A FRAMEWORK FOR SOCIAL FRANCHISING IN INDIA

A Report for The Department for International Development

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by

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CONTENTS

ACRONYMS

DHS	Demographic and Health Surveys
GoI	Government of India
IT	Information technology
NGOs	Non governmental organisations
MoH	Ministry of Health
RH	Reproductive Health

TERMINOLOGY

The following terms are used throughout this report; those unfamiliar with these terms may need the following clarification:

Franchisor: The owner and originator of the franchise brand and policies, or principal in the principal-agent contracting relationship.

Franchisee: the individual outlet owner in the franchise, or agent in the principal-agent contracting relationship.

Master franchisee: a franchisee who owns a number of outlets.

Fractional franchise: a situation whereby the franchisee's business encompasses a wider range of products/services than those under the franchise umbrella. For example, a general practice doctor whose reproductive health service (and perhaps product provision) is franchised, would be a fractional franchise.

PARAMETERS OF THE REPORT

The ultimate audience for this report is the MoH in India who are constructing their Strategy for Social Marketing and would like advice/inputs as to how the state governments can make further use of social franchising as a tool to increase the public's access to healthcare products and services in remote and rural areas.

The report starts with the premise that social franchising is, in principle, an attractive option for increasing access to services and products that meet public health goals in India. The report focuses on providing practical considerations, issues and advice for how social franchising could be further utilised.

The first section of the report highlights issues and information that need to be addressed before such a programme is implemented. These issues include:

- What are the comparative advantages of the state government in India as compared with other actors that might be involved such a system?
- What information needs to be gathered before such a programme should be implemented?

The second section focuses on practical management questions that will inevitably arise in developing the system and constructing the contracts between franchisor and franchisee, including:

- Which factors should be considered in selecting and managing new franchisees?
- What incentives could be offered by the franchisor to encourage clinics to enter and stay in the network?
- What factors would the franchisor need to regulate and how would the franchisor go about monitoring these factors?
- How sustainable would such a system be? What are the options for either i) subsidy or ii) recovering costs?
- What are some organisational considerations/issues the programme will encounter as it grows?

It should be noted that it was not entirely clear from the brief given the consultant, whether the MoH is considering franchising health care *services*, or *products*, or both. Because health care *products* are usually more tangible and the markets more contestable relative to some types of healthcare *services*, there may be relatively more potential for expanded use of the private sector to supply products that meet public health goals[1]. However, failures in the pharmaceutical market highlight the need for public regulation or involvement as contractor in order to correct problems such as radically inflated, black-market prices and inappropriate, impure, or expired drugs being sold.

It was also not clear whether the franchised services and/or products of concern are solely *reproductive health* related, or if the government is considering franchising as a mechanism to increase access to a wider range of healthcare goods and services. It was not clear whether the government is considering *expanding existing* social franchise operations in India (e.g. Janani) or whether the government is considering starting up an altogether *new* franchise system.

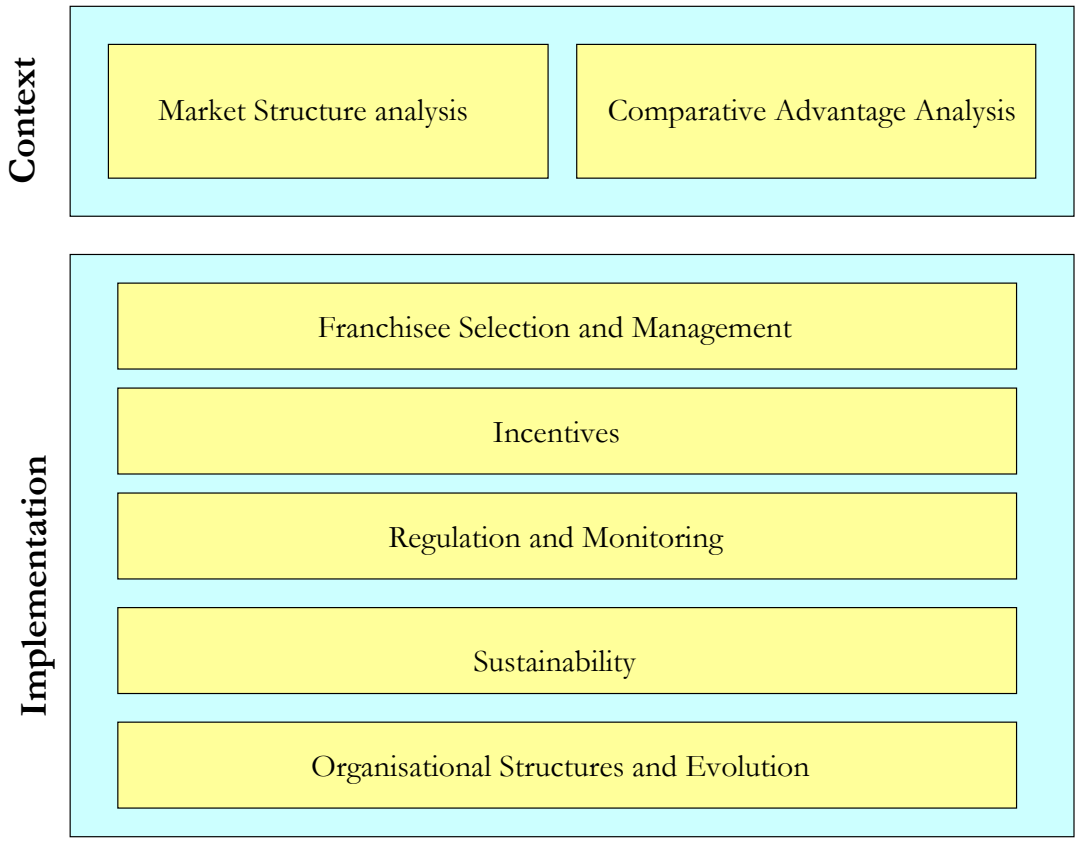
[1] Preker, A., Harding, A., Travis, P., 2000. 'Make or Buy' decisions in the production of health care goods and services: new insights from institutional economics and organisational theory. Bulletin of the World Health Organisation, 2000, 78 (6)

Finally, whether the system would be a fractional or a full franchise also needs to be considered. The consultant has assumed that the brief was not specific because the government may still be in the process of deciding the exact parameters.

Therefore, the approach taken was to discuss issues that relate to expansion *and* start-ups, franchising products *and* services, reproductive health *and* general healthcare, and fractional as well as full franchises. There would be differences between each of these during implementation, but there are important similar issues as well. This report covers issues that are common to all of the above.

CONCEPTUAL FRAMEWORK

The following diagram presents a framework for thinking about the initiation and organisation of a social franchise operation for increasing access to public health goods and services. The structure of the report more or less follows this framework as an outline.



PART 1: CONTEXT

1. CONSIDERATIONS FOR SOCIAL FRANCHISING

The following points highlight pre-conditions for implementing franchising:

- Is there an existing under-employed private sector?
- Is it sufficiently widespread that it justifies the cost of building an umbrella franchise organisation?
- Are clients willing and able to pay for the services/products being franchised? Most curative services offered in urban areas will meet this criterion, but it has been well established that people rarely pay for preventative services or cures requiring long-term treatment regimes.
- A franchise can only be developed where there exists sufficient local capacity to build and manage a large organisation, working in an effectively for-profit manner.

In order to answer these questions, there needs to be an understanding of:

- Market structure;
- Comparative advantage of different parties to take on different roles in the franchise system.

1.1 Market Structure

It is appropriate for the government to consider market structure because it should aim to find gaps in the market where the new, franchised services can improve upon existing services or product quality, prices, or geographic coverage. It would be a waste of resources for the government to use public money to enter a market where customer's needs are already well met; this is especially the case if the franchised products and/or services are subsidised. This could lead to exit of private sector (non-franchised) operators from the market, and in the long term, could decrease competition[2] and availability to consumers.

The issues that need to be understood include:

- What percentage of different types of health care (especially RH) is provided and financed by the state and what percentage by the private sector (non-profit, commercial, 'traditional' practitioners)?
- How does each compare, in a particular region, in terms of service or product quality, price, product range, geographic coverage, market segment strategy? What gaps exist in the market?
- Are there a sufficient number of suppliers (e.g. healthcare personnel with the right specialisation) for a new service to be offered? Or would the new service end up poaching existing healthcare personnel from competitors?
- If new RH services or products are offered, do these complement or substitute for existing RH care services?

The diagram in Appendix 1 summarises the considerations.

[2] It has been widely documented that competition can increase service quality

1.2 Comparative Advantage: Roles and Responsibilities [3]

The most common model in social franchising is for a non-profit organisation to act as franchisor, with for-profit entities (small clinics/pharmacies/outlets) as franchisees.[4] India has been an exception, when it comes to social marketing; the government has been involved in managing social marketing programmes for many years, and it may continue this kind of involvement in franchising as well.

The Table below sets out the most typical roles and responsibilities between a franchisor and franchisee. Some of the line items may be more/less applicable, depending on what types of products or services are included in the franchise programme in India. The relevant question here is: which party, whether government, NGO or commercial sector, is the most capable party to fulfil each role/responsibility in the franchisor and franchisee relationship?

Responsibility	Franchisor	Franchisee
Liaison with International donors and NGOs	+++	
Support of central fundraising (engaging with international donors/NGOs as necessary)		+++
Provision of information on store finances, governance structure and policies, community impact		+++
Provision of feedback/advice on the above	+++	
Provision of innovative ideas for programme improvement	++	+++
Defining the overall concept of the programme, the goals, principles and minimum requirements	+++	
Franchise business model development	+++	+
Initial definition and structuring of contract rights and responsibilities	+++	+
Ongoing contract rights and responsibilities	+++	+++
Decision making ability with regard to changes in contract rights and responsibilities	++	++
Selection and training	+++	+ (Decision making ability on proximity of new sites)
Central marketing: brand positioning, contracting with advertisers	+++	
Acquisition of necessary 'hardware' (signage, etc.)	+++	
Marketing research to identify new products to add to portfolio	++	++
Central procurement of products	+++	
Local marketing		+++
Brand name/logo development	+++	

[3] Adapted from 'Social franchising: a Worthwhile Alternative for Development Co-operation, Report Workshop on Social franchising held by the German Foundation for World Population (DSW) facilitated by the Wellcome Trust.

[4] On page 67 of Phil Harvey's book, 'Let Every Child Be Wanted: How Social marketing is Revolutionising contraceptive use around the world' 1999. Westport, Conn.: Auburn House, it notes that India and Jamaica are the only two governments that have actively managed social marketing programmes, and 'India was moving quickly to privatise the whole process in the mid-1990s'. (This book was written several years ago, probably before the government of Vietnam became an active manager of its own social marketing programme, so we should now say that three governments have been active in managing their own programmes. The government of Vietnam, however, has not been successful, whereas Phil Harvey notes that Jamaica and India have been somewhat successful.)

The table above can also be used as an initial framework from which to approach a participative exercise between franchisees and franchisors. Clarifying roles and responsibilities initially can help to build trust, set limitations, policies and expectations.

PART 2: IMPLEMENTATION

1. FACTORS TO CONSIDER IN SELECTING AND MANAGING NEW FRANCHISEES

1.1 Using a Pre-Existing Network

One of the first issues to resolve is: where can the franchisor find a supply of medical/health personnel with the appropriate qualifications and specialisations? Depending the specifics of the product or services being franchised, the franchisor may consider tapping into existing professional networks or mission networks. For example, a social franchising operation in Kenya, set up to increase access to essential drugs, utilised an existing church network as a mechanism for advertising to, screening and selecting franchisees. [5]

1.2 Site Selection

A well-positioned site is a key success factor of both commercial and social franchise operations. Commercial franchisors have sophisticated methods for considering the number and placing of stores relative to demand and competition. Social franchisors, on the other hand, are typically not as sophisticated, often relying on more on supply-side motivations (desire to rapidly expand services to target populations) at the expense of considering demand variables and competition. The appropriate research parameters are outlined in Appendix 2, business planning.

1.3 Franchisee Selection

The franchisor can screen potential franchisees according to the following criteria:

- Number of years in the business
- Required qualifications
- Affiliations with a certain group (e.g. church networks)
- Interview and observe candidates during training;
- Quality of business plan
- Requirement for up-front financial investment or willingness to pay for training (screens for motivation)

1.4 Business Plan

In some cases, especially in full franchise operations where the franchisor provides micro-financing, franchisee candidates should be required to submit a business plan. One benefit to this is that potential franchisees are screened for motivation and for calibre. Details of what should be included in the Business Plan are shown in Appendix 2. A business plan would probably not be feasible in fractional franchises; however, there are other ways to screen for motivation and calibre. Once the franchise reputation has developed, it may be possible to charge a fee for training, for example.

[5] See http://www.cfwshops.org/ and Grace, C. April 2001, *Social Franchising: A New Business Model for Increasing Access to Essential Drugs in Developing Countries.* Evaluation report for CFW Foundation (for Oxford Policy Management) 100 pages..

1.5 Franchise Products or Services or Both?

A very common model in health service franchising is for the franchise to include both products and services. If the franchise only involves products and not services, the following considerations would apply:

- There are different minimum efficient scales for 'services only' clinics versus services/product clinics. One of the lessons learned from other countries is that there's a trade off between the degree to which less populated areas can be served, and the degree of financial self-sufficiency (because, usually the population catchment size decreases as one serves less populated areas.) One way of potentially being able to serve less populated areas is by offering a wider range of products and services; this way sales can be increased potentially to a level to cover overheads.[6]
- The inclusion of a product also gives the franchisor greater potential to control the operation. Quality can be controlled through restricting the products that the franchisee is allowed to offer to solely those quality-assured products the franchisor provides, for example. The franchisor would also have a good record of sales, if there were this sort of prime vendor agreement.
- Branding is sometimes easier if products are included
- It is also easier to convince franchisees to enter the network if one of the benefits is access to subsidised or proprietary products.[7] Otherwise, it is rather difficult to incentivise franchisees to join the network in the beginning, since the brand will not yet be built. Perhaps training and networking would be seen as potential benefits, but it is unlikely that these would be powerful motivators (for joining the network) relative to things that the franchisee can immediately recognise as benefits that will improve the competitiveness of his business (i.e. access to subsidized products or to a recognised brand name).

1.6 Monitoring Ease

It is assumed that the benefits of franchising, namely the increased incentives at the service delivery/consumer interface level, outweigh the costs of implementing such a system. These costs include measuring and monitoring performance and negotiating and monitoring contracts. The assumption is that the beneficial performance achieved from stronger incentive structures offsets the heightened transaction costs organisations undergo in the process of entering and maintaining a franchise contract.

The factors that affect the degree of transaction/monitoring cost primarily relate to the degree to which the performance sought can be specified and measured, which is a function of:

- The degree to which performance can be measured quantitatively
- The ease with which quality can be measured
- Information gaps[8] between those doing the measuring/monitoring and those being measured
- Geographic proximity between those doing the measuring/monitoring and those being measured
- Size and number of units to be measured/monitored relative to number of those doing the measuring/monitoring

[6] Another way of being able to serve less populated areas is via mobile franchise vans which offer health related products and services; the mobility of the van essentially changes the catchment areas, and therefore the economics of the franchisee, making this model more tenable for serving less populated areas on an intermittent basis.

[7] See Grace, C., *Contraceptive Social Marketing in Pakistan: Negotiations with Pharmaceutical Supplier* (for John Snow International), February 2000, for an example of how this works.

[8] Information asymmetries, for example, when the one doing the monitoring has less information than the individuals/groups being monitored, often resulting in a failure of the monitoring system

- The degree of similarity between franchisees in the business format/service delivery model: Standardisation is a crucial franchising principle; it is important not only because it reduces monitoring costs but also because brand consistency and clarity strengthens the brand in the consumers mind.
- The frequency of the activities being measured.

Information technology is often used as a transaction cost reducing device in commercial franchising. The use of sophisticated IT systems is likely to be beyond the realm of the programme being considered here but the development of standardised paper based systems will be an important monitoring cost reducing devise in this context.

The above list of consideration should be revisited as the franchisor expands and develops the business model. There will inevitably be policy pressure on a social franchisor to progressively add additional products and services and target less densely populated areas.[9] The franchisor will need to maintain a balance between these policy pressures and the ability to manage products/services/geographic locations which are more monitoring intensive.

2. INCENTIVES THE FRANCHISOR CAN OFFER TO ENCOURAGE FRANCHISEES TO ENTER AND STAY IN THE NETWORK

What the franchisee wants from membership in this network is an ability to increase the competitiveness of his outlet to attract more business. The franchisor can help the franchisee to do this through offering one or a combination of the following:

2.1 Access to Products

These may include subsidised or unsubsidised medicines and contraceptives, products that only franchise members can purchase (proprietary), the latter including franchise 'own-brands'. See Appendix 5 for a discussion of how leakage of subsidised public products can reduce sales of the social marketing and social franchising operations, and consequently, reduce the value of participation in the network.

2.2 Access To Proprietary Know-How

Franchisees are typically offered training programmes, follow-up and on-site support. Many providers place a high value on opportunities for post-medical education and access to new medical techniques. See Appendix 3 for an evidence of this in Pakistan with Green Star.

2.3 Access To The Brand Name

The franchisor is usually responsible for national advertising of the brand and/or the commodity while the franchisee is responsible for local advertising. If the MoH/GoI begins a franchise programme from scratch, it is unlikely that brand name association will be sufficient to attract new enrollees. A large network of affiliate members is a form of advertising in itself. Attempting to build the brand through advertising, before the service is offered, risks creating frustrated consumers. Yet, until demand exists it will be difficult to get the interest of potential franchisees.

[9] For an example of such policy pressure, see Crapper, D., Grace, C., Handyside, A., Hussain, S. *Output to Purpose Review of Two DFID funded Social Marketing Programmes in Pakistan: Pakistan Private Sector Population Project (KSM) and Social Marketing of Contraceptives (SMP/PSI)* (for John Snow International), Feb/Mar 2002.

In the commercial sector, one way firms get around this 'catch 22' is by building the brand through company-owned outlets, before starting to franchise. In social franchising, it is common to reward early members of a franchise with greater benefits, such as low interest loans, franchise fee remissions or subsidized access to signage and store renovation.[10] However, it is wise to alert members from the start that these perks are only temporary.

Once the brand has been built, the franchisee may gain benefits from the brand name affiliation spilling over to other aspects of his business that do not fall under the brand umbrella. In an undifferentiated market for healthcare, an affiliation with a well-respected brand may make an important difference in a provider's reputation, even if the brand is for only a portion of medical care offered, or fractional franchise. (Leonard 2000)

2.4 Access To Capital

The franchisor may subsidise loans or may simply provide access to loans for those persons whose business is too small or whose business is perceived as being too risky for consideration by a commercial lender. 'Access to capital' may also include access to subsidised equipment or access to products at subsidised prices. If the franchisor is the provider of credit, there are issues around determining the interest rate and what amount (as percentage of sales) the franchisee should be required to pay on a monthly basis.

2.5 Other

Non-pecuniary benefits are valued by franchisees, including prestige in being associated with a particular network, a sense of community, and access to a professional network. Other benefits may include inter-franchise referrals and referral fees.

2.6 Considerations

In order to attract franchisees to enter and stay in the programme, the benefits/incentives offered by the franchisor must be commensurate with the restrictions/costs imposed on the franchisee to be in the network. In order to bring about social benefits, the incentives offered must also not cause distortions. For example, if services are provided with large subsidies, then drawbacks include high costs of running the programme (and risk that the programme lacks sustainability), potential for corruption and undercutting of existing private providers. The issue of subsidies is discussed in more detail below.

3. REGULATION AND SOCIAL LICENSING

The previous section discussed incentives that the franchisor can offer the franchisee. An alternative to offering incentives is the 'stick' of regulation. Correspondingly, an alternative to social franchising is social licensing, where regulation is used as the devise to increase consumer access to quality services. In social licensing, government acts as regulator rather than as franchisor and grants access to its quality stamp or symbol to those organisations that meet the standards. The next section of the report is relevant to both social franchising (where the principal[11] in the contracting relationship is able to offer incentives as well as regulation) and social licensing (where the principal is primarily a regulator).

[10] See Appendix 2: CFW programme in Kenya
[11] The franchisor, in this case

3.1 Regulatory Factors and Monitoring

In return for the advantages the franchisee obtains from being part of the network, the franchisee has a contractual obligation to abide by certain rules and standards. These may include any of the following:

- Meeting sales quotas;
- Maintaining service quality, including a high service orientation (counseling and health information) and compulsory good dispensing practice;
- Paying franchise fees;
- Adhering to a standardised retail outlet design and colour and a uniform system of display and retail management;
- Offering a standard range or price of services and goods;
- Providing transparency to the patient: services/products with price lists clearly displayed;
- Gathering public health statistics to provide to the franchisor;
- Participating in health information and promotion campaigns;
- Abiding by standardised stock management, sales reporting, and patient monitoring systems.

3.2 Quality Monitoring

It is important for the franchisor to monitor service quality since it is difficult for patients to accurately assess the quality of the healthcare received. The Planned Parenthood Federation of America conducts extensive evaluations and re-certifications of its local affiliates every four years in order to assure that their service quality, pricing and financial management fits with the Planned Parenthood brand.

The nature of services offered in medical care makes standardisation difficult, quality evaluation imprecise and monitoring costly. Quasi-franchises like the Planned Parenthood affiliate programme choose to deal with this by monitoring and controlling only a fraction of the services offered by the affiliates – those services that are under the brand umbrella.

In health service franchising, only those aspects of service quality that are observable and verifiable are typically measured and monitored. Routine 'quality checklist' visits and periodic mystery client surveys are often the verifying mechanism. Items verified might include:

- Record keeping
- Compliance with standardised procedures, such as:
    - Sterilisation of equipment, cleanliness of consulting and operating rooms, and proper disposal of single-use needles;
    - Availability of medicines and other materials;
    - Knowledge of potential side effects associated with the franchised services/products and compliance with treatment protocols.

Quality control of service provision typically will not extend beyond this limited range of standardised procedures. The more advanced the service is, the more difficult is quality monitoring and standardisation, and the more difficult it is to offer it as part of a franchised system. So for example, a reproductive health service that involves counselling, checking for higher blood pressure and for proteinuria (oral contraceptives) is an 'easier' service to standardise (and thus have as part of a franchise services) than IUD insertion. Similarly, IUD insertion is an 'easier' service to have as part of a franchise network relative to cardiac or neurological services, which carry a higher degree of uncertainty in diagnosis and specialisation in care.

4. SUSTAINABILITY OPTIONS AND ISSUES

Financial sustainability is a function of the target population served and the corresponding positioning of the franchise brand in the market. It is unlikely that services targeted at the poor and/or rural populations will ever be financially sustainable through franchising or any other market-based programme. The variables of concern are market size, potential demand for the service and structure of the private medical sector, but generally speaking, urban programmes have greater potential to become financially sustainable over time.

4.1 Subsidy Options and Issues

Two types of subsidies are considered here: subsidies to individual franchisees who are meeting public health goals, but not commercially viable, and subsidies to finance the overhead costs and administration of the franchise system.

4.1.1 Subsidising Franchisees

There are drawbacks to instituting a subsidisation policy, especially at programme initiation:

- If subsidies are available, it may affect the franchisee's incentive to report accurately and may divert attention to 'how to work the system' rather than how to increase the unit's sales. This would make it difficult to know at the outset which shops are truly viable;
- Subsidising franchisees also introduces the need for micro-adaptation and this is almost always avoided in franchising, as it raises administration and monitoring costs. The goal should be to try and make the model as standard as possible so that administrative burdens are eased and ability to compare is enhanced.

However, since this report is concerned with the use of franchising to meet public health needs, subsidising may be appropriate. The following options exist:

- Subsidising training costs of the franchisees;
- Offering a grant on the loan (if micro-credit is part of the scheme);
- Subsidising the interest rate on loan;
- Subsidising the rent for remote facilities;
- Subsidising overheads/administration;
- Giving discounts on the wholesale price, (if products are involved in the relationship) or subsidising the franchise fee[12].

4.2 Raising Revenues From Franchisees To Cover Central Overheads: Options

If the MoH desires a more sustainable approach, eventually weaning itself away from government and/or donor funding, the diagram in Appendix 4 summarises the options available.

5. SUMMARY OF IMPLEMENTATION STEPS

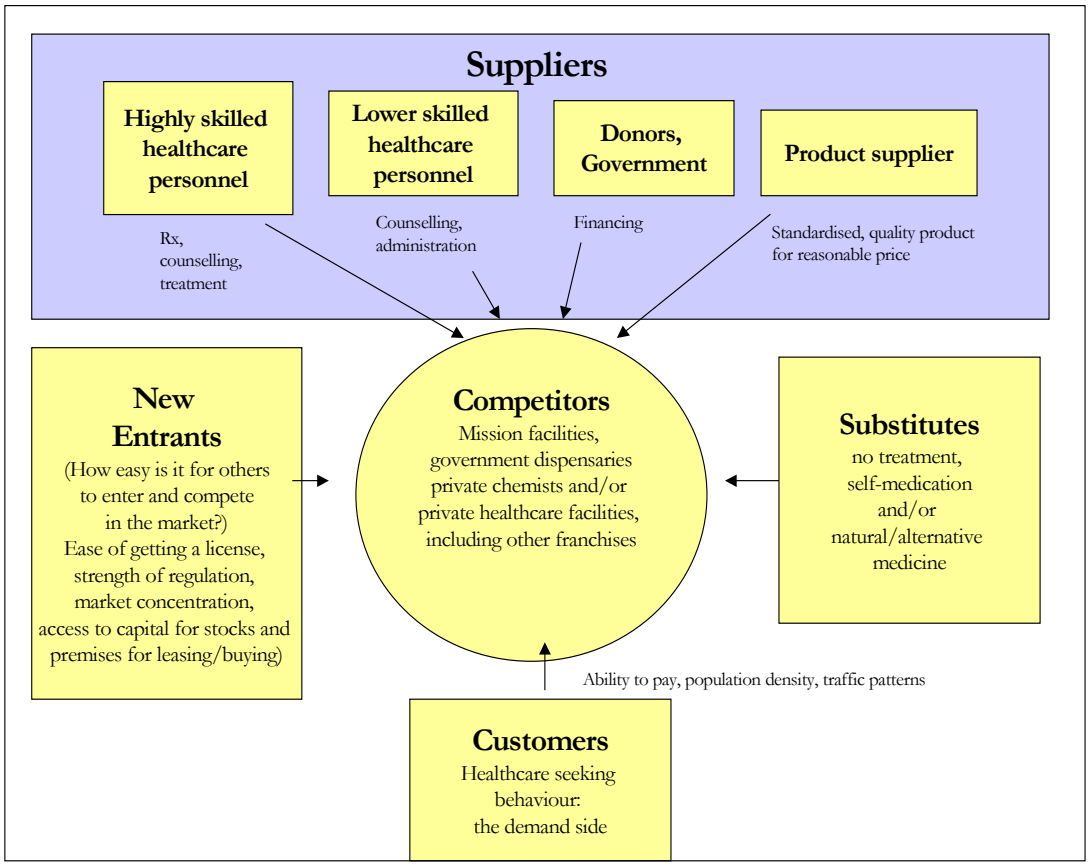
The following steps should be undertaken by the franchisor:

1) Market structure analysis
2) Comparative advantage analysis
3) Decision: Will the programme use social franchising for *products* and/or *services*, *reproductive health* related or *general* healthcare products/services? Will it expand upon existing initiatives (e.g. Janani) or will it develop an entirely new system?
4) Decide what incentives to offer

[12] This would be appropriate to early joiners in the network anyway, for pure commercial reasons, as mentioned earlier

5) Decide what factors to regulate/monitor in return for those incentives
6) Decide eligibility and screening criteria for applicants. Does the franchiser want to tap into existing networks, and if so, which ones?
7) Develop initial and on-going training programmes, justified by the numbers
8) Decide initial and likely evolution that logistics support will take (distribution and monitoring/inspection). This will be justified by the size of the network.
9) Organise interface with health system, including local health authorities and referral systems
10) As relevant, decide how the franchiser will handle centralised procurement; IT (or paper-based systems); national communication/advertising and brand building; packaging.
11) Work out the economics: how many franchisee units needed to cover overheads; minimum efficient scale of a franchisee unit, amount of donor or public funding needed over what projected time period
12) Recognise and develop strategies for common problems that occur in franchises: develop tactics to resolve likely conflicts that will occur, to promote innovation and to manage change as the network grows.

APPENDIX 1: CONSIDERATIONS FOR ANALYSING MARKET STRUCTURE FOR SOCIAL FRANCHISING



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APPENDIX 2: BUSINESS PLAN FOR FRANCHISEES

The factors listed below are those that should ideally be covered in the business plan. The franchisor will need to consider, given specific circumstances and target audience of franchisees, how capable the group is to answer all the questions. It would be appropriate for the franchisor to offer technical assistance (via workshops, for example) to the franchisees in answering these questions. Much of this information should be available from the DHS.

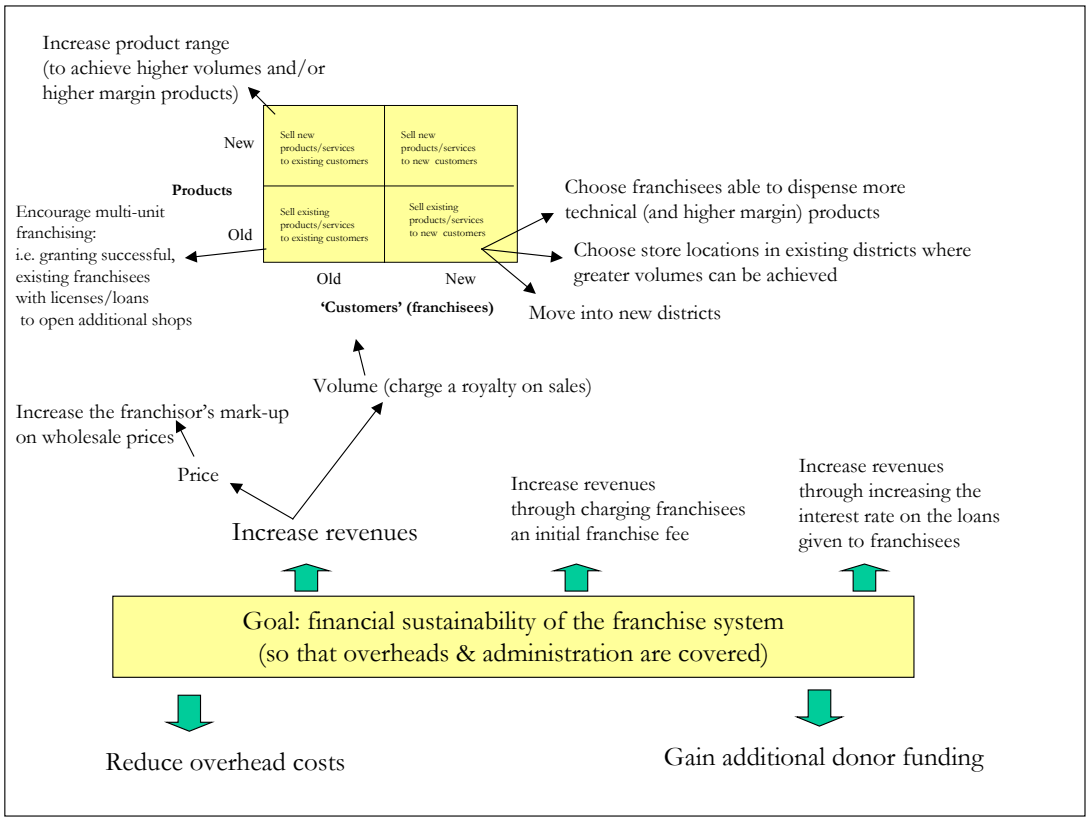
- Factors affecting demand:
  - What is the catchment area, or the geographic region the franchisee intends to serve
  - What volumes of patients are envisioned per day/month (justified by population size, numbers seen by competitors, traffic patterns (near a market, etc)
  - Monthly income of population, main source of income, factors influencing regularity of income (specific economic conditions? weather conditions?) Health expenditures as percentage of monthly expenditure
  - Statistics on RH (or other) diseases, or age composition of population (which affects demand for RH care)
  - Mean distances travelled to the usual provider of care
- Prices the franchisee intends to charge for different services, justified by income per population (above) and competitors prices
- Competitive survey: Who are the other health care providers in the area[13], what services do they offer, at what prices? What is the franchisee's strategy for competing (or complementing) those other providers? How will he/she offer a better or new product or service, or lower prices, thereby attracting customers? What does the DHS say about provider preference and reasons for the preference?
- Costs of setting up and running the operation, for example, building lease/purchase, security, staff costs, stock levels (working capital), other.
- How much capital the owners have available and how much is needed to start/run the operation. How the franchisee plans to get access to additional capital (if needed)
- If operation needs to take loan, what percentage payback can the operation afford each month, given the assumptions outlined above? What is the 'pay-back' period, when the entire loan has been paid back? (See more on this subject below, in the 'Incentives the franchisor can offer' section)
- Ideally, the business plan should include a calculation of the break-even volume of patients at assumed prices to cover costs and allow the operation to reach its profit goal

[13] Catchment 'area' will need to be defined differently in each province, but within a days travel might do as a standard benchmark

APPENDIX 3: GREEN STAR CLINICS IN PAKISTAN

The Green Star network in Pakistan franchises a range of family planning services through its network of 6,000 private doctors. The doctors receive subsidised supplies, signage and benefit from advertising for both the clinic network and the socially marketed contraceptives, which have an affiliated brand. However, the providers perceive one of the most important benefits of membership to be the start up training and monthly visits from Green Star doctors. Franchisees use these visits to discuss difficult cases, learn about advances in clinical practices in reproductive health, and have one-on-one training in aspects where the provider feels weak. Most Green Star members make little profit from family planning services but find the side-benefits are very attractive. (Agha et al. 1997)

APPENDIX 4: OPTIONS FOR RAISING REVENUES FROM FRANCHISEES



APPENDIX 5: THE IMPORTANCE OF MARKET SEPARATION

In many countries, public sector health commodities end up in the commercial market, effectively via government workers selling the product to supplement their incomes. This can result in the following distortions i) a decrease in supply available in public sector facilities, ii) crowding out of the commercial sector, who might otherwise supply that market, and iii) reducing sales of the social marketing and social franchising operations, and consequently, reducing the value of participation in the network to providers. It is consequently very important to segment the markets between those for which public, subsidised supply is intended and those who have higher purchasing power and access to commercial or NGO supply (the latter sometimes also being subsidised, but to a lesser extent). Devising market segmentation mechanisms has proven to be an effective method of decreasing parallel trade of pharmaceuticals from poor to rich nations. Equally, it has been used effectively within countries to decrease product leakage from poor to rich users.[14]

The higher the resemblance[15] of the government's product to SM and commercial brands, the higher the temptation for government workers to sell it into the private sector, where it has commercial value. This would most likely result in product being diverted to areas where the population is wealthier, and in the process displacing SM and commercial sources. Health workers and primarily, middlemen would be the winners in this case, as it is these people who make the profit when the product is marked up from a minimal price to a commercial price. Creating profit for middlemen who divert product to wealthier customers would not be an efficient use of public funds.

By differentiating government product through the product itself, the packaging, the languages and markings used on the packaging, and advertising messages, consumers can then enter into pharmacies and distinguish for themselves the difference between government and SM/commercial brands. This should result in a decreasing willingness, on the part of the wealthier, to pay commercial prices for government product, and this, in turn should decrease incentives for government product to be sold into commercial channels.

Market segmentation may involve a social marketing campaign to differentiate government supply. Challenges in creating such a campaign include i) the necessity of educating consumers about the differences between government and SM/commercial brands, while still maintaining the product's attractiveness to poorer customers, and ii) the relatively more difficult job of implementing a differentiation campaign in situation where the government and non-government supplies closely resemble each other in terms of product type, packaging, etc.

Improving the government's supply chain management is another difficult, but important means of ensuring that government supply reaches its intended beneficiaries. Supply chain improvement can be accomplished either through improving government systems or by privatising the function. It should be noted that, in the environment of increasing talk, and implementation, of tiered pricing systems for essential drugs, the integrity of government supply systems[16] is one pre-condition given by pharmaceutical suppliers for offering significantly reduced prices for drugs to treat HIV/AIDS and TB.[17]

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[14] Maskus, Keith. April 2001. *Parallel Imports in Pharmaceuticals: Implications for Competition and Prices in Developing Countries.* Final report to World Intellectual Property Organization.

[15] In terms of product type, packaging, branding, and languages used on the packaging

[16] or indeed, of alternative, NGO supply systems

[17] Patent holders want to ensure that lower income country drug supply systems do not allow leakage of the differentially priced drugs, intended for lower income country markets, i) back to rich country markets, where the products are priced substantially higher and ii) into the commercial sector within the lower income country, where the patent holders often skim the market for the wealthier customers

APPENDIX 6: REFERENCES

Agha S., Squire C., Ahmed R., 1997. *Evaluation of the Green Star Pilot Project*. Population Services International. Washington D.C.

Crapper, D., Grace, C., Handyside, A., Hussain, S. *Output to Purpose Review of Two DFID funded Social Marketing Programmes in Pakistan: Pakistan Private Sector Population Project (KSM) and Social Marketing of Contraceptives (SMP/PSI)* (for John Snow International), Feb/Mar 2002.

Grace, C., *Social Franchising: A New Business Model for Increasing Access to Essential Drugs in Developing Countries*. Evaluation report for CFW Foundation (for Oxford Policy Management), April 2001, 100 pages.

Grace, C., *Contraceptive Social Marketing in Pakistan: Negotiations with Pharmaceutical Supplier* (for John Snow International), February 2000.

Leonard D., 2000. Africa's *Changing Markets for Health and Veterinary Services: The New Institutional Issues*. Palgrave.

Maskus, Keith. April 2001. *Parallel Imports in Pharmaceuticals: Implications for Competition and Prices in Developing Countries*. Final report to World Intellectual Property Organization.

Preker, A., Harding, A., Travis, P., 2000. *'Make or Buy' decisions in the production of health care goods and services: new insights from institutional economics and organisational theory*. Bulletin of the World Health Organisation, 2000, 78 (6)

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