



HOW EQUITABLE IS SOCIAL FRANCHISING?

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Case studies of three maternal healthcare franchises in Uganda and India

Access to quality maternal health services for all is a key component of the SDGs

In many developing countries, private providers play a major role in maternal healthcare provision, leading international agencies to support interventions to strengthen the care they provide. The private health care sector encompasses both for-profit and not-for-profit providers that are highly heterogeneous.

One of the fastest growing private health care sector interventions in recent years has been clinical social franchising, which aims to improve quality of care and increase utilisation of services.

What is social franchising?

Social franchising applies commercial franchising business principles to support the provision of branded, quality-assured

services of social importance, such as healthcare, via a network of private providers. Social franchises are typically run by a third party administrator such as an NGO, which manages the brand and supervises the network through regular visits and audits.

Why is equity important?

Although the social franchise model does not inherently include a focus on reaching poorer groups, the funders and implementers of healthcare social franchises in low- and middle-income countries (LMICs) generally have a stated goal of reaching vulnerable populations and providing care to those most in need. As a result, equity has come to be seen as a key measure of performance, and a policy concern, although evidence on this topic remains patchy.

This study assessed the socio-economic profile of clients of three maternal health social franchises: the ProFam network in Uganda, the Merrygold network in Rajasthan, India, and the Sky network in Uttar Pradesh, India. These three programmes all received funding from *MSD for Mothers*.

Using a common methodology, the study situated the social franchise users within national or state representative wealth quintiles and so assessed their relative wealth compared with the general population. It also assessed whether women's reports of the content of ANC and delivery care received at social franchise facilities differed across wealth quintiles. In total, 2188 women were surveyed.

Key findings

Antenatal and delivery users were concentrated in higher wealth quintiles

Although all the programmes had a stated aim to serve poorer groups, or to provide affordable care, the study found that franchise users were concentrated in the higher wealth quintiles of the

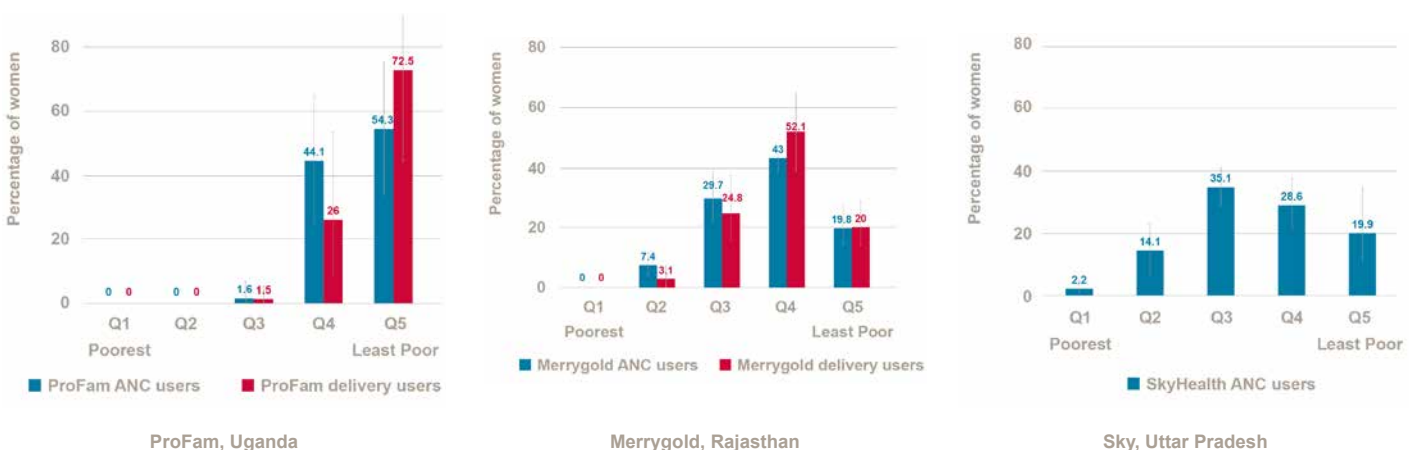
national/state population distribution in all three programmes.

The percentage of women in the top two quintiles was highest for the ProFam network (>98% for both services), followed by Merrygold (62.8% for ANC and 72.1% for delivery) and Sky (48.5% for ANC).

the lowest two quintiles was zero for ProFam, 7.1 and 3.1% for Merrygold ANC and delivery users, respectively, and 16.3% for Sky.

Results suggest that most content of care indicators did not generally vary by SES.

Figure 1: Distribution of social franchise users by national/state wealth quintile (percentage, with 95% CI)





Interpretation

It is important to note that the quintiles are calculated relative to the population in each setting, and therefore the absolute wealth level of a given quintile will vary across settings.

It is possible that the more skewed distribution in Uganda compared with Rajasthan and Uttar Pradesh simply reflects the lower average SES of Uganda compared with the Indian states, meaning that fewer women

in the bottom one-half of the SES distribution can even contemplate using private facilities in Uganda compared with India. In the Sky Health programme ANC was free, and this might explain why poorer women accessed services.

Based on this study, what should change?

Social franchising programmes should be clear about their intentions and strategies to reach lower SES populations, and report equity data more systematically

Although most social franchises acknowledge they will not reach the very poorest, the tension between targeting poorer groups and financial sustainability remains a challenge for this type of intervention, and it seems unlikely that middle income and poorer groups will be reached in large numbers in the absence of additional targeted subsidies.

Whatever strategies are adopted, it is essential that social franchise programmes be clear about who they are targeting in the socio-economic distribution, and report systematically on their equity results.

Simplify the goals for social franchising models

All three programmes in this analysis included a wide range of objectives: establishing a recognised brand, recruiting providers to the network, generating demand, improving quality of care, developing the business of private facilities and targeting the poor.

There may be tensions between these objectives—particularly between targeting the poor and improving quality or developing the business, especially over a relatively short timeframe.

Carefully evaluate whether such large investments in social franchising are warranted

A growing body of evidence points to the limitations of social franchising models, as they have been implemented, to yield promised results. Enormous investments have been made in social franchising programmes, which warrant careful evaluation.

What more do we need to know?

Are these inequalities specific to social franchising?

The inequalities in service coverage documented in this study are not unique to social franchises, with distributions favouring the better off also documented in the private sector in general and in some cases in the public sector. Comparisons need to be made to other private provider service models, as well as the public sector.

What effect does social franchising (and other private sector initiatives) have on alleviating pressure on public facilities?

One claimed benefit of investing in private sector initiatives is that increased utilisation of private facilities will relieve the burden on public facilities, freeing up space and resources for those who more acutely need it. Additional research is needed to understand patient journeys between public and private facilities and how to best leverage the private sector to support the country's health system.

This study explored this theory in Uganda and did not find any increase in average patient volumes at franchise facilities post-entry to the franchise, indicating that such shifting was not occurring, at least within the first couple of years of franchise membership.



Image credit: Pieter ten Hoopen/London School of Hygiene & Tropical Medicine/India/2016

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