchise membership also positively affected the number of RH services offered. In Pakistan and India, franchise participation predicted an increase in RH clients; in Pakistan, franchise participation also increased FP clients. Franchised providers in Ethiopia reported improvements in several aspects of their practice, most notably client satisfaction and income. However, ongoing challenges related to quality assurance and costs associated with demand generation were noted for all three countries (Tsui, 2005).

The Commercial Market Strategies (CMS) Project conducted two quasi-experimental evaluations of networks in Nepal and Nicaragua. In Nepal, CMS conducted both client exit and population-based surveys to evaluate the impact of the Sewa network, a nurse and paramedic franchise whose name means "service" in Nepali. Patients at franchised outlets reported significantly higher satisfaction with services than did patients at other private outlets and were significantly more likely to return to the franchised outlet for care, even though providers had increased their service charges. At the population

level, CMS found a marginally significant difference in trends in family planning use between the intervention and control districts. However, franchised providers did little to promote preventive RH/FP services in favor of more lucrative curative care (Agha et al., 2004).

The evaluation of the CMS/PROFAMILIA clinic network in Nicaragua involved a population-based survey of women in four regions. Findings mirrored those of the Nepal evaluation in that women reported higher satisfaction with the PROFAMILIA clinics than with other clinics (public and private) they had previously visited. The study also found that, after only two years of clinic operation, 25 percent of women living near a PROFAMILIA clinic had sought care from one of the network facilities. The networked clinics also appeared to fill a niche in terms of affordability, as median household incomes of PROFAMILIA clients (US $106) fell between those of women who received care from public (US $64) and other private clinics (US $128). Women living near a PROFAMILIA clinic also reported better health status than did women in the control group. However, the evaluation did not find other significant effects at the population level, possibly due to the short intervention period (Sulzbach, 2003).

The 2003 evaluation of the TOP Réseau social franchise in Madagascar, one of the few franchises specifically designed for youth, used data from two rounds of adolescent surveys in Toamasina province to assess exposure to the behavior change communication (BCC) campaign, and effects of the franchise on RH/FP utilization. The study found that 7 percent of adolescents had visited a TOP Réseau clinic during the two-year period, 12 percent had contact with a peer educator, and about half had heard radio or television advertisements promoting the clinic. Regression results demonstrated that the franchise increased use of condoms, improved access to services for sexually treated infections (STI) for males, and increased the use of contraception among females. The evaluation concluded that attendance at a TOP Réseau clinic by itself was not sufficient to increase RH/FP utilization; rather, exposure to BCC efforts coupled with a clinic visit was essential to effect behavior change (Plautz, 2003).

2. DEFINITIONS AND TYPES OF NETWORKS

DEFINITION

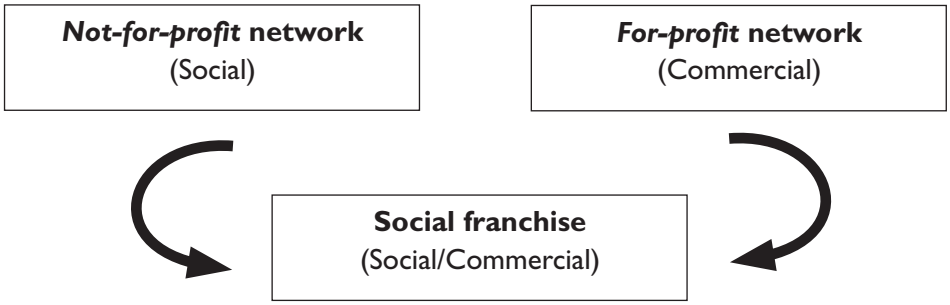
Networks are an affiliation of health service providers (members) who are grouped together under an umbrella structure or organization (the parent). The parent and members are bound together by mutual benefits and obligations articulated through an active and enforceable mechanism of control. The definition above pertains to the *structural* nature of a network and is intentionally broad to include all health networks regardless of their objectives. While many networks have been organized to deliver high-quality RH/FP services at uniform prices that reach the poor, such a service delivery focus is a network attribute, not a prerequisite to network organization.

As a mechanism to expand the supply of health services, all networks share certain characteristics. Most notably, membership confers benefits to providers that join the network, and, when members join the network, the parent receives a benefit. In theory, the relationship between parent and member, defined through a common mechanism of control, is predictable and easily replicable, making networks an attractive mechanism for the expansion of high-quality, standardized health services to a large market.

NETWORK TYPES

Depending on the factors of interest, networks may be categorized according to various dimensions. For the purpose of this paper, the authors have created categories that reflect the key aspects of *objectives* (in terms of profit or not-for-profit) and *ownership* (at both the parent and member levels). With respect to the *objectives/profit motives* of a network, the paper focuses on two mutually exclusive types of networks: not-for-profit and for-profit. A third type of network, the social franchise, is an alternative model worthy of separate analysis. While most social franchises operate with the same objectives as not-for-profit networks, they differ significantly in terms of ownership in that social franchises are a collective of independently owned for-profit service outlets. Moreover, although some social franchises are fully commercial, their mission is often markedly different from that of other commercial networks. As shown in Figure 1, these three types of networks form the basis of analysis and application of a framework of viability.

FIGURE 1. CATEGORIZATION OF NETWORKS



2.1 NOT-FOR-PROFIT NETWORKS

Not-for-profit networks comprise a broad category, extending from global network arrangements to regional and local community associations.[1] All not-for profit networks are fundamentally directed by social rather than commercial objectives and granted not-for-profit tax status, i.e., all profits are channeled to meeting the organizational mission and are not used for individual or commercial gain.

Many not-for-profit networks operate in an "integrated" structure; that is, the parent has full control over each service delivery point, which in turn depends on the parent for financial, managerial and other resources. PROSALUD in Bolivia and PROFAMILIA in Nicaragua are examples of integrated not-for-profit networks.

GLOBAL AFFILIATE NETWORKS

Global reproductive health affiliations are not-for profit networks that operate with a two-tiered relationship between, first, the headquarters and partner affiliate in a given country and, second, the partner affiliate and service delivery outlets at the local level. The structure of a partner or affiliate in a given country varies with health objectives, the market, and the policy environment. All not-for-profit networks, and particularly global affiliates, are versatile in accommodating different arrangements with providers. Both the International Planned Parenthood Federation (IPPF) and Marie Stopes International (MSI) may be characterized as global reproductive health affiliations.

2.2 SOCIAL FRANCHISES

Classic franchises are a business form that allows for rapid expansion; they attract individual capital to replicate a proven business idea, taking advantage of operating efficiencies and the distribution of fixed costs across outlets. They offer far less risk of failure to both parent and members. According to the U.S. Small Business Administration, fewer than 5 percent of all franchise efforts fail each year as compared with an annual failure rate of over 30 percent among small businesses.[2]

A social franchise is a fusion of a classic franchise and a social marketing program. Just as social marketing uses traditional retail outlets to expand the sale of low-cost commodities in the private sector, social franchising is a mechanism to expand the delivery of affordable health services (Montagu, 2002; Stephenson et al., 2004).

Although drawing from the commercial model, social franchises differ from their commercial counterparts in several ways. The parent and members of a commercial franchise are both for-profit entities as compared with the social franchise, in which the parent is typically a not-for-profit entity and the members are independent for-profit health providers (although for-profit franchisors are beginning to emerge). Social franchises are compelled to meet social objectives, such as increased access to priority health services, which may require altering their business practices (Smith, 2002; Montagu, 2002).

[1] The phrase "not-for-profit," rather than nongovernmental organization (NGO), will be used throughout the paper; NGOs can include commercial for-profit companies.

[2] www.franchising.com Web site, 2005.

KEY DEFINITIONS

Classic Franchise. "A system by which a company (franchisor) grants to others (franchisees) the right and license (franchise) to sell a product or a service within a specified area and to use the business system developed by the company" (International Franchise Association, 2005). The business system may also include a brand name or branded product sold exclusively by the franchise.

Social Franchise. "Process by which a developer of a successfully tested social concept, the franchisor, in order to scale up the coverage of a target group and the quality of product (services), enables others, the franchisees, to replicate the model, using the tested system, using the brand name, in return for social results, system development and impact information" (DSW, 2000). All service delivery points are generally connected by a recognizable brand name or logo.

Social franchises can be either stand-alone or fractional in terms of their service portfolio, and the franchisor may own several of the clinics, which is known as "plural franchising".

STAND-ALONE FRANCHISES

Stand-alone franchises more closely mirror commercial franchises, such as McDonald's restaurants, and are sometimes termed "brick and mortar" franchises, a reference to the requirement that physical buildings must be built or reconstructed with a uniform appearance. However, not all stand-alone franchises require franchise sites to share identical layouts. The distinguishing element of stand-alone franchises is that franchisees are the exclusive provider of the franchisor's services and products, adhering to a required operations system (Montagu, 2002; Smith, 2002). Healthstore (formerly CFWshops) in Kenya is an example of a stand-alone health franchise.

FRACTIONAL FRANCHISES

Fractional franchises are a further adaptation of a classic franchise, where existing health providers add a specified set of services to their current practice. Given that the franchise system involves converting existing practitioners into franchisees, the term "conversion franchise" is sometimes used. In fact, fractional franchises are the most common type of franchise in the health sector, particularly with regard to reproductive health and family planning services. While fractional franchises require lower start-up costs than stand-alone franchises, the fact that quality assurance extends only to the franchised services, opens the door for un-franchised services and products to tarnish the brand name. (Montagu, 2002; Grant et al., 2004.) Greenstar in Pakistan and Well Family Midwife Clinics in the Philippines are two widely known fractional franchises (Smith, 2002).

PLURAL FRANCHISES

With plural franchises, the franchisor owns and operates some but not all of the franchised outlets (Bradach, 1998). Owning one or more franchised outlets can contribute to franchisor viability through increased revenues, and can also provide a "model" training facility.

Janani in India is a franchise that fits all three definitions of social franchise. Its Titli outlets are organized around the fractional structure while its Surya clinics represent the stand-alone structure. More recently, Janani has purchased and now operates some of the Surya clinics and as such, is also a plural franchise.

2.3 COMMERCIAL NETWORKS

In commercial networks, both the parent organization and members operate on a for-profit basis. The members typically comprise one or more of the following types of providers: hospitals, out-patient clinics, diagnostic centers, workplace sites and retail pharmacies. Commercial networks can offer a range of comprehensive curative and preventive care, including dental, vision, and ambulance services. The relationship between parent and member can be one of ownership or contract or a combination of the two. Generally, however, commercial networks take the form of a holding company whereby the parent owns all or part of the member entities. Prime Cure in South Africa and Hygeia in Nigeria are commercial networks structured as holding companies.

KEY DIFFERENCES BETWEEN FOR-PROFIT AND NOT-FOR-PROFIT NETWORKS

A commercial network differs from its not-for-profit counterpart in the use of its profits, ownership structure, choice of legal form, and tax liability. Commercial networks rely on the revenue from the sale of goods and services to pay for current and capital expenditures. When revenues exceed expenses, the network is said to have made a profit. The primary distinction between for-profit and not-for-profit networks lies in what can be done with the profit.

The owner(s), shareholders, or board of directors of a commercial network has discretion over how profits are reinvested or distributed. A not-for-profit corporation, however, is not owned by anyone and is legally bound to channel any profit to its social objective. Furthermore, for-profit networks are subject to income and other taxes levied by government, whereas a not-for-profit network is generally not subject to taxes.

Like not-for-profit networks, commercial networks may be organized into a variety of structures, of which the most common is the health maintenance organization (HMO network). Other structures include health systems or hospital groups that tend to be especially large and are often publicly traded organizations. This review excludes from consideration several large commercial networks that primarily target high-income clients, such as the Apollo Hospitals Group in India, MESA Group in Turkey, and Beijing United Family Hospitals and Clinics in China.

HEALTH MAINTENANCE ORGANIZATIONS

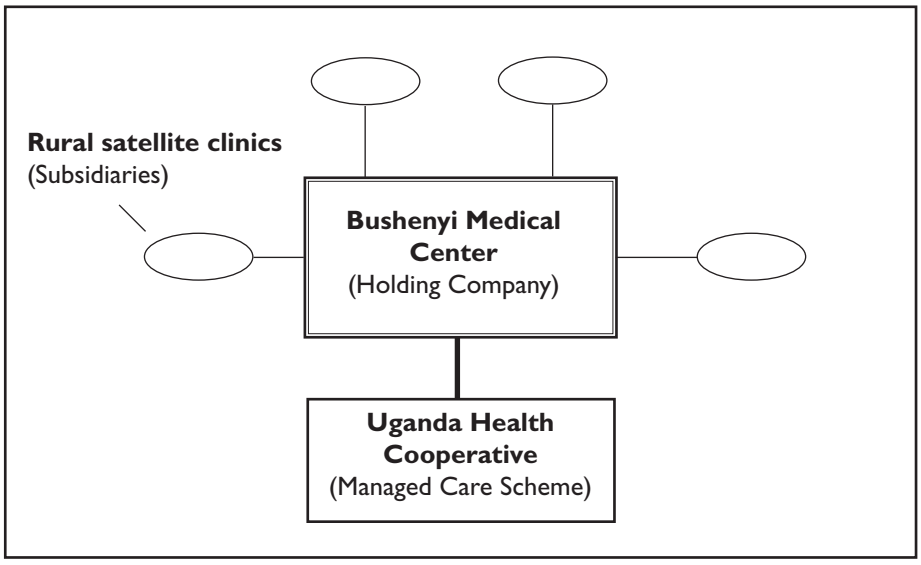
The most common form of commercial network structure—often called a health maintenance organization (HMO)—is associated with a health insurance entity.[3] The parent typically has a contractual relationship with members in the HMO network; however, providers can and often do belong to several HMO networks. This can result in different services and prices offered at individual sites.

[3] HMOs may or may not be similar to what is familiar in the U.S. market as an HMO. Moreover, this report does not categorize or describe the risk mechanisms with which networks may be associated.

SPOKE AND WHEEL NETWORKS

In spoke and wheel networks, satellite clinics are structured around a central hospital or larger medical center and, as with any commercial network, may be combined with an HMO. Generally owned by the hospital, the clinics share a common brand, price, and portfolio of services. While each satellite operates as an individual cost center, the entire structure is a single corporation with centralized financing. Illustrated by Figure 2, the **Bushenyi Medical Center (BMC)** in Uganda provides an example of a spoke and wheel structure The medical center, which serves as the network headquarters, provides comprehensive medical care, while a network of four satellite clinics serves hard-to-reach rural clients. The rural clinics are primarily out-patient centers that offer maternity, RH/FP, pediatric services and malaria treatment. BMC also operates 15 prepaid health plans through the Uganda Health Cooperative, serving over 10,000 members (Summa Foundation Investment Brief, 2003).

FIGURE 2. SPOKE AND WHEEL COMMERCIAL NETWORKS



3. METHODOLOGY

The methods used in formulating this paper included a literature review, development of a framework of network viability, and in-depth interviews with representatives of selected networks. The analysis emphasized factors that contribute to network viability and the conditions associated with scale-up.

LITERATURE REVIEW

The first step in the research consisted of a desk review of existing literature on not-for-profit, commercial, and social franchise networks. We reviewed and synthesized the results of published and unpublished documents on private sector provision of RH/FP services and examined detailed resources on over 50 networks. We relied on the following sources:

- Predecessor USAID projects including the Commercial Market Strategies Project and the Summa Foundation
- USAID Cooperating Agencies (CAs);
- Bilateral and multilateral donors;
- Providers associated with commercial insurance schemes; and
- Public health and related research institutes.

Through consultations with PSP-*One* and CA staff and through internet scans, we compiled and updated a list of networks. To the extent possible, we collected the following information on each network: historical background and mission, organizational structure, service mix and statistics, summary financial data, institutional partnerships, and lessons learned.

CRITERIA FOR INCLUSION IN THE TECHNICAL REVIEW

As already noted, we define a network as an affiliation of health service providers (members) who are grouped together under an umbrella structure or organization (the parent). Networks considered in the review also share the following characteristics:

- Provide reproductive health and/or family planning services;
- Operate through several service delivery points; and
- Serve low-middle-income populations.

DEVELOPMENT OF A VIABILITY FRAMEWORK

We constructed an analytic framework to assess the factors and conditions that support network viability, which is a prerequisite for scale-up. The elements of viability are external and internal—such as the policy environment and market conditions or a network's institutional capacity and marketing strategies—and define the specific benefits and obligations for which members of any network are held accountable.

INTERVIEWS WITH SELECTED NETWORKS

Once defined, the elements of viability provided the foundation for developing the survey instrument for in-depth telephone interviews with network representatives. In total, we conducted 23 interviews between March and May 2005 (See Appendix A for a complete list and description of networks whose representatives agreed to an interview).

We conducted telephone interviews with networks that (1) showed promise in their innovative capacity and/or potential to scale up and (2) whose information was simply lacking or outdated. In addition, we made an attempt to represent the various network models and geographic regions, as shown in Table 1.

TABLE 1. PRIVATE NETWORKS INTERVIEWED BY TYPE AND REGION

Type of network	Africa	Asia	Latin America and Caribbean	Eastern Europe	Global	Total
Not-for-profit	1	-	2	-	2	**5**
Social franchises	4	3	2	-	-	**9**
Commercial	5	1	2	1	-	**9**

ANALYSIS OF FINDINGS

Applying the framework of viability, we analyzed data collected through interviews in conjunction with findings from the literature review. The analysis identified the challenges faced by networks, important trends in the evolution of private provider networks, and emerging lessons.

4. FRAMEWORK TO ASSESS NETWORK VIABILITY

The framework of network viability, as presented in Figure 3, analyzes the structural components of network models and identifies the factors and conditions that have supported or hindered the achievement of financial and health objectives. The framework highlights networks' relative strengths and facilitates the sharing of lessons learned across sectors, particularly between commercial and donor-supported networks.

A viable network has the capacity to provide services and sustain its operations with marginal or no donor support. For the purpose of this review, financial viability does not refer to complete independence from donor or public funds but rather assumes a clear long-term plan for guiding the network's negotiation of and improved funding mechanisms. Often, financial viability translates into far less reliance on donor support. Measures of viability include increased cost recovery through sales of health services and products, cost-effectiveness of operations, or diversification of donor support.

For the purpose of the framework, it is useful to distinguish between networks structured as integrated organizations with several outlets versus franchises of independent providers. The distinction in the relationship between parent (organizer) and member (service delivery point) has implications for how incentives and obligations are designed and instituted.

MECHANISMS OF CONTROL WITHIN NETWORKS

Networks are generally organized by, and in relation to, the central parent. The parent manages varying degrees of control and cooperation vis-à-vis members as a way to influence member behavior. Depending on the network type, the mechanism of control may be exercised through a binding legal contract, complete or partial ownership, or an informal written agreement. The agreement typically spells out the benefits to and obligations of each party and provides a means to monitor compliance with standards and to enforce sanctions.

BENEFITS AND OBLIGATIONS

A network's overall incentive structure, as mapped out in the benefits and obligations between parent and member, is fundamental to network viability. The extent to which providers are motivated to join a network and perform according to its objectives is a function of the network's initial design. The design, in turn, emerges from a network's primary objectives (public health, financial profit, or other), its institutional and financial capacity, and market opportunities and constraints.

MUTUAL BENEFITS AND OBLIGATIONS TO NETWORK PARENT AND MEMBERS

Benefits. Both parent and member receive benefits from participating in a network. The parent benefits from each member through increased revenue and market penetration and the ability to achieve greater scale and deliver on its health objectives. Benefits to the member may be financial, such as increased revenue, market share, and access to credit, or they may be non-financial incentives such as training, quality accreditation, marketing support, improved information and management systems, and peer support.

Obligations. In return for the benefits of participation, the parent is obligated to deliver on the agreed-upon membership benefits as well as maintain a plan to ensure the network's financial and institutional viability. For their part, members generally have financial or performance obligations. They may be obligated to pay fees or royalties, adhere to quality standards, follow business and clinical protocols, deliver a certain mix of products and services, accept uniform pricing, and participate in training activities. Other obligations include the requirement to provide service utilization or revenue data.

FACTORS AFFECTING NETWORK VIABILITY

In any network, the structure of benefits and obligations is a function of various internal and external factors; taken together, the factors dynamically affect network viability. This paper assessed networks in terms of seven key elements:

1. Policy Environment

The broader political and regulatory context shapes the need for a particular intervention and determines the specific opportunities and constraints influencing private sector delivery of priority health services.

2. Mission of a Network

Basic objectives drive institutional priorities and resource allocation, yet every network is driven by a "bottom line" that is usually a balance of health or social impact and financial performance.

3. Institutional and Business Planning Capacity

A network's management, staffing, and operational structure, including its training capacity and monitoring and information systems, affects the allocation of resources and overall operational efficiency. Part of its institutional capacity is a network's ability to develop a long-term business plan, an essential foundation for viability.

4. Sources of Financing

Fundamental to achieving viability is a network's ability to access financing, whether from commercial sources or from donors or social investors. Grants may take the form of funds or in-kind contributions from donors or the public sector. Typical sources of financing are:

- Commercial debt
- Private equity
- Grants and subsidies

5. Revenue and Expenses

Revenue generated through the sale of products and services constitutes the business income of a health network. Services may be purchased directly by consumers or through a contract with government health ministries. Other revenues that accrue to a network include membership fees/royalties. The balance between revenues and expenses determines a network's profit or efficiency. Common sources of revenue and expenses are:

- Sales of products and services (to consumers or via purchase contracts)
- Franchise fees and/or royalties
- Capital and operating costs

6. Marketing and Promotion Strategies

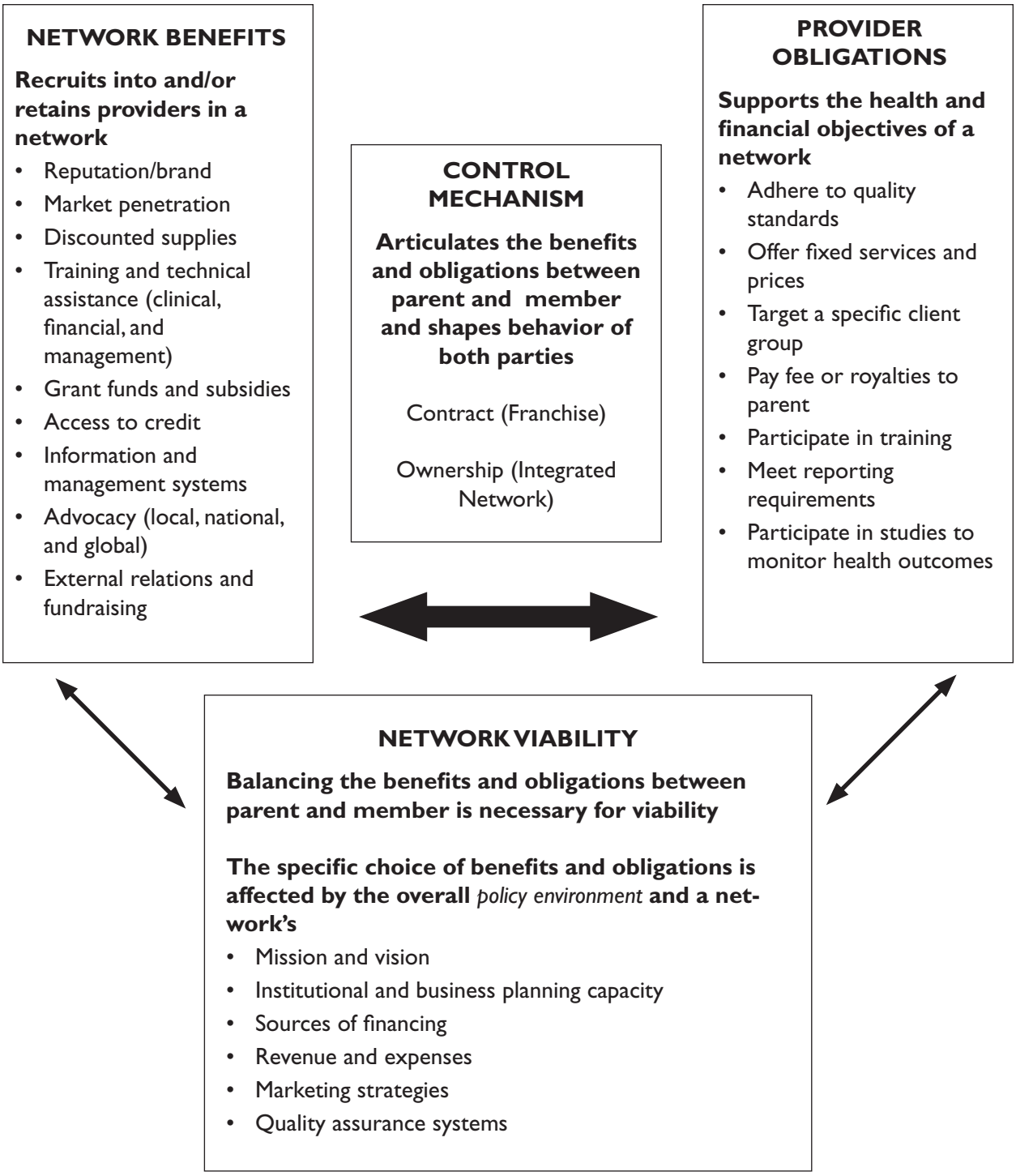
The market of consumers and providers affects the basic choices faced by a network in designing and sustaining an intervention. Given that markets are dynamic, network viability depends on provider willingness to join and continue participation, and on the strategies used by the network to understand and continually respond to consumer demand for services.

7. Monitoring and Quality Assurance

Quality assurance is essential to health networks and affects the core business practice of any service provider. Direct costs and benefits are associated with instituting standards, branding services, and developing systems to ensure compliance with standards.

The above factors, illustrated in Figure 3, collectively affect the viability and thus the ability of a network to provide sustained RH/FP services.

FIGURE 3. FRAMEWORK OF NETWORK VIABILITY



5. FINDINGS

The findings are discussed according to the seven factors that influence network viability.

5.1 POLICY ENVIRONMENT

An environment conducive to private sector participation in health service delivery is essential to network viability. Policy environment encompasses legal and regulatory guidelines that govern the delivery of healthcare, and specifically of RHFP services; it also dictates incentives for private sector participation in a given market. Together, national and local policies influence basic choices in network design. For example, if the provision of IUDs is central to a network's objectives, health regulations dictating whether midwives can insert IUDs may affect the decision to work with midwives.

- **Not-for-profits are strong innovators in adapting to the local environment.** Not-for-profits are versatile institutions that take on a variety of structures. They contract with the public sector, operate through a variety of service outlets, and understand and meet the needs of high-risk target groups. Depending on the specific context, not-for-profits are structured as integrated networks whose providers are effectively full- or part-time employees; in the case of a global affiliate network, not-for-profits may franchise all or part of their services through independent providers.

  Global affiliate networks are particularly versatile in responding to the local environment. In Malawi, for example, where private sector provision of RH/FP services is nascent, **Marie Stopes International (MSI)** deemed it effective to integrate its services with the government's national health sector strategy, serving as the lead partner offering RH/FP services (see Box 1). Similarly, the government of Belize selected an IPPF affiliate, the **Belize Family Life Association (BFLA),** to test a model for the delivery of basic health services by providing care to 6,000 clients every month. To support the expansion of services, BFLA built a three-story clinic in Belize City to house its headquarters, clinical and surgical facilities, and a youth center.

BOX 1. COORDINATING WITH GOVERNMENT HEALTH STRATEGY WHERE THE PRIVATE SECTOR IS NASCENT: AN MSI PARTNER IN MALAWI

In Malawi, the government subcontracts with the Marie Stopes partner **Banja La Mtsogolo (BLM)** to serve as the country's largest provider of RH/FP services. BLM has worked within the government's sector-wide national strategy, playing a catalytic role in championing and delivering innovative RH/FP services. By 1999, BLM was estimated to have provided up to one-third of all RH/FP services delivered in the country; by 2005, it had cumulatively served more than 1.8 million FP clients.

- **The concept of competition in a franchise works only in an environment of plentiful private providers.** An adequate pool of private health providers is a prerequisite if a health network is to flourish. In the case of RH/FP services in particular, regulatory and licensing conditions must also support private sector provision of such services and permit the distribution of long acting

and re-supply contraceptive methods. The **Janani** franchise in India (see Box 2) is a compelling model in which a dense market of providers--with varying qualifications and ability to practice--offers a continuum of RH/FP services to rural and urban clients. Another Asian market that is thriving in terms of private practice is the Philippines, where independent midwives offer a range of clinical methods through the **Well Family Midwife Clinics (WFMC).**

BOX 2. CAPITALIZING ON AN ABUNDANCE OF PRIVATE PRACTITIONERS: THE JANANI FRANCHISE IN INDIA

The **Janani** franchise in Bihar and Jharkhand began largely as a social marketing program (pills and condoms) focused on retail shops. Given the abundance of private practitioners and retail outlets in Bihar and Jharkhand, Janani organized rural medical practitioners (RMPs) into a network and created the Titli franchise, which offers contraceptives and limited RH services. Shortly thereafter, full-service Surya clinics staffed with physicians were added to the network, serving as referral points for Titli providers. The competitive nature of the private provider market has allowed the franchise to recruit different types of health providers and ensure compliance with standards. For example, in every district, at least one RMP is on "stand-by" to take the place of an underperforming Titli provider. Existing market competition has increased the value of membership and has allowed Janani to influence provider behavior and improve the range and quality of health services.

Alternatively, policy regulations governing the provision of a particular service or method can affect provider networks and the incentives for providers to join a network. Networks seeking to promote a certain type of service, such as the Amua franchise (see Box 3) that delivers long-acting and permanent methods (LAPMs) in Kenya, may find it necessary to adapt their service delivery model to ensure that a full range of desired services is available.

BOX 3. USING AN ALTERNATIVE DELIVERY MODEL TO OVERCOME HEALTH SERVICE RESTRICTIONS IN THE PROVISION OF CLINICAL FAMILY PLANNING METHODS: THE AMUA FRANCHISE IN KENYA

Amua is a social franchise in Kenya initiated in 2004 by the Ministry of Health and Marie Stopes Kenya to promote long-acting and permanent family planning methods. The franchise has since recruited over 100 midwives who are trained to insert IUDs and administer injectables. Although there is also demand for surgical sterilization, Amua has not been able to recruit medical doctors into the franchise to provide this service, as the financial incentives are not sufficient. In response, the network has instituted mobile clinics staffed with salaried medical doctors to perform the procedure. While operation of the clinics increases costs for the franchisor and presents challenges for follow-up care, it was the best available short-term solution to providing greater access to LAPMs.

- **Private providers thrive in markets that either offer private health insurance or present opportunities to contract with government schemes.** Purely commercial provider networks are prominent in countries that have developed a market for health insurance and managed care schemes. Commercial networks frequently offer capitated insurance packages for their clients or create an HMO that manages risk pooling.

  Often, private health insurance can be an important precursor to wider national health insurance schemes (Sekhri et al., 2005) if an existing cadre of private providers can be recruited to expand service coverage. Such has been the case in Nigeria, where HMO networks have advocated for an expanded role for private providers within the recently legislated National Health Insurance Scheme (NHIS). As a result, many networks have expanded the scale of their services and expect to reach a still broader clientele as the insurance scheme expands to cover informal sector workers. For example, **Total Health Trust,** an HMO that manages contracts through the NHIS, rapidly increased in scale from 280 to 1,000 networked providers in 2005 alone.

  In Nicaragua, the national health reform process that was initiated in 1993 has strengthened the private provider market. The **Social Security Institute (INSS)** is contracting with public and private healthcare providers–called Empresas Médicas Previsionales (EMPs)–to deliver a comprehensive health package that includes RH/FP services. The contracted EMPs include for-profits providers, NGOs, and Ministry of Health facilities. In total, 49 EMPs serve approximately 16 percent of the economically active population and their dependents. Approximately three-quarters of these EMPs are private providers, signaling a growing private sector share of the healthcare market.

5.2 MISSION OF THE NETWORK

A network's organizational vision, usually articulated in a mission statement, guides the activities of any network. The mission statement does not in itself contribute to network viability but rather serves as a compass to guide decisions in support of stated objectives. Health networks exist for different reasons—some are commercial businesses motivated by profit, and others operate with social or public health goals. They can be positioned on a continuum of financial and public health goals, with commercial networks at one end of the spectrum and not-for-profit networks at the other. Most donor-supported networks interviewed for this review seek to improve access to and the quality of priority health services, often in a specific geographic area (e.g., urban centers) or among a target group (e.g., youth). Other networks are motivated by increasing financial access to healthcare (e.g., affordable services) and delivery of a particular type of service (e.g., family planning).

- **Many networks operate with a combination of social and financial objectives while a few hold themselves to a double bottom line of making a profit and meeting pro-poor health objectives.** Beyond meeting their stated health objectives, many not-for-profits and social franchises consider sustainability to be part of their mission. However, the extent to which they deliberately plan for sustainability depends on the donor and the organization's institutional capacity. A few, like the **RedPlan Salud** network in Peru, have clear financial profitability goals and public health objectives (see Box 4). For others, such as Population Services International's **TOP Réseau** network in Madagascar, sustainability refers to the institutionalization of better health practices among providers and long-term health impact. While there is no uniform measure of financial sustainability across networks, some common indicators of sustainability include improved cost-recovery rates and reduced unit costs of service/product provision.

BOX 4. ACHIEVING A DOUBLE BOTTOM LINE: REDPLAN SALUD IN PERU

Operating with a clear profit motive, RedPlan Salud is a network of midwives in Peru that provides RH/FP services to low and middle-income women in Peru. The network was established in 2002 through a partnership between INPPARES (Instituto Peruano de Paternidad Responsible, a local NGO), Apropo (a social marketing NGO), CATALYST Consortium, and Schering Peruana. Over a three-year period, the franchise has grown from 50 midwives in five districts in Lima to over 500 midwives covering four urban areas. By joining the franchise, participating midwives are able to procure discounted commercial RH products, participate in training, and benefit from INPPARES's promotion of the franchise. Since its inception, the network has distributed 135,219 contraceptive products resulting in 27,589 couple years protection (CYP). As a result of its operational efficiencies and strategic partnerships, RedPlan Salud is meeting its health objectives and has achieved financial sustainability. The franchise was capitalized with less than $50,000 in seed funding, an amount that reflects the contributions of INPPARES, Schering Peruana, and USAID through the CATALYST Consortium.

While it is the prerogative of purely commercial networks to meet their financial bottom line, many commercial networks also support public health goals by delivering health services in certain geographic areas. Depending on the location and characteristics of the country, low-income clients may constitute a marketable constituency for commercial networks. Some commercial networks are deliberate about meeting stated public health concerns and institute sliding-scale fee structures to reach mixed-income client groups.

The Clinix Health Group is a commercial network of hospitals in South Africa whose mission is "to own, establish and manage affordable high quality health care services in previously underprivileged communities." While the Clinix Group finds it difficult to compete against larger hospital groups, it is well positioned to bid on government contracts, including contracts targeted to underserved communities in South Africa.

5.3 INSTITUTIONAL CAPACITY AND BUSINESS PLANNING

CAPACITY BUILDING

Institutional capacity broadly encompasses a network's human resources, management and information systems, and financial strength. It refers to the ability of a network to identify the essential aspects of management and operations, make effective decisions, and allocate competent staff and resources in a way that achieves viability.

- **Global networks offer strong centralized capacity and technical assistance to affiliate country members.** Global affiliate networks are well positioned to test, refine, and support the mechanisms through which their members can consistently meet their health and financial objectives. Their core expertise and competence in RH/FP services allows the networks to pilot, cross-fertilize, and transfer the latest clinical technology and business practices to their local affiliates (see Box 5). Their centralized coordination and control mechanisms permit the networks to enforce quality standards, realize economies of scale by streamlining capacity and training, share and disseminate knowledge, and easily replicate their structure in other countries. Nonetheless, the

performance and capacity of individual members can vary, requiring different levels of support and assistance from the parent.

BOX 5. CENTRALIZED MONITORING AND TECHNICAL ASSISTANCE: The London Support Office of Marie Stopes International (MSI) maintains a centralized financial accounting system and portal for service statistics and health outcomes, providing regular feedback on the status of partner organizations. The London Support Office draws on the available data to identify needs and respond with specific training and technical assistance.

- **Commercial networks focus on centralizing operations to achieve efficiencies.** In commercial networks, the parent usually centralizes operations in the areas of financial and business management, information technology, human resources, brand management, medical guidelines, and procurement. However, in HMO networks that do not directly provide services—as is the case with **Total Health Trust** in Nigeria—the parent exercises little control over providers' financial operations and marketing strategies. The providers are autonomous healthcare facilities that contract with an HMO for increased clientele, and may hold contracts with several networks. Total Health Trust ensures that providers uphold quality standards and protocols but does not intervene in individual providers' financing or marketing strategies.
- **Business expertise among staff is valuable for social franchises.** Social franchises bridge entrepreneurial and health-focused objectives and demand an orientation to commercial business practices. Ideally, experienced business professionals should lead any franchising effort launched by a not-for-profit--an important lesson learned in an effort to franchise midwives in the Philippines under USAID's TANGO I project in the early 1990s. A review of the franchise effort found that NGO staff who brought public health experience were not adequately equipped to manage the franchise or to provide the business training required by the midwife franchisees (Lagman, 2000). One of the most well-known health franchises, **Greenstar** in Pakistan has recently hired an insurance company executive to help in its restructuring initiative.

BUSINESS PLANNING

To become viable as an institution, all networks must develop a realistic roadmap or business plan that includes an analysis of the market and competition, an assessment of the policy/regulatory environment, an account of all start-up and ongoing costs, and projected revenue sources.

- **Donor-funded networks tend to be driven by donor objectives rather than by market conditions and are less inclined to develop a long-term business plan.** The integrated, donor-funded networks and social franchises reviewed for this paper typically did not engage in upfront business planning. While socially driven networks have a wealth of experience in designing and implementing health programs, they are weak in the areas of commercial marketing, financial systems, and planning for sustainability. The priority among most donors is to ensure that networks are accountable and transparent in their reporting procedures and that they achieve their immediate health objectives within budget. Often, donor-funded networks place less emphasis on longer-term strategic and financial planning. For networks that do invest in strategic planning, such as the Pro Redes Salud (see Box 6) network in Guatemala, financial sustainability goals are achievable.

BOX 6. PLANNING FOR SUSTAINABILITY: PRO REDES SALUD IN GUATEMALA

The Pro Redes Salud network in Guatemala is an example of an institution that developed a sustainability plan from the outset. The network established revolving medicine funds for eight participating NGO networks, with detailed plans on personnel needs and fund management. Over the first two years from 2002 to 2004, the average value of the seed capital in the revolving funds increased by 166 percent. As planned, the participating networks used the loan funds to establish rural pharmacies that continue to generate revenue for the Pro Redes Salud network (Pro Redes Salud Final Project Report, 2004).

- **Evolution of a social franchise may be necessary, but adequate business planning will prepare the franchise to adapt appropriately to the market.** A lack of business planning among social franchises in particular has tended to result in the need to restructure or reinvent the original model. While the need for such activities points to the flexibility of social franchises, the activities themselves are intensive and costly and can usually be avoided with a better understanding—from the outset--of the local market. Ongoing financial and business planning is critical to build a strong foundation for a network and ensure that it is responsive to changing market conditions. The Janani franchise in India was among the few to develop a sound business plan and to remain sensitive to the market (see Box 7).

BOX 7. JANANI'S PHASED AND STRATEGIC EVOLUTION

Janani in India is in the process of restructuring its model in response to its rapid growth and in an effort to improve its overall viability. The franchise consists of three interconnected networks implemented in the following order: retail shops, rural medication practitioners (Titli outlets) and private clinics (Surya clinics). Although the Surya network was the last to be implemented, these clinics are seen as the cornerstone of the franchise because they act as referral points from the other networks, and also because they generate more profits through the provision of clinical RH services. Surya clinics typically become profitable within 2-3 years. As of 2005 there were 500 Surya clinics, but supervising the quality of all these clinics proved to be a challenge. To better assure quality, Janani is rethinking its strategy, and has plans to reduce the number of Surya clinics to 320 (one clinic per town) through implementing an accreditation process requiring higher quality standards. This change will result in increased competition to become a Surya clinic, and will improve quality assurance. To enhance viability, the basket of services provided at the clinics will be expanded to include general health services and surgery. Changes to the Titli network include broadening the products sold at participating outlets, and instituting peer supervision, whereby high performing Titli providers will supervise other outlets in their area. Janani's various strategies indicate a keen understanding of the market and an ability to make adjustments to the franchise model.

- **Commercial networks develop detailed business plans with a long-term strategy to achieve financial profitability.** As market-driven institutions, commercial networks develop detailed business plans to achieve their mission and growth objectives. Given that they rely solely on the sales of products and services to generate revenue, they must be particularly astute in assessing

market conditions in order to remain viable. All commercial networks participating in this review reported that they had developed a long-term strategy to achieve profitability--and, for many, including Hygeia in Nigeria, the strategy underwent significant change in the face of shifting economic and policy conditions (see Box 8).

BOX 8. ADAPTATION OF A STRATEGY TO ACHIEVE PROFITABILITY: HYGEIA NIGERIA LIMITED

Hygeia Nigeria Limited was incorporated in 1986 as a limited liability corporation to serve a high-end consumer market through a network of primary and tertiary hospitals. At that time, Hygeia was serving the top 4 percent of Nigeria's population. By 1998, owing to deteriorating economic conditions that were eroding its market base, the company developed a strategy for healthcare financing to expand its clientele to include mixed-income groups. As an HMO, Hygeia was able to offer health insurance products to complement direct service provision. Today, only 10 percent of its 70,000 clients pay out-of-pocket or have individual plans, with 90 percent sponsored through an employer. Hygeia operates through three hospitals in Lagos, 27 workplace sites, and 205 contracted providers across the country, serving an extremely diverse client market.

5.4 SOURCES OF FINANCING

The ways in which networks finance themselves vary according to their primary mission, donor partnerships, and existing market opportunities. Apart from the sale of goods and services that constitute their business revenue (discussed in Section V), networks finance themselves through commercial debt, equity and donor grants, and subsidies.

- **There is a growing trend among not-for-profit networks to diversify their sources of donor support.** Large bilateral and multilateral agencies such as Great Britain's Department for International Development and United Nations Population Program that support global affiliate networks have shown a preference for decentralized funding at the country level instead of channeling funds through network headquarters. Global networks have therefore experienced a decline in centralized funding and have re-evaluated their own resource allocation strategy to ensure that they can meet the needs of high-priority countries and program areas.[4] As a result, the networks now support their affiliates in developing institutional partnerships with public and commercial sectors, improving their fundraising capabilities to secure funds from other donors, and, finally, streamlining their business operations and increasing their overall cost-effectiveness.

  For example, at the start of every partnership, **Marie Stopes International (MSI)** focuses on building the capacity of its partners in-country to achieve self-sufficiency. MSI aims to ensure that a service center or clinic is self-sufficient in roughly three years while it treats partner sustainability as a longer-term process. MSI encourages members to operate efficiently with clear benchmarks and goals and teaches them how to forge alliances with other donors and the public sector as needed.

[4] IPPF Annual Program Review 2003–2004.

Similarly, a decline in funding from international sources has underscored the need for IPPF affiliates to secure alternative sources of funding and become financially sustainable (See Box 9).

BOX 9. DIVERSIFYING REVENUE AND STREAMLINING OPERATIONS TO BECOME VIABLE: AN IPPF AFFILIATE IN BARBADOS

IPPF's Barbados affiliate received technical assistance from a task force of governing council members and IPPF consultants to restructure its staffing, product offering, and operational procedures. After a strategic planning process, the affiliate introduced user fees for the first time as well as a line of 12 new services—including several high-margin services such as cryosurgery and infertility counseling; it also lobbied the government for increased support. As a result, despite a 29 percent decrease in funding from IPPF, the Barbados affiliate has enjoyed a 15 percent increase in both government subsidies and total revenue.

Generally, financial sustainability for socially driven institutions indicates a shift away from complete reliance on donor or public subsidies and toward greater reliance on operational revenue (user fees, employer contributions, and so forth). Diversification of donor and public support, however, is also considered a proxy of financial sustainability.

- **Commercial networks use a combination of financing sources to achieve viability and scale.** The need to diversify funding is critical to any institution. In addition to leveraging commercial debt from financial institutions, commercial networks may attract equity investments to support growth of their business. In the case of **San Pablo Hospital Complex** in Peru (see Box 10), a group of doctors invested private equity to build what has become a large urban hospital network.

BOX 10. USING A COMBINATION OF DEBT AND EQUITY TO GROW AND ACHIEVE SCALE: THE SAN PABLO HOSPITAL COMPLEX HOSPITAL GROUP

The San Pablo Hospital Complex in Lima, Peru is one of the leading healthcare providers, offering a combination of high-quality services, cutting-edge technology, and competitive prices. Started in 1991 by Dr. Alvarez, a leading Peruvian physician, the hospital relied on both commercial debt and equity to finance its initial growth. For equity investments, Dr. Alvarez tapped physicians who operated their health practices in his facilities, effectively ensuring their role as partners in the business. Through this group investment, the hospital was able to purchase several other clinics and expand services to the north and south of Lima, leading to the acquisition of seven institutions that currently make up the San Pablo Hospital Complex.

- **There is a new trend toward "plural" franchising as a way to improve viability.** One way to increase a franchise's financial sustainability is for the parent to own and operate some of the service delivery points. Such an arrangement allows the parent to generate consistent revenues to support franchise operations and often permits the operation of a "model" clinic that delivers high-quality care and inspires other providers to do the same. The arrangement draws from the classical franchise model whereby, for example, the McDonald's Corporation owns roughly 30 percent of all McDonald's restaurants (Love 1995). As for social franchises, **Greenstar** in Pakistan has recently bought three franchised clinics, and **Janani** in India has identified the optimal proportion of owned versus franchised clinics needed to meet its financial objectives. Specifically, Janani considers 15 percent ownership its break-even point and plans to acquire 40 Surya clinics in its network.

5.5 REVENUE AND EXPENSES

Whether a network achieves viability is largely dependent on its ability to strike a balance between income—derived from the sale of health products and services--and operating costs—the funds needed to run the business.

- **RH/FP services alone are not sufficient to sustain a network; many networks are therefore expanding their basket of services.** Early experience made it clear to social franchises that the delivery of FP services alone is not sufficient to achieve viability. Provision of an integrated package of services—services that complement FP and include deliveries, ultrasound, and curative care--can increase a franchised outlet's revenues and thus better support the network as a whole. However, for a social franchise that closely monitors the service quality of its members, expanding the basket of services has implications for the cost of monitoring and compliance.

  An evaluation of the **PROFAMILIA** clinic network in Nicaragua found that offering an expanded package of services contributed to the financial sustainability of networked clinics. The Commercial Market Strategies Project built six integrated health clinics after Hurricane Mitch devastated Nicaragua's health infrastructure. The clinics were later incorporated into the existing PROFAMILIA network. Three of the clinics offered basic health services, including RH/FP, curative care, and ultrasound, while three offered enhanced services such as X-rays, mammography, and surgery. A 2003 evaluation found that the enhanced clinics were outperforming the clinics that offered only basic services. The cost-recovery rate for the enhanced clinics between first-quarter 2002 and first-quarter 2003 was 100 percent as compared with 65 percent for the basic clinics (Sulzbach, 2003).

- **Not-for-profit networks sell goods and services that generate revenue.** Donors and network implementers are realizing that sales are critical to sustaining network activities. Not-for-profit networks, such as PROSALUD in Bolivia, charge user fees for services and products in order to recover a portion of their costs (see Box 11). Generally, not-for-profit networks have targeted the market between the commercial and public sectors, setting prices accordingly. In terms of services, clients are willing to pay for ancillary and curative care and, to lesser degree, for preventive RH/FP services. Ancillary services may include diagnostic and laboratory services, and surgical care. In many markets, these lucrative services complement the provision of RH/FP services.

BOX 11. PROSALUD'S DIVERSE SERVICE PORTFOLIO RESULTS IN HIGHER COST RECOVERY

PROSALUD in Bolivia has tested a variety of strategies for achieving financial sustainability, including cost-sharing arrangements with physicians, capitated insurance products, and, most important, a sliding-fee scale for the provision of curative and preventive care. Eighty percent of PROSALUD's revenue is generated through the sale of curative services. Preventive services, in fact, account for only 30 percent of its portfolio and ancillary and curative care for approximately 35 percent each. Despite variation in the cost-recovery rate at different sites, PROSALUD's cumulative cost-recovery rate has steadily increased over the years; it was at 74 percent in 2004 and 80 percent in 2005, and its goal is to reach 93 percent by 2007.

- **Integrated networks can cross-subsidize markets through different service delivery points.** Integrated networks, particularly not-for-profit networks that try to balance health and financial objectives, can naturally cross-subsidize their operations across service delivery points, permitting them to serve a variety of markets and income groups even if their cost-recovery rates vary substantially across clinics. Such cross-subsidization between clinics affords not-for-profit networks the flexibility to balance their social mission with their financial targets. For example, **Mexfam** in Mexico operates a variety of service delivery outlets that offer targeted services and prices to different population segments in accordance with the needs of the region and clients' socioeconomic profile (see Box 12).

BOX 12. SEVERAL TYPES OF SERVICE DELIVERY POINTS IN A SINGLE ORGANIZATION: MEXFAM. An IPPF affiliate in Mexico, **Mexfam** operates through several service delivery arrangements. It owns 24 clinics run by 270 full-time nurse practitioners who offer a standard package of RH/FP services. Mexfam also works with a network of 300 private physicians under an agreement of "mutual collaboration" that does not involve any financial exchange or obligation. The physicians undergo training to meet Mexfam's clinical standards and provide youth-friendly services that are fully subsidized by the network. For each of its programs, Mexfam has established a cost and resource structure that responds to different provider and consumer markets; each service delivery outlet has a different cost-recovery rate. Cumulatively, Mexfam recovers 67 percent of its costs.

- **Social franchises traditionally have not charged franchise fees, but the practice is starting to change.** While some franchises are moving toward revenue diversification, fewer than half the social franchises included in this review have introduced franchise fees as part of their agreement. In a classical commercial franchise, franchisees are required at the outset to pay fees to the franchisor in the form of (1) upfront fees for securing rights to a territory and (2) ongoing fees from sales (royalties). Many social franchises, however, are reluctant to charge fees for fear that they might discourage participation, especially given that membership is not guaranteed to increase profits. But, with growing experience in social franchising, the reluctance to charge fees is starting to erode. In particular, franchisors have found that it is more difficult to impose fees later—rather than earlier—when franchisees have grown accustomed to receiving the benefits of membership without sharing the costs. Box 13 describes Greenstar's experience.

BOX 13. GREENSTAR'S EXPERIENCE WITH INTRODUCING USER FEES

Greenstar in Pakistan is a tiered network of 2,500 physician, nurse and retail outlet members, of which 1,100 are considered "franchisees." The network originally refrained from introducing membership fees in order to ensure growth of the franchise. More recently, however, it has introduced fees among a smaller group of franchisees and offered them increased benefits, including special training and participation in a voucher program. Imposing the fees selectively, and long after the network was established, has resulted in a low level of control over the franchises. In combination with other factors, this has prompted Greenstar to consider restructuring the network.

- **Networks can rapidly achieve scale by contracting with government.** Networks can achieve scale and expand their service coverage through government contracting, whereby the public sector outsources service delivery to private providers. From the perspective of public health ministries, networks are attractive vehicles for contracting with as they operate through a single parent or franchisor and can potentially achieve scale and ensure quality.

  Large contracts with the government for the provision of RH/FP services are possible in the context of national health insurance. For example, through Colombia's health sector reform, Profamilia, an IPPF affiliate in Colombia, significantly expanded its service portfolio. Under contract with the National Council on Health Social Security, **Profamilia** became the largest provider of RH/FP services in the country, operating 35 clinics, 45 operating rooms, and 220 medial offices. Between 1990 and 2000 Profamilia increased its RH/FP caseload by as much as 146 percent (Lopez and Perez, 2003).

5.6 MARKETING AND PROMOTION STRATEGIES

A sound understanding of the consumer and provider market is critical for the viability of any network, especially, when new RH/FP services are introduced through either existing providers or a new delivery channel. Social franchises, however, are particularly sensitive to the provider market as they typically draw from an existing pool of independent private providers.

CONSUMER MARKET

Knowledge about the needs and preferences of the end-consumer is essential if networks are to offer the appropriate mix of services and products that ultimately meet their objectives--both public health and financial. In theory, consumer demand for services should guide both the mix of services and their market price. Whether private providers currently offer a particular service to a given market is another litmus test of consumer demand for franchised services.

Given that consumers are more willing to pay for curative rather than preventive care, networks often must stimulate demand for RH/FP services. Demand-generating activities will increase a network's cost of operations, and should be realistically accounted for in a business plan.

- An understanding of the market is necessary to diversify services and set prices appropriately. To diversify revenue, a network must first understand its market and respond to consumer demand. Networks that intend to become financially self-sufficient or at least reduce their reliance on donor funds must identify the mix of products, services, and clientele that will enable them to recover a predetermined portion of their costs and achieve intended health impacts. Introducing user fees, establishing capitated prepayment systems, and negotiating contracts for employer contributions are typical mechanisms used by networks to generate sustained revenue. However, as PROSALUD has demonstrated (see Box 14), reliance on any one of these financing mechanisms requires adequate knowledge of the consumer market, appropriate business planning, and the ability to test new services and products.

BOX 14. TESTING PAYMENT MECHANISMS: LESSONS LEARNED BY PROSALUD

In 1998, PROSALUD tested a variety of mechanisms to generate revenue, including fee-for-service and prepayment schemes. The mechanisms called for market and risk analysis particular to each mechanism. PROSALUD abandoned the prepayment system one year after its launch as a result of overutilization of services and high drug costs, but the sliding-scale, fee-for service program continues successfully. PROSALUD learned that prepayment schemes are difficult to administer in some markets--complete cost information is required to set premiums, and clients need to understand how insurance operates (Cueller, 2000). Fortunately, with rigorous operations research, PROSALUD was able to respond quickly and discontinue the insurance product that had proved too costly.

A network not only needs to understand the form of payment that is optimal for network operations, but it also needs to understand the implications of price changes on client utilization. Even marginal price increases, as in the Janani franchise (see Box 15), had serious consequences on utilization by a particular target market.

BOX 15. SENSITIVITY TO PRICE INCREASES IN THE JANANI FRANCHISE

In an attempt to increase resources for the franchise, Janani recently used a willingness-to-pay tool developed by the Population Council to determine whether the franchise could raise prices. Results of the exercise indicated that Janani outlets could raise prices by 20 to 30 percent and still meet the needs of their target population. However, six months after increasing its prices, Janani found that, while overall revenues had increased by 11 percent, caseloads had dropped by 17 percent and CYP had decreased by 14 percent. The higher prices had disproportionately affected poor women, necessitating price adjustments to reduce the prices slightly to remain affordable to low-income clients.

PROVIDER MARKET

- **If providers do not perceive a benefit to network participation, they are less likely to join or retain their membership.** Sufficient provider demand for a network's services is a prerequisite to success. Unfortunately, many preventive RH/FP services supplied by donor-supported networks, particularly re-supply family planning methods, generate little profit for the provider and may not offer sufficient incentive to join a network. When the obligations for network participation are perceived to be substantial, this undermines a provider's motivation to join the network.

  Incentives to attract providers into a network include access to lower cost drugs and supplies, financial credit, marketing and business development services, training, and referrals to guarantee increased clientele. Physicians who are usually less likely to join a social franchise for financial reasons may instead be motivated to participate in exchange for advanced training or the opportunity to support a social cause. The **Sun Quality** franchise in Myanmar, for example, believes that an important motivation for physician participation in the network is the altruistic desire to "do good." Most clients served by the franchise represent the lowest three socioeconomic groups, and the franchise is strict in enforcing price caps on services. In the short term, some providers have in fact experienced reductions in their profit margins. If the sole motivation of providers was profit it is conceivable that many would not join the network.

- **Networks have been able to expand their market and diversify service mix by including different cadres of service providers.** Providers are more likely to join a franchise when they recognize an immediate value to their business operation and clientele. Typically, franchises are able to draw mid-level providers, such as midwives or licensed pharmacists, who see value in selling a branded service. Less established providers are more inclined to join in the hope of building a reputation and expanding their client base.

  Social franchises have the ability to establish several levels (cadres) of service providers to offer different tiers of services and products, thereby expanding their reach and creating a referral network. The availability of a range of providers has been especially important in expanding access to rural areas and developing the skills of providers who otherwise have little opportunity to upgrade the quality of their services.

5.7 MONITORING AND QUALITY ASSURANCE

- **Quality assurance comes at a price.** While monitoring the quality of services and products is a cornerstone of social franchises, this function has proven to be costly to the franchisor both in terms of staff time and required financial support. As such, it is necessary to find alternative ways for ensuring quality while minimizing the trade-off between sustainability and high-quality service provision. One approach, pioneered by the Biruh Tesfah network in Ethiopia (see Box 16), is to partner with a professional association.

BOX 16. TRANSFERRING THE ROLE OF FRANCHISOR TO INCREASE SUSTAINABILITY: BIRUH TESFAH FRANCHISE IN ETHIOPIA

Biruh Tesfa is a social franchise in Ethiopia with the objective of increasing access to RH/FP services. Although the franchise experienced significant challenges in its early years, Biruh Tesfa has persevered and is preparing for its next evolution. As part of its strategic planning, the franchisor (i.e. Pathfinder International) realized that it must change its operations in order to become financially sustainable. Pathfinder established the Medical Association of Physicians in Private Practice in Ethiopia (MAPPP-E) as an entity to provide training and technical assistance to franchisees. The goal is to transfer the role of franchisor from Pathfinder to MAPPP-E, which has already taken over quality assurance functions. This is the first example of such an evolution of a donor-support franchise, and the experience can offer lessons to other social franchises interested in increasing their financial sustainability.

- **Shifting the burden of quality assurance from the franchisor to the provider can support the institutionalization of high-quality practices.** Empowering consumers to make informed choices about service quality can help shift the burden of quality assurance to the provider. The greater the value consumers place on high quality, the more likely consumers will purchase their services from reputed providers. As part of its effort to deliver high-quality services, the Janani franchise in India launches mass media campaigns to inform consumers about important aspects of high-quality services and products. The franchise also publicly displays complaint boards at its outlets so that consumers may post comments about a particular provider, thereby creating incentives for providers to adhere to quality standards.

6. LESSONS LEARNED

To consolidate the findings described in Section 5, the following section offers a synthesis of important lessons related to the viability of private provider networks, with a special emphasis on factors and conditions that support scale-up and expanded supply of priority health services.

POLICY ENVIRONMENT

- **Private provider networks require a policy environment conducive to private sector provision of RH/FP services.** A prerequisite to the formation of a private provider network is an adequate pool of private providers. Regulations that govern the licensing, accreditation and range of services offered by private providers are key factors in supporting or impeding the formation of a network. It is also important that policy reforms encourage growth of the private sector, for instance, through opportunities to contract with the government for provision of services or to expand clientele within national health insurance schemes.

MISSION AND OBJECTIVE

- **Networks can operate with a double bottom line of achieving health objectives and attaining financial viability.** Depending on a network's core mandate and the market in which a network operates, it is possible to balance social and financial objectives. However, especially with the provision of preventive health services, the trade-off between serving the poor and/or underserved communities and making a financial profit may pose a challenge. To achieve a double bottom line, a network can diversify its clientele by targeting mixed-income groups, offer a variety of curative and preventive services, or cross-subsidize service delivery outlets.

INSTITUTIONAL AND BUSINESS PLANNING CAPACITY

- **All networks must be designed in accordance with the market and guided with a realistic, long-term business plan.** An understanding of consumer and provider markets and their dynamic relationship is fundamental to defining the objectives and scope of any network. In addition, it is useful to map all stakeholders involved in the demand and supply chain (product suppliers, public health ministries, professional institutions, and so forth) in order to understand the opportunities and constraints presented by the market and to design a network that responds accordingly. Following a thorough market assessment, for example, a prospective network might realize that a looser affiliation of providers is more suitable than a tightly-controlled franchise. Whatever the particular network model, a business plan should serve as the network's strategic roadmap, taking into account the network's institutional and management capacity, governance structure, and financing mechanisms over time.
- **Any plan to achieve growth or to scale up must be based on a tested and perfected model and built into the business plan.** Opportunities for growth within a commercial network are inherent in the market environment and may be signaled by, for example, increased consumer demand for services or improved network efficiency relative to other service providers. With the

provision of a public good, however, demand is typically latent, and may require stimulation to increase coverage. For example, behavior change campaigns or government-funded vouchers can result in increased utilization of family planning methods. Whatever the impetus behind growth of a network, realistic assumptions and risks must be incorporated into the business plan from the outset.

SOURCES OF FINANCING

- **Most networks diversify revenue by identifying alternative institutional structures and sources of financing.** Donor-supported networks are increasingly diversifying their revenue by soliciting funds from other donors and developing partnerships with the public sector for the transfer of infrastructure or resources. For example, PROSALUD in Bolivia acquired property from the Ministry of Health to grow the network. A new trend among social franchises in particular is "plural" franchising, whereby the central franchisor owns a set number of clinics as a way to generate revenue and sustain the entire network. Commercial networks rely on commercial finance and private equity as well as on public sector transfers or contracts.

REVENUE AND EXPENSES

- **Offering a broader package of services, inclusive of RH/FP, may be necessary for a network to achieve financial viability.** The provision of RH/FP services alone does not generate adequate revenue to sustain a network. Many networks recognize the need to diversify their service mix and offer curative and ancillary services, for which clients usually demonstrate a higher ability and willingness to pay. Commercial networks, on the other hand, may need incentives to offer preventive RH/FP services that are usually less lucrative than curative services. Health insurance schemes that cover a full package of services, offered through government contracts with private providers or private employer contributions, often provide such incentives.
- **Networks must streamline their administrative, technical, and management functions to realize efficiencies and achieve growth.** For any network, whether commercial or not-for-profit, the decision to expand its portfolio of services must be based on (1) demand, (2) an understanding of market opportunities and service mix that will best complement its existing portfolio, (3) investment in the staff's clinical capacity in order to offer a wider menu of services, and (4) upgraded monitoring and quality assurance systems tailored to a differentiated package of services. Meanwhile, streamlining the delivery of services by achieving efficiencies through bulk product procurement, training, advertising, and so forth is also necessary to reduce operating costs.

MARKETING AND PROMOTION

- **It is necessary to balance the benefits and obligations between the parent and network members and ensure that each honors their respective obligations.** A major lesson learned by social franchises is the importance of defining the benefit-obligation balance upfront and building it into the network design. For example, it is difficult to introduce fees or royalties after providers have already joined a network and received benefits for free.
- **Networks are able to expand their market and diversify their service mix when they include several levels of providers.** All networks can identify a range of service delivery structures that are suited to their consumer market, especially if a network serves a differentiated

clientele. Social franchises, in particular, lend themselves to establishing several levels (cadres) of providers that can be easily linked together through an internal referral system. Rural and urban consumers may benefit from access to a variety of reliable, high-quality products and services under a uniform brand, also ensuring continuum of care. Providers, on the other hand, are motivated to join a network in the hope of attracting a larger client base.

MONITORING AND QUALITY ASSURANCE

- **There is a need to identify cost-effective monitoring and supervision approaches that will benefit from scale.** Networks naturally optimize economies of scale; however, some activities are more likely than others to benefit from efficiencies related to scale. For example, the cost per unit of training, the procurement of equipment and products, and marketing services decrease with increased scale. Quality assurance systems, on the other hand, do not naturally benefit from scale efficiencies, as the unit cost of visits to providers and ongoing supervision may not decrease. However, alternative mechanisms may help reduce the costs of quality assurance, such as partnering with a professional association to fold franchise services into its accreditation schemes, developing peer oversight or self-assessment mechanisms, or empowering consumers to respond to signals of high-quality service provision.

A Continuum of Network Viability, Annex B, draws on the above lessons to present pathways to viability, demonstrating progress toward operational and financial viability. The continuum applies to each network type identified in this paper, providing the opportunity for networks to self-assess their place along the continuum.

7. DISCUSSION

Networks are an institutional arrangement that permit the cost-effective expansion of the supply of RH/FP services in the private sector. They achieve efficiencies through economies of scale, improve access through uniform prices and services, and offer the potential to ensure high-quality healthcare. Typically, networks are organized around a core business that is standardized across units and easily replicated and thus have the potential to rapidly scale up. At the same time, networks are inherently versatile businesses whose structure is determined by their objectives as well as by the opportunities and constraints presented in the market and broader policy context.

In light of insufficient public and donor support, the public health community is concerned with ensuring the quality and sustainable provision of RH/FP services in the private sector. The business practices of commercial networks offer important lessons that can be adapted to ensure the viability of donor-supported institutions, including an orientation to market opportunities, an understanding of differentiated consumer preferences, and an ability to plan according to a long-term strategic roadmap. Alternatively, incentives for commercial providers to expand their delivery of RH/FP services, possibly in synergy with donor-supported institutions or public health ministries, are necessary for expanding overall supply.

Ultimately, no single "best" model or approach will ensure an expanded supply of RH/FP services. Networks must make practical trade-offs associated with serving the poor, offering preventive RH/FP services, and making a profit. Donors and health practitioners need to realize the limitations of the private sector in meeting public health objectives, while determining how best to target their funding to maximize a social return. They may need to identify synergies with the commercial sector to expand RH/FP service provision and/or facilitate partnerships between public health ministries and private networks to achieve scale.

Networks are an important institutional structure that can bridge commercial and social objectives; it is precisely this nexus that also lends itself to scaling up the delivery of RH/FP services. As argued in this paper, the viability of a network is a precondition to achieving scale, along with both the desire and the means to do so. Strategies necessary to achieve viability include, first, expanding the basket of health services beyond RH/FP and, second, targeting clients with differentiated incomes and capacity to purchase services. The ability to leverage public sector financing through government service contracts or insurance schemes can also be critical for network viability and achieving scale.

CHALLENGES AND LOOKING FORWARD

It is important to understand the challenges inherent in expanding the supply of RH/FP services through private sector channels, and identify promising approaches to overcome these barriers.

Driven primarily by market incentives, commercial networks do not explicitly or directly respond to social or public health objectives. With little or no financial incentive to do so, most commercial networks do not actively promote RH/FP services. Nonetheless, the market does offer opportunities that can stimulate **commercial networks** to provide a wider range of preventive services as well

as serve a broader clientele that could include low-income communities. Health insurance is one promising mechanism through which commercial networks can be incentivized to promote preventive RH/FP services. For example, insurance packages that are based on capitation, rather than on a fee-for-service structure, and cover deliveries, may offer providers a financial incentive to promote family planning. When contracted through private providers, nationally mandated insurance is an important vehicle for promoting preventive care and diversifying the clientele of for-profit providers. In Nicaragua, through contracts with the national insurance scheme, private providers are playing an important role in increasing the utilization of RH/FP services nationally.

Donor-supported networks face the long-standing challenge of balancing their public health mandate with the need to achieve financial viability. Yet, such networks may consider several approaches to address this challenge, such as negotiating commercial pharmaceutical partnerships, transitioning into a "center of influence," and allowing the natural graduation of franchised providers.

Negotiating partnerships between donor-supported networks and pharmaceutical companies is an approach that has demonstrated considerable promise. Given that the delivery of RH/FP services involves the distribution of contraceptive products, social franchises and pharmaceutical companies enjoy a natural synergy. Partnerships generally involve the provision of lower-priced, high-quality branded products in return for a larger market base for the pharmaceutical partner. The RedPlan Salud midwife franchise in Peru has brokered a win-win relationship between commercial, NGO and private midwife partners to achieve a double bottom line.

In the interest of increased efficiency, one promising approach for not-for profit networks or social franchises is to structure a looser arrangement or a "center of influence." As a strategy for ensuring a network's long-term viability and institutionalizing high-quality health practices, existing local associations such as professional associations, educational institutes, or training centers could gradually take on some or all functions of a network parent. For example, monitoring, oversight, and ongoing training, functions whose costs are difficult to recover, may be gradually transferred to an existing local association already involved in these activities. Beyond supporting the viability of a particular network, centers of influence can serve as advocates for the health sector beyond an individual network's scope and mandate. For example, they may support the development of professional standards and improve the accreditation protocol of an industry. The Biruh Tesfah social franchise in Ethiopia is evolving into a center of influence, whereby, in an effort to increase the franchise's financial sustainability, the franchisor will gradually shift from Pathfinder International to the Medical Association of Physicians in Private Practice in Ethiopia. MAPPP-E is currently an active partner, having taken over the functions of training and quality assurance for the franchise. The association's eventual role as franchisor represents the first evolution of its type—an innovative approach to increasing a social franchise's viability.

A challenge particular to social franchises relates to retaining providers in the network. As younger providers become more established (through their participation in the franchise) and build up a consistent volume of clients, they may perceive diminished value in their continued membership in the franchise. Moreover, evidence suggests that older, established providers are less motivated to join a franchise because they have already solidified their client base and reputation. Rather than battle with the retention problem, social franchises might be better advised to support franchises' natural evolution. Thus, the objectives of the franchisor would shift from working to retain all franchisees in the network

to allowing a natural graduation from the franchise, encouraging the franchisor to focus on recruiting new (younger) providers.

While the cycling of providers through a social franchise might be construed as a weakening of the franchise, it is likely that once providers have participated in the franchise and established a strong business, they will continue to provide many (if not most) of the services demanded by their clients. And while those providers' prices may no longer be regulated, clients would be willing to pay higher prices only if they perceived that they were receiving higher-quality services. The demand for higher-quality services would motivate providers to maintain high standards as required by the franchisor or risk losing clients to a franchised clinic that would assure adherence with quality standards.

Given that some social franchises have operated long enough to see such an evolution (e.g., Greenstar, Janani, and WFMC), it would be possible to study what happens to providers who leave a franchise.

CONCLUSION

Largely owing to their ability to bridge commercial and social objectives, private provider networks are a compelling business arrangement that offer great potential for increasing the supply of RH/FP services. Such networks must carefully consider the trade-offs between achieving financial viability and promoting preventive RH/FP services. In addition, it is essential to understand the relative strengths and best practices of commercial and donor-supported models in order to optimize both health and efficiency objectives.

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APPENDIX A: LIST AND DESCRIPTION OF INTERVIEWED NETWORKS

Name	Location	Type of Network	Internet Information
Africa Air Rescue Health Services (AAR)	Kenya	Commercial	www.aarhealth.com
Biruh Tesfa	Ethiopia	Social franchise	www.pathfind.org
Bushenyi Medical Center (BMC)	Uganda	Commercial	
CAREShop	Ghana	Social franchise	www.gsmf.com.gh
Clinix Health Group Limited	South Africa	Commercial	www.clinix.co.za
Farmacia Joven	Mexico	Pharmacy network	www.celsam.org
Greenstar	India	Social franchise	www.greenstar.org.pk
Grupo Hospiten	Dominican Republic and Mexico	Commercial	www.hospiten.es
HealthSpot	Kenya	Social franchise	www.healthfranchise.org
HealthStore (formerly CFWshops)	Kenya	Social franchise	www.cfwshops.org
Hygeia Nigeria Limited	Nigeria	Commercial	www.hygeiahmo.com
International Hospital Corporation	Mexico, Costa Rica, Brazil	Commercial	www.internationalhospital.com
International Planned Parenthood Federation (IPPF)	London Headquarters	Not-for-profit	www.ippf.org
Janani	India	Social franchise	www.janani.org
K-MET	Kenya	Not-for-profit	
Marie Stopes International	London Headquarters	Not-for-profit	www.mariestopes.org.uk
Medicover	Poland, Romania, Czech Republic, Estonia, Hungary	Commercial	www.medicover.com
Mexfam	Mexico	Not-for-profit	www.mexfam.org.mx
PROSALUD	Bolivia	Not-for-profit	www.prosalud.org
Redplan Salud	Peru	Social franchise	www.pathfind.org
Sun Quality Health	Myanmar	Social franchise	www.psi.org
Telemedicine Reference Medical Center	Bangladesh	Commercial	www.trclcare.com
TOP Réseau	Madagascar	Social franchise	www.psi.org
Total Health Trust	Nigeria	Commercial	www.totalhealthtrust.com

Africa Air Rescue Health Services (AAR)
The first private health management company in East Africa, AAR began more than 20 years ago as a private air rescue and emergency medical evacuation company. Currently, AAR members receive a wide range of medical and health support services, including hospital services, franchised clinics, and a preferred provider network for members in Kenya, Rwanda, Tanzania, and Uganda. Medical services include primary healthcare, family planning, and maternal and child health services for all members of the community. As a commercial network, AAR serves clients in all income groups and has reached lower-income clients with affordable pricing and offers corporate health membership packages.

Biruh Tesfa
Biruh Tesfa, a private sector franchise initiative in Ethiopia, began operations in 2000 by leveraging private sector providers to add preventive reproductive health services to existing curative services. Franchise outlets offer reproductive health services including STI diagnosis and treatment and FP. Some clinics within the franchise also offer perinatal services, immunizations, and voluntary counseling and testing (VCT) for HIV. Biruh Tesfa was originally implemented with funding from the David and Lucille Packard Foundation, but has also received support from USAID. Pathfinder International acts as the franchisor, although there are plans to transfer the role of franchisor to a local professional association. The franchise includes different types of outlets, including 140 private clinics, 90 workplace programs, 300 community health agents, and 100 market vendors.

Bushenyi Medical Centre (BMC)
Located in Bushenyi, Uganda, BMC was established in 1998 as a commercial network comprised of a central clinic and three satellite clinics. Started by a physician with an interest in STIs and HIV/AIDS, the clinics seek to provide high-quality healthcare to district residents, especially lower- income and student populations. Services include primary healthcare, RH/FP services, HIV/AIDS prevention and treatment, and STI diagnosis and treatment. Students are also eligible for a prepaid health program.

Clinix Health Group
Clinix Health Group was started in 1992 to bring high-quality healthcare to underserved and disadvantaged communities in South Africa. Clinix owns a system of four hospitals with independent doctors in Johannesburg and works with Medical Aid Schemes and area mining companies to provide workplace health services. By working with traditionally underserved communities, Clinix qualifies for reserved status, which affords it the opportunity to bid on government tenders.

Greenstar
As one of the largest developing-country private reproductive health networks in the world, the Greenstar network provides comprehensive, accessible, and affordable RH/FP products and services to low and middle-income Pakistanis. Established in 1995 by Social Marketing Pakistan (a PSI affiliate), Greenstar currently has 2,500 active members, although the network has trained over 17,000 providers. In an effort to incorporate lessons learned during its decade of operation and respond to changing market conditions, Greenstar is planning to pilot a new franchise called GoodLife in 10 rural districts. The new franchise will emphasize a broader package of healthcare services, including maternal, neonatal, child health and family planning services.

Grupo Hospiten
Founded in Spain almost 30 years ago, Grupo Hospiten is a for-profit company offering a full range of services, including primary care, RH/FP services, and highly specialized care, to all levels of clientele, but with an emphasis on tourists. The company operates a network of 10 hospitals with local partners in primarily tourist areas in the Dominican Republic, Mexico, and Spain and serves the tourist industries of each community in which they work. As a complement to its services, Grupo Hospiten also operates Clinic Assist, a service providing emergency care 24 hours a day in private homes and hotels.

Healthspot Franchise
Healthspot is a new health franchise model that focuses on TB and HIV/AIDS. Healthspot markets its franchise as not only cost-effective, but also as a unique approach that targets lower-income populations, and offers integrated healthcare services with a strong TB component. The Healthspot franchise began partnering with the HealthStore Foundation in 2004 to transform selected franchised drug shops into clinics staffed by nurses who can provide TB treatment and other health services.

HealthStore Network (formerly CFWshops)
First piloted in 2000, HealthStore now operates as a micro-franchise with approximately 60 outlets (a mix of drug shops and clinics) serving low-income clients in rural areas in Kenya. HealthStore outlets provide access to affordably priced essential medicines and health services, including primary healthcare and limited RH/FP services, in communities where supplies and services are scare, overpriced, or of poor quality.

Hygeia Nigeria Limited
Hygeia, a Nigerian HMO, counts over 70,000 members, operates 27 workplace clinics and three hospitals under the Lagoon brand, and has contracted with over 200 providers in all 36 Nigerian states. Hygeia's Lagoon hospitals provide uniform services while clinics provide a broad range of services depending on area and type of provider. Hygeia initially focused on serving the Nigerian upper class, but, following an economic downturn and subsequent erosion of its market base, expanded its market to include the middle class through the development of an HMO network. Hygeia emphasizes high-quality services and provides quality assurance training to all participating providers.

International Hospital Corporation (IHC)
International Hospital Corporation (IHC), a Texas-based holding company, develops hospitals and clinics in Latin America. IHC's mission is to create a network of hospitals whose quality and services meet the highest international standards. IHC has set forth a goal to become Latin America's preeminent private healthcare system. It currently develops, owns, and manages private healthcare facilities in México (CIMA México), Central America (CIMA Central America), and Brazil (VITA). Each of the three independent regional holding companies typically owns the majority position in its facilities, including seven hospitals and one medical diagnostic and imaging center. The facilities serve individuals covered by a private health insurance plan and those able to pay out of pocket.

International Planned Parenthood Federation (IPPF)
IPPF was started in 1952 as the conglomeration of several family planning associations that decided to create a global family planning umbrella association. Headquartered in London, IPPF is a federation of family planning associations with 149 member associations in 166 countries. IPPF also funds and operates six regional offices that do not provide client services but rather offer logistical support and training for

country affiliates. IPPF affiliates must complete an acceptance process to join the federation and must undergo an assessment every year as well as accreditation every five years. Generally, IPPF affiliates target low-income clients and provide RH/FP services as well as additional services, which vary by affiliate.

Janani (Titli and Surya networks)
Janani, an Indian NGO affiliated with DKT International, is the franchisor of three interconnected networks: retail shops, rural medical practitioners (Titli centers) and private health facilities (Surya clinics). Janani developed the franchise to respond to rapid population growth, high unmet need for family planning, and insufficient public health services in three of India's poorest states, Bihar, Jharkhand and Madhya Pradesh. Retail shops sell FP products and replenish supplies to Titli and Surya providers; Titli outlets sell non-clinical products and tests and provide limited counseling; while the Surya providers offer a range of clinical health services and act as referral centers. As of 2005, Janani has trained over 40,000 rural health providers, has established 520 medical clinics, and is delivering products through 31,000 retail shops. In an effort to address issues of retention, quality assurance and overall viability, Janani is in the process of restructuring its franchise operations. Adjustments include expanding the basket of services and products, increasing prices, instituting peer supervision, and streamlining the number of franchised outlets.

Marie Stopes International (MSI)
Established as Marie Stopes International in London in 1976, MSI grew out of an organization created by Dr. Marie Stopes in 1921 to provide free family planning services to married women. Today, MSI affiliates provide RH/FP information and services to men and women in 39 countries. Within each partner country, the MSI-affiliated program is an NGO that chooses the service mix most appropriate for its setting. MSI programs and services vary by location but focus on underserved communities. All affiliates share MSI's vision to design and deliver innovative, high-quality RH/FP programs that are culturally appropriate and respond to local needs.

Medicover
Medicover, a commercial network, began operations in 1995 in Poland and has since expanded rapidly to Estonia, Hungary, Romania, and the Czech Republic. Medicover currently owns 56 medical centers and operates a private provider network. In areas where Medicover does not operate a facility, clients are referred to a provider network of 356 facilities in the five countries. The majority of clients participate in prepaid schemes rather than in fee-for-service arrangements. Medicover offers a full range of services, including primary healthcare and RH/FP services. Depending on a facility's location, Medicover members' income levels vary widely.

Mexfam
Mexfam was established in 1965 as a foundation dedicated to population studies, although it also offered some RH/FP services. Currently, Mexfam is a nonprofit civil association providing RH/FP services and education throughout Mexico. It focuses on vulnerable populations in cities and rural areas, including the young and the poor. In urban areas, the Mexfam market is typically middle-income segments of the population and, in rural areas, low income. In rural areas, trained health promoters conduct outreach, distribute FP products, and refer patients to service delivery points. Mexfam funded and built its clinics and hospitals and retains ownership of the facilities. There are 24 Mexfam clinics with 270 providers; an additional 300 doctors work independently as part of the network.

PROSALUD

PROSALUD is a private nonprofit organization that oversees a national network of health facilities in Bolivia. It began in 1985 and currently operates 34 outlets throughout the country. PROSALUD partners with the Ministry of Health and regional health offices to sustain the network. It operates three types of service delivery points: centros de salud, which focus on maternal and child health and primary care; *policlinicos,* which offer primary care and specialized secondary care, such as dermatology, cardiology, and physical therapy; and clinicas, which offer tertiary care and surgery. Preventive services are offered without cost, and other services are priced competitively between private provider and MOH clinic prices. PROSALUD primarily serves lower- to middle-income Bolivians who often work in the informal sector and thus do not qualify for the government-run health plan for formal sector employees.

RedPlan Salud

RedPlan Salud, a network of midwives established in 2002, provides RH/FP services to low and middle income women in urban areas of Peru. A local NGO, INPPARES, acts as the franchisor, although other partners include Schering Peruana and Apropo (a social marketing NGO). The network has grown from an initial 50 midwives to over 500, and the coverage area has expanded from Lima to include four additional cities. Franchisees are independent midwives who have completed advance training and meet quality standards. Midwives must agree to exclusively sell RH products procured through INPPARES. The franchise was established with minimal donor funding, and has become financially sustainable in a period of three years.

Sun Quality Health Clinic

The Sun Quality Health Clinic in Myanmar is a franchise network with 463 active clinics in Yangon and Mandalay. Established in 2001 to provide high-quality and affordable RH/FP services to impoverished urban and peri-urban communities, Sun Quality largely serves clients in the lowest three socioeconomic classes. The franchise consists of individual fractional franchise clinics operated by physicians who offer RH/FP services at a standardized price; some of the clinics also offer malaria, TB, and STI treatment.

Telemedicine Reference Center Limited (TRCL)

TRCL is a not-for-profit telemedicine network in Dhaka, Bangladesh. Begun in 2002, TRCL's mission is to extend basic primary medical care throughout the country. It currently operates nine remote sites with plans for expansion. The government of Bangladesh makes loans to doctors who agree to set up offices in rural areas. In Dhaka, computers link the rural clinics to the main hub that serves as a medical call center. The call center helps assess whether patients can be treated at the rural center or require hospitalization. The center does not diagnose or prescribe treatment; it offers treatment guidance for doctors as needed.

TOP Réseau

The TOP Réseau network, started in 2001, operates 123 member clinics in five high-risk urban centers of Madagascar. The network is targeted to youth, and includes components such as mass communication and peer education. The clinics deliver an integrated intervention of interpersonal activities, mass media communication, and youth-friendly clinical service to motivate youth to adopt safer behavior and thus improve their sexual and reproductive health. Each clinic is a fractional franchise and offers a varied menu of services in addition to RH/FP services; however, services are uniformly priced within each region.

Total Health Trust (THT)

One of the first group HMO models in Nigeria, THT began operations in 1997 and currently contracts with 1,000 private provider clinics throughout the country. It offers prepaid insurance schemes for private employer-based groups and for public sector employees through the National Health Insurance Scheme (NHIS). The plans provide coverage for a fixed set of services, including primary healthcare, maternal and RH/FP services; middle-class Nigerians are the primary users of the services.

APPENDIX B: CONTINUUM OF NETWORK VIABILITY

Dynamic relationship between elements of viability	LESS VIABLE →			MORE VIABLE
	Policy Environment	Policies discourage or prohibit private sector health provision. The pool of private providers is not sufficient to support a health network.	Policies may not discourage private practice, although regulations limit the range of services an individual provider can offer.	Policies encourage private practice, permitting a wide range of service delivery options and facilitating registration of new health products/ medicines.
	Mission and vision	Network is motivated purely by social/public health objectives with no stated objective to reach financial viability.	Network is motivated by social objectives and has a stated objective to be financially sustainable; however, it does not have a clear strategy to achieve viability.	Network is driven by a "double bottom line" to meet social and financial objectives and has clearly articulated a market-based strategy to meet both objectives.
	Institutional and Business Planning Capacity	Institutional and business planning capacity is limited or entirely dependent on a donor. Parent lacks personnel with business or management orientation, and has limited ability to articulate a long-term plan.	Parent has capacity in some areas (e.g., training, recruitment) but not in others (e.g., business planning, financial analysis). Limited capacity to fill resource gaps, identify market opportunities, and develop a long-term business plan.	Parent has strong management, governance, and technical capacity, with an ability to adapt its business strategy to market conditions and respond to new opportunities.
	Sources of financing	Network relies on grants and in-kind support from a single donor to cover its capital and operating costs.	Network relies on a combination of donor and public grants/in-kind support to cover operations but has little access to subsidized loans or commercial finance.	Network relies on diversified and predictable funding, including private equity and commercial finance, with little or no donor funding for operations.
	Revenues and expenses	Revenues from sales of products or services are nominal and generated through limited sources. Expenditures are not based on sales or revenue but are tied to the availability of grants.	Revenues from sales of products or services increase but are not adequately diversified or predictable. Systems to analyze costs and revenues are basic and not used for financial planning or to increase efficiency.	Revenues from sales and products are diversified and predictable, including service contracts with public sector or corporate employers; expenses directly tied to revenue streams; network able to optimize efficiencies.
	Monitoring and Quality Assurance	Quality requirements for participation are minimal; no consequences for poor performance.	Quality requirements for participation are adequate, with systems in place for regularly monitoring member performance. Failure to meet quality standards has adverse consequences.	Quality requirements for participation are high, with systems in place for regularly monitoring member performance; failure to meet quality standards results in expulsion.
	Marketing and Promotion Strategies	No detailed analysis of provider and consumer markets before launching network. Beyond a basic brand identification of network, there is no long-term marketing strategy.	Some market analysis conducted before launching the network, but little strategic targeting or adaptation based on changing market opportunities and constraints.	Thorough market analysis conducted before establishing network and as ongoing practice. Analysis drives member recruitment, branding, and pricing as well as consumer-market segmentation and communications.

Explanatory Notes

The continuum of viability illustrates pathways toward viability centered on the elements defined in Section 4. The matrix is intended to apply to each type of network identified in this paper (commercial, social franchise, not-for-profit), making it possible for networks to assess where they fall along the continuum. However, a few caveats are in order in interpreting the continuum. First, viability as defined in this paper is the dynamic interaction between various elements, thus making it difficult to tease out individual measures of viability for each of the elements. Second, the measures of viability for each level are largely illustrative. Finally, recognizing the interplay and even tension between various elements, the continuum depicts the progression toward best practices rather than toward viability per se. For example, while ongoing quality assurance is a best practice, some networks have been able to achieve financial sustainability without such a mechanism.