



Social franchises: The bridge between private healthcare providers and national health insurance programs

Lessons learned from two initiatives in the Philippines

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Contents

Key terms and concepts | 1

Social franchising of health services and commodities | 1
Social health insurance | 1

Acronyms | 2

Background | 3

Significance of the case study | 4

Methods | 5

Sample | 5
Sampling methods | 5
Data collection | 5
Ethical considerations | 5

Context: Health and spending in the Philippines | 6

Health status | 6
The private healthcare sector | 7
Healthcare expenditures and financing | 7
National health insurance program | 7
Maternity and newborn care packages | 8

Introduction to Well-Family Midwife Clinics and Bluestar Pilipinas | 9

Well-Family Midwife Clinics | 9
BlueStar Pilipinas | 10

Findings | 13

Strategies used to build and support links with the NHIP | 13
Understanding the value proposition: To the franchisee and the franchisor | 16

Lessons learned | 19

Conclusion | 23

References | 24

Appendix: PhilHealth accreditation | 26

Initial accreditation or reaccreditation | 26

Renewal of accreditation | 26
Service capabilities | 27
Technical standards | 27

Key terms and concepts

Social franchising of health services and commodities

Commercial franchising has been used effectively to sell standardized and predictable commodities and services at a large scale. Clinical social franchising applies select commercial franchising principles to create networks of private healthcare providers and vendors that are similarly accountable for the provision of quality-checked and standardized clinical and non-clinical health services and commodities that are important for population health.

This approach may be used to standardize the quality and range of health services offered by the private health sector, to increase the number of points of service-delivery for a particular set of health services, or otherwise address issues that are challenging to meet by the public health system alone.

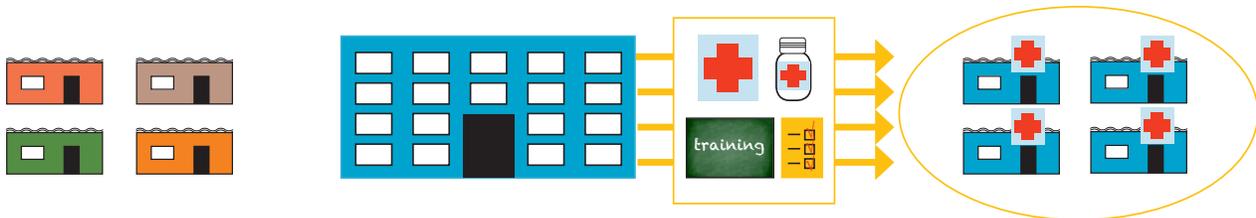
The graphic below offers a conceptual snapshot of how a social franchise program is typically organized.

In this model, a third party ‘franchisor’ catalyzes the growth of a network of franchisees by offering members a range of financial and social incentives to join. These incentives may include the creation of a brand identity, mass marketing campaigns for that brand or on behalf of members, access to medical commodities at cost or below market rates, and technical and business management trainings. In return, a member agrees to comply with standards set by the franchise program, to report on performance across certain parameters, and to pay fees to maintain membership.

Social health insurance

Social health insurance pools high- and low-risk people and allows enrollees to contribute based on their ability to pay.¹ Social health insurance is characterized by compulsory membership, a set of eligibility requirements that is usually based on timely premium payments, and a social compact between enrollees and the insurance program.¹ Social health insurance programs around the world have been associated with lower out-of-pocket payments and lower financial burden on consumers of health services.^{2,3}

The Clinical Social Franchise Model



Private sector healthcare providers may offer a range of health services, with little or no quality oversight from an independent body.

The Franchisor (an independent agency or program) recruits private sector health providers, and offers them:

- a shared brand identity, and marketing support
- access to subsidized branded health commodities
- trainings in better clinical and business management practices
- stipulated standards in relation to the franchised commodities and services, and quality oversight

As **Franchisees**, private sector healthcare providers now offer franchised health services and commodities that are linked to protocols and standards.

Acronyms

BSP	BlueStar Pilipinas	OOP	Out-of-pocket payment
DALY	Disability-adjusted life year	PHP	Philippine peso
DOH	Philippine Department of Health	PSPI	Population Services Pilipinas, Incorporated
FTM	Field team member	RSH	Reproductive and sexual health
FP	Family planning	SHI	Social health insurance
HIV/AIDS	Human immunodeficiency virus/acquired immunodeficiency syndrome	SMS	Short messaging system
IUD	Intrauterine device	STI	Sexually transmitted infection
JSI	John Snow, Inc.	TANGO	Technical Assistance for the Conduct of Integrated Family Planning and Maternal Health Activities by Philippine Nongovernmental Organizations
MNCH	Maternal, newborn, and child health	TB-DOTS	Tuberculosis directly observed therapy, short course
MCP	Maternity Care Package	UCSF	University of California, San Francisco
MDG	Millennium Development Goals	USAID	United States Agency for International Development
MMR	Maternal mortality ratio	USD	US dollar
MSI	Marie Stopes International	WFMC	Well-Family Midwife Clinic
NCP	Newborn Care Package		
NDHS	National demographic and health survey		
NGO	Nongovernmental organization		
NHIP	National Health Insurance Program		

Background

The private health sector—which includes non-governmental and faith-based organizations, for-profit companies, and formal and informal private providers—is a major source of healthcare in low- and middle-income countries.⁴⁻⁷ Improving population health without including the private health sector in a system-wide response has become an untenable option in many countries. However, major challenges in engaging the private health sector persist. Many private health sector providers operate outside of networks, and are not subject to oversight or regulation once they are initially certified and licensed. Quality of care is also highly variable.

In the 1990s, the first few clinical social franchising programs were created in south and southeast Asia. These programs, led by franchisor agencies, brought thousands of health professionals into the newly created franchise networks, with a specific focus on improving the quality and range of family planning (FP) services offered. There are now over 80 programs operating in 43 countries, and their missions and operating models vary significantly. However, they tend to offer similar sets of ‘value propositions’ to health professionals to participate in their networks, including (1) the potential for greater client volume, (2) the potential for greater revenue, (3) access to networking and knowledge-exchange opportunities with other health professionals, (4) access to commodities and equipment at below-market rates, and (5) the potential to deliver better quality healthcare.

This case study focuses on programs in the Philippines, a country that has been home to social franchising programs for nearly 20 years. Two programs, Well-Family Midwife Clinics (WFMC) and BlueStar Pilipinas (BSP), have built networks of private midwives that provide FP and maternal, newborn, and child health (MNCH) services. These programs have stimulated and leveraged developments in national health insurance policies in the Philippines in order to ensure their networks and clients could benefit from them.

This case study documents the approaches that WFMC and BSP undertook to link their networks to the National Health Insurance Program (NHIP). We also investigate if and how the franchisor agencies were able to benefit from the linkages, and if this has implications for their sustainability plans.

The two franchise programs that participated in this case study—**Well-Family Midwife Clinics** and **BlueStar Pilipinas**—are also the subjects of other case studies.

- Beyeler, N., Briegleb, C., Sieverding, M. (2014). *Financial sustainability in social franchising: promising approaches and emerging questions*. San Francisco: Global Health Group, Global Health Sciences, University of California, San Francisco.
- SHOPS Project. (2014). *Private Midwife Provision of IUDs: Lessons from the Philippines. Brief*. Bethesda, MD: Strengthening Health Outcomes through the Private Sector Project, Abt Associates Inc.
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Significance of the case study

Social franchise programs strive to achieve multiple goals that may be at odds with each other:

- Public health goals: equity, quality, expansion of the market to new users, cost-effectiveness, and health impact
- Business goals: financial sustainability of the franchisees and franchisor

A program that strives to meet the health needs of the poorest in the most geographically isolated regions may suffer in terms of its ability to generate revenue for the franchisor or franchisee, or may appear less cost-effective.

Benefits of linking a franchise program to a social health insurance program

Franchisor	Franchisee/ clinic	Client
<p>May serve as a recruitment incentive for franchisees</p> <p>May support achievement of public health goals such as equity, improvement of health services, and health improvement at a population-level</p>	<p>May increase client-load</p> <p>May increase revenue</p>	<p>May reduce out-of-pocket spending</p> <p>May increase access to government subsidized health services</p>

Trade-offs may however become less necessary where financing for the provision of franchised health services is available from social health insurance programs. Social health insurance is posited to reduce cost burden on clients,^{2,3} raise the quality of care through associated accreditation and claims reimbursement requirements,⁸ and may contribute to greater revenue for franchisees.⁹ Franchise programs that can promise support for accreditation and claims processing to private midwives may also be able to use this service as an important hook to recruit or retain members within a franchise network.

The two franchise programs that participated in this study—WFMC and BSP—have offered substantial support to midwives to enable them to become eligible for participation in the NHIP, and to draw revenue from it on an ongoing basis.

There is, however, little evidence to show that franchisors have been able to leverage this costly form of support, or social health insurance financing generally, toward improving prospects for financial sustainability of the franchise program itself. This report can therefore provide important input for programs, donors and social investors that are seeking to learn from the Philippines experience.

Methods

Sample

Twenty-nine semi-structured interviews were conducted among 16 franchisees, seven franchise program administrators, three representatives of the NHIP and the Philippine Department of Health (DOH), and three topic experts that were unaffiliated with the social franchise programs or the NHIP and DOH.

Sampling methods

Interview respondents included key informants, the management and administrative personnel of the two franchise programs, and accredited franchisees operating in the National Capital Region and Western Visayas. Key informants were selected because they had expert knowledge regarding the social health insurance program, or the two social franchise programs being studied.

Franchisees were selected and referred to the researchers by the managers of the social franchise programs. Only franchisees that are accredited by the national health insurance program were included.

Data collection

Data was gathered from a review of peer-reviewed literature; published and unpublished case studies; e-mail correspondence with the managers of the WFMC and BSP

programs; and semi-structured interviews with franchisees in two regions, key informants, and topical experts.

Interviews were conducted in-person, lasted approximately 42 minutes (range 21–84 minutes), on average, and were held in the offices of the respondents. Eleven interviews were conducted by the researchers in English, ten in Tagalog, and eight in a mixture of both languages and Hiligaynon. The English and Tagalog interviews were conducted by the researchers; the Hiligaynon interviews were conducted by a paid interpreter.

Post-interview clarifications were sought via email correspondence. Key findings from the interviews were also confirmed using official documents or forms, studies, and reports published on the internet for public use or provided by respondents.

Ethical considerations

Ethical approval was obtained from the UCSF Committee on Human Research and the University of the Philippines, Manila Review Ethics Board. Letters of approval were obtained from the administrators of both social franchise programs.

All respondents were informed of their right to refuse participation in the study, and only respondents that agreed to sign the consent forms were included in the study.

Context: Health and spending in the Philippines

The Philippines is a lower middle-income country located in Southeast Asia. It has a population of over 96 million, with an annual population growth rate of 1.7%. In the last few years, the Philippines reported high economic growth rates. In 2013, the gross domestic product (GDP) growth rate was at 7.2%.¹⁰ Poverty, however, continues to affect Filipinos in both urban and rural areas. In 2012, over a quarter of the population, or 19.7% of all Filipino families lived in poverty with an estimated monthly income of less than 7,980 PHP (179 USD) for a family of five.¹¹ Over 9.8 million of all Filipinos are living in extreme poverty.

Select population and economic development statistics, 2012

Population	96,710,000
Annual population growth rate (%)	1.7
Adult literacy rate (%)	95.4
Percent urban population (%)	52.5
Percent of population living in poverty (%)	25.2
Percent of families living in poverty (%)	19.7
Gross domestic product per capita (current USD)	2,587
Gross national income per capita, PPP (current USD)	2,500
Life expectancy at birth (years)	69

Source: The World Bank. 2014. World Development Indicators. Available from www.data.worldbank.org.

Health status

While the Philippines has witnessed significant improvements in public health, several challenges remain. There is an inequitable distribution of healthcare facilities throughout the country, and many of them are poorly equipped.^{12, 13} There is also a shortage of healthcare providers such as doctors, dentists, and occupational therapists.¹² Both the public and private sectors provide health services of variable quality, and many private facilities charge high out-of-pocket (OOP) payments, which may lead to impoverishment, particularly among the poor.^{14, 15}

While the country's maternal death rates have decreased since the 1990s, the Philippines is not expected to meet its targets for Millennium Development Goal (MDG) 5.

According to a 2009 survey by the Philippines DOH, the leading causes of maternal mortality are complications during labor, delivery, and the puerperal period, hypertension during early pregnancy and childbirth, and postpartum hemorrhage.¹⁷

The under-five mortality rate, which is defined as the probability of dying between birth and five years of age, is estimated at 31 deaths per 1,000 live births.¹⁶ If the annual rate of decline continues in 2015, the Philippines is expected to meet the MDG 4 target of 20 deaths per 1,000 births.¹⁸ Close to 50% of all under-five child mortality is due to neonatal deaths or deaths within the first 28 days of life.¹⁹

Select health statistics

Maternal mortality rate (per 100,000 births)	221	2011
Under five mortality rate (per 1,000 live births)	31	2013
Infant mortality rate (per 1,000 live births)	23	2013
Proportion of births attended by skilled health personnel (%)	74.9	2011
Proportion of pregnant women who receive at least four antenatal care visits (%)	84.3	2013
Unmet need for family planning (%)	19.3	2011
Contraceptive prevalence rate (%)	55.1	2013
Adolescent birth rate (per 1,000 women ages 15 to 19)	37.7	2013

Source: Philippine Statistics Authority - National Statistical Coordination Board. 2014. The Philippines Millennium Development Goals. Available from www.nscb.gov.ph.

One of the barriers to reducing maternal mortality is the low use of skilled attendants and facility-based delivery services among poorer women.^{20, 21} Studies have shown that wealthier women are more than 15 times as likely as poor women to give birth in a health facility or be attended by a skilled professional when giving birth.²² The preliminary results of the 2013 Philippine national demographic and health survey (NDHS) do however indicate progress—the percent of births taking place at health facilities has increased by approximately 16% between 2008 and 2013.²³

Preliminary results from the 2013 NDHS also suggest that antenatal care has improved in the Philippines. Over 80% of women receive the recommended four antenatal care visits before birth. In 2008, midwives provided 50% of all antenatal care—a share larger than that of doctors and nurses combined.¹⁹

The private healthcare sector

The healthcare system in the Philippines is characterized by a diverse private sector and a decentralized public sector that is used mostly by the poor in both urban and rural areas.²⁴

Private sector providers, which include doctors, nurses, midwives, dentists, pharmacists, and occupational and physical therapists, outnumber public providers. The Philippines government acknowledges that the private sector is a key player in the national health system, and they have engaged with private providers in delivering a number of public health services such as tuberculosis directly observed therapy, short course (TB-DOTS), FP, and MNCH services.¹² The private sector is also represented in a number of interagency committees and technical advisory groups at the DOH.

Healthcare expenditures and financing

In 2011, 4.4% of gross GDP—or 431 billion PHP (9.69 billion USD)—was spent on health.²⁵ Public spending on health is also increasing, primarily due to the expansion of the national health insurance program of the Philippines, popularly referred to as PhilHealth.

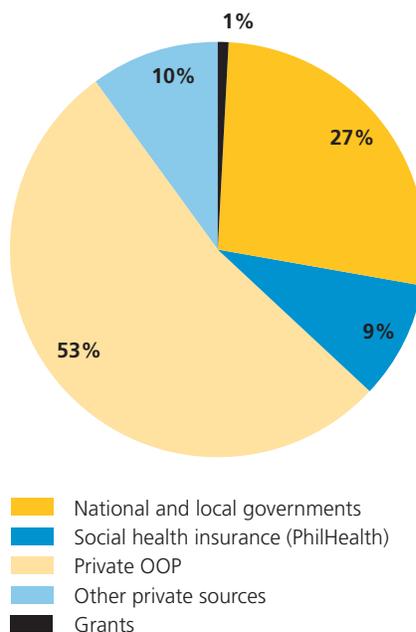
National health expenditures, 2011

Per capita health expenditures (in current PHP)	4,577 (103 USD)
Per capita health expenditure growth rate	11.3
Health expenditure as % of GDP	4.4
Health expenditure as % of GNI	3.3

Source: Philippine Statistics Authority - National Statistical Coordination Board. 2013. Philippine National Health Accounts. Available from www.nscb.gov.ph.

In 2011, close to two thirds of health expenditures came from private sources. The single largest source of health spending in the Philippines is private OOPs (53% or 227 billion PHP). In 2011, 9% of health spending or 39 billion PHP came from the NHIP.

Distribution of health expenditure by source, 2011



Source: Philippine Statistics Authority - National Statistical Coordination Board. 2013. Philippine National Health Accounts. Available from www.nscb.gov.ph.

National health insurance program

In the Philippines, the NHIP is managed by the Philippine Health Insurance Corporation, or PhilHealth. Aside from premium payments and employer-employee contributions, PhilHealth receives funds from general taxes such as the excise tax on cigarettes and alcohol products.²⁶

There are several types of PhilHealth coverage that Filipinos can avail. Private and government employers are required to enroll all of their employees into PhilHealth; self-employed and unemployed persons are encouraged to sign up. Free membership is offered to indigent persons, dependents of PhilHealth members (such as children and spouses), and other populations (such as overseas Filipino workers); however, studies have shown that PhilHealth faces some challenges in reaching the poorest in the country.²⁷

The Philippines government claims that 81 to 85% of Filipinos are covered by PhilHealth as of 2013, although independent studies show that coverage rates may be around 52%.^{27, 28} In June 2013, the president of the Philippines signed a law (Republic Act 10606) that mandated PhilHealth enrollment for all Filipinos, including workers in the informal sector.²⁹ The implementing rules and regulations of this law, however, have not been approved. This is considered a move from social health insurance towards universal healthcare coverage in the Philippines, which is one of the goals of the current national government.³⁰⁻³³

Maternity and newborn care packages

Since 2003, PhilHealth has bundled essential healthcare services into case-based packages.³⁴ These packages were developed in order to help the Philippines reach its MDG goals through increased access to and use of select healthcare services. MDG packages also represent PhilHealth's shift from a pay-for-service system to a case rate system where providers are paid a predetermined, risk-adjusted amount for a set of healthcare services needed to treat a specific disease or condition.^{15, 35, 36} Providers are not allowed to charge clients for additional costs associated with provision of the bundled services.³¹

The social franchise programs are currently making use of two MDG packages: the Maternity Care Package (MCP) and the Newborn Care Package (NCP). The MCP provides reimbursements for normal spontaneous births delivered in non-hospital facilities. A franchisee that provides all the prescribed maternal care services, including all four prenatal visits, will receive 8000 PHP (180 USD) per patient.³⁷ The NCP reimburses for the provision of essential newborn care and newborn screening services. Franchisees can receive as much as 1750 PHP (41 USD) for the provision of the full package.^{38, 39}

Maternity care package⁴⁰

- Four prenatal visits (includes essential drugs, laboratory tests and ancillary services, tetanus immunization, and professional fee for consultation)
- Professional fee (includes delivery, postpartum care, and counseling for reproductive health, breastfeeding, and newborn screening)
- Room and board
- Drugs and medicines
- Laboratory supplies and other ancillary services
- Use of labor, delivery, and recovery rooms
- Other medically necessary charges for delivery and postpartum care

Newborn care package^{39, 41, 42}

- Resuscitation for newborns with abnormal breathing (e.g., suctioning, administration of oxygen)⁴¹
- Newborn screening tests recommended by the DOH (e.g., metabolic conditions, hearing)
- First dose of Hepatitis B vaccine
- BCG vaccination
- Umbilical cord care
- Eye prophylaxis
- Administration of Vitamin K
- Thermal care

Introduction to Well-Family Midwife Clinics and Bluestar Pilipinas

Well-Family Midwife Clinics

WFMC is a clinical social franchise program that includes 132 WFMC franchisees in 20 provinces throughout the Philippines. All franchisees are private sector midwives, and all are authorized, under the WFMC brand, to provide at minimum the following services:

- Family planning: family planning counseling, contraceptives, and referrals for sterilizations
- Women’s reproductive health services: Pap smear, pelvic and breast examination, and pregnancy testing
- Maternal and child health care: ANC and well-baby check-ups, including immunizations, vitamin supplementation, nutrition and breastfeeding counseling, disease screening, and de-worming
- Other services: blood pressure screening, ear piercing, wound care, and sale of over-the-counter drugs, family planning commodities, and other supplies

Organizational structure

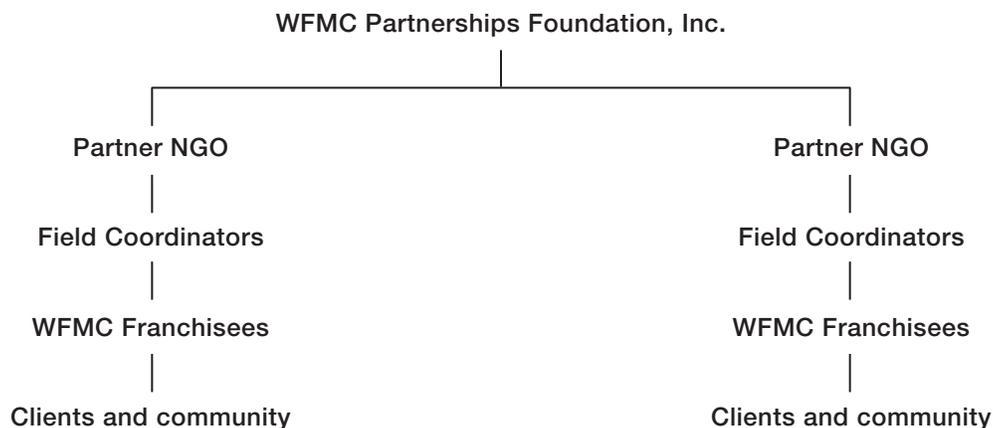
The program has a three-tiered organizational structure. The Well-Family Midwife Clinic Partnership Foundation, Inc. (WPFI) oversees the entire project, and is responsible for network-wide support activities, including monitoring and maintaining service quality, marketing and advertising,

facilitating access to credit, providing low cost supplies, and disseminating information to the WFMC network on various matters of interest. WPFI is also responsible for ensuring the financial viability of the franchise program through recruitment and expansion, and finding new sources of revenue.

There are 11 non-governmental organizations (NGOs) that are then directly responsible for a number of operational and technical support activities for franchisees located in their catchment areas. They are termed ‘local area franchisors.’ They are in charge of recruiting midwives, expanding their local networks, selecting clinic locations, overseeing quality, and monitoring franchisees for adherence to program standards. The NGOs are expected to implement WFMC policies, practices and procedures. They may also offer additional support to franchisees, including access to credit, support for accreditation and licensure under the national health insurance program and Department of Health respectively, and networking opportunities.

The NGOs have field coordinators that visit the franchisees regularly—particularly around the first few months of a clinic’s opening—and offer assistance in relation to clinical practices, business management, and marketing. The NGOs also secure the timely collection and submission of data from the franchisees to WPFI regarding the services that were provided and other key metrics.

WFMC Organizational Structure⁴³



Minimum requirements for franchisees

Midwives must possess a set of minimum qualifications, assets or access to assets, and entrepreneurial interest, in order to be considered for inclusion in the network. These qualifications are intended to maximize the profitability of the franchisee's business enterprise, and minimize the need for the franchisor to intervene financially.

Midwife selection criteria	Site selection considerations
Possession of a midwifery license	Population density in the catchment area
Interest in owning and running a business	Disposable household income
Has funds to rent or buy a clinic and to make needed renovations	Access to various means of transportation
Willingness to relocate in the geographic area of the NGO franchisor	Proximity to referral doctors and hospitals

Once in the network, midwives are also expected to meet minimum standards in order to remain in the network. Franchisees must be able to meet quality standards, pay franchise fees, and comply with reporting requirements. Chronically underperforming franchisees are removed by the NGO from the network.

Financial arrangements

When a midwife agrees to join WFMC, she signs a five-year contract and pays a franchise fee of 100,000 PHP (2,247 USD). Franchisees also pay a quarterly royalty fee of 30,000 PHP (674 USD). NGOs receive 90% of collected fees, and put this and other revenue toward covering operational expenses. WPFJ receives 10% of the fees, and also receives annual interest on a trust fund left by John Snow International, Inc. (JSI) in the 1990s.

Midwives earn revenue from the direct sale of health services to clients. Those that are accredited under the NHIP receive reimbursements from that program for the provision of services to enrolled beneficiaries. Lastly, many midwives earn revenue from the sale of sundry items or family planning commodities.

Timeline: 1993 to present

Between 1993 and 1995, the United States Agency for International Development (USAID) provided funds to John Snow, Inc (JSI) to transform two NGOs into franchisors that would convert existing midwife networks into franchise networks specializing in the provision of family planning services. While these efforts failed due to poor planning and training of the private providers, USAID continued to work with JSI through a series of new projects under the name TANGO (1995–2004).

Under TANGO, the WFMC brand and a restructured social franchising model were developed. Maternity, infancy and child health services were added to the menu to generate additional revenue for the franchisees. Several additional NGOs were brought on board, and each was designated to oversee franchisee networks in their respective localities. JSI remained as the national franchisor until 2002, when WPFJ was established to replace it.

The program was restructured with the intent of becoming self-sustaining and non-reliant on donor funds. WPFJ stopped receiving USAID funds in 2004. JSI however left a trust fund for the program. The interest on the trust fund continues to finance the lead franchisor, WPFJ.

BlueStar Pilipinas

BlueStar is a franchise brand developed and owned by Marie Stopes International (MSI), a UK-based non-profit agency. Population Services Pilipinas, Inc. (PSPPI) is the national franchisor of BSP; it manages BlueStar branded clinics in the Philippines, and implements its own FP outreach programs.

All franchisees are midwives that work exclusively in the private sector, and all are authorized, under the BlueStar brand, to provide the following franchised services, alongside any other non-franchised services already offered at the clinics:^{45, 46}

- Family planning: family planning counseling, contraceptives, and referrals for tubal ligations
- Women's reproductive health services: Pap smear and management of reproductive tract infections

Organizational structure

PSPI is responsible for the oversight and expansion of the program. The agency also provides franchisees with competency trainings, technical assistance, subsidized commodities and supplies, quality monitoring and assurance services, promotions and marketing, and branding support.

PSPI personnel known as field team members (FTMs) work directly with franchisees to generate local demand for services through community activities (e.g., buntis parties, which are lively gatherings for pregnant women or mothers), collect timely payments from franchisees, and ensure the delivery of family planning services. Aside from regular visits to franchisee clinics, FTMs also conduct business system audits twice a year where they check the reported service numbers and stock records of the franchisees, and administer member and customer satisfaction surveys. FTMs report all their activities and findings to the BSP brand associate, who in turn works closely with PSPI senior management. FTMs are directly responsible for supporting franchisee midwives to become accredited under the NHIP.

BSP Organizational Structure⁴⁷



Minimum requirements for franchisees

The following criteria are used to determine eligibility of midwives for the BlueStar program:

Midwife selection criteria	Franchise contract requirements
Licensed by the Philippine Regulatory Commission and registered with the Integrated Midwives Association of the Philippines	Provide adequate space for clinic
No existing agreements or contracts with organizations or agencies providing similar assistance as PSPI	Timely payment to PSPI for equipment and supplies and technical assistance
Has an existing private practice	Adherence to standard operational procedures and format
Not employed in a government or private health facility	Proactive promotion of contraceptives to clients including referral for sterilization services
No plans to work abroad	Proper maintenance of clinic equipment
Committed to provide family planning	Cannot join any other franchise program or network
Willingness to complete all required trainings	Cover cost of clinic's utilities
Good reputation in the community	Submit weekly and monthly data on revenue and delivered services

When a midwife agrees to become a franchisee, she undergoes trainings on BSP's business systems module and a comprehensive competency-based clinical training on FP (that includes IUD didactics and practicum). After successful completion of training requirements, the franchisees' facilities are renovated with PhilHealth accreditation standards in mind. They are also given the equipment they need to provide MNCH and reproductive and sexual health (RSH) services, as well as a six-month supply of essential commodities.

Franchisees may be removed from the program if they consistently fail to comply with the franchise agreement.

Financial arrangements

When a franchisee first joins BSP, the initial package of clinic equipment and supplies—amounting to approximately 50,000 PHP—is subsidized by PSPI. Franchisees pay back part of the cost of the equipment and supplies through a monthly payment of 1,000 PHP (22 USD) for three years. An additional yearly membership fee of 1,500 PHP (33 USD) is also paid by the franchisees to cover costs associated with the technical assistance provided by PSPI. PSPI uses the revenue generated from these fees, as well as grant money from MSI, to finance the operational costs of BSP.

Midwives earn revenue from the direct sale of health services to clients. Those that are accredited under the NHIP receive reimbursements from that program from the provision of services to enrolled beneficiaries. Lastly, midwives earn revenue from the sale of FP commodities, which PSPI provides to them at cost.

A brief profile

In 2008, MSI and its senior partner in the Philippines, PSPI, established BSP midwife clinics in order to increase access to short and long-acting modern family planning methods through the private sector. BSP later expanded its remit to providing technical support for the provision of maternal and newborn health services as a response to opportunities to link to the NHIP.

BSP operates on a fractional franchise model, where additional RSH services are added to the existing MNCH services provided by midwives. BSP's target population is women found in urban, peri-urban, and rural areas with the capacity and willingness to pay for low cost MNCH and RSH services.

BSP is primarily financed by grants, which are channeled through MSI.

Findings

Strategies used to build and support links with the NHIP

Linking franchisees with the NHIP has presented both WFMC and BSP with opportunities and challenges. Accreditation requirements for midwives and their clinics are complex and paper-work intensive, but PhilHealth reimbursements can be substantial in comparison to typical OOP payments. Additionally, accreditation may reduce cost burden on clients.

Both franchise programs have therefore played a substantive role as intermediaries and technical advisors for franchisees that are in the process of first-time or re-accreditation. In some instances, they have performed the required leg-work on their behalf. Many of these activities are costly, requiring direct visits to clients, the provision of in-kind or financial support to meet infrastructure or equipment requirements, and the investment of personnel time to build expertise on policies relating to accreditation. Where possible, these approaches have been built onto pre-existing franchise program activities. However, given the complexity and costs associated with meeting shifting accreditation requirements (see the appendix for more on PhilHealth accreditation requirements), innovative new activities have been added to the menu of services offered by each program.



This sign is used to display both the franchise brand and NHIP accreditation status of the clinic.

Advocacy at the national level

In the mid-1990s, under renewed political commitment and with funding from donors, new initiatives to engage midwives within a broader strategy to improve maternal health were launched. At that time, midwives were not yet eligible to become accredited under the national health insurance scheme.

WFMC, before it was known under that name, was a significant actor in policy development on this issue. In developing its own business plan, it produced reports that become influential in setting standards for the Maternity Care Package. A time and motion study it executed produced costing estimates that were subsequently directly adopted for the Maternity Care Package. WFMC was also a participant in the Technical Working Group to determine the standards and contents of the MCP.

Since that time, the franchise programs continue to engage in advocacy at the national level, namely in relation to influencing reimbursement rates and re/accreditation standards for midwives. As one WFMC area franchisor notes, “In the past it was 6,000 (PHP) per delivery. Now I think its 9,000. So, we’ve been assisting our midwives, and we’ve been attending meetings with PhilHealth because they do research, and the WFMCs are part of where they get their respondents and their cases for deciding on certain policies—particularly on rates for PhilHealth accreditation.”

WFMC encourages Manila-based franchisee midwives to participate in PhilHealth meetings, and PhilHealth also pro-actively invites midwives to seek their opinions. This level of engagement was engendered by the long history of joint work, and by excellent relationships between the former WFMC leadership, local area franchisors, and policy-makers.

The role of effective early leadership in propelling the WFMC agenda forward was a theme that emerged in multiple conversations. One PhilHealth representative explained that relationships between Philhealth and the franchise were built early on, and “...we are really in close contact with these organizations, particularly with the preparation of the accreditation. And concerning the benefits, they are one of our stakeholders who mainly suggests appropriate actions on how we could give out reasonable benefits that would benefit the midwives and our members with regards to MCP... Once we get their feedback we take that into consideration in revising or developing other packages, or improving our accreditation process.”

Access to capital and supplies

Accreditation requires that the participating provider meet strict requirements set by the Department of Health in terms of equipment and facilities. Meeting these requirements can pose a significant challenge to healthcare providers, especially those that rent clinic space, or have inadequate access to capital. To support the franchisees, both social franchise programs therefore began either directly disbursing grants or low-interest loans, or facilitated access to loans through local banks. Additionally, ad hoc small-scale loans were administered by franchise program personnel.

Initial financing for the loans and grants provided by the PSPI program came from the program's general operating funds, derived from Marie Stopes International, and ultimately, from donors. It was anticipated that the interest and return payments from the franchisees would sustain this particular initiative. It has since halted due to the uncertainties of future funding, lower-than-anticipated return payments from loan and grant recipients, and more stringent facility requirements by the health insurance program. In the effort to mitigate the financial risks it assumes in supporting franchisees to get accredited, BSP has increased qualification requirements for midwives interested in participating in the franchise; formerly, midwives that rented their facilities were allowed to participate. Now clinic ownership is required.

The Department of Health will impose stricter facility requirements in 2015, and this presents a significant challenge to both franchise programs in their work to support the remaining unaccredited midwives.

There were also private bank loans available for the first recruits of WFMC. WFPI negotiated with a micro-lending bank, Opportunity Microfinance Bank, on behalf of the franchisees. This arrangement fell through, however, because the bank had only one office in Manila and franchisees in the provinces found the travel and costs to be burdensome. Respondents of this study noted that they were resistant to taking large institutional loans, and preferred to rely on personal or familial reserves. Very few midwives were reported to have availed of the loans.

Due to the strict nature of the facility and equipment requirements for accreditation to provide MCP and NCP packages, the franchise programs' entry and membership requirements and policies have come to mirror those of PhilHealth. As one BlueStar franchisee noted, "Without them I wouldn't have a clinic. And if I did have a clinic, I won't have PhilHealth [accreditation] because there really are so many requirements and they really did so much so we could be PH accredited."

Additionally, both franchise programs donated supplies and large equipment (e.g., delivery tables, autoclaves) to franchisees. Donations were largely determined on a case-by-case basis, and in many instances were substantial. Several of the franchisees that participated in this study noted that the contributions were transformative, enabling them to grow and sustain a profitable business.



Patient education material and family planning supplies donated by a franchise program

Meeting facility layout requirements

To meet accreditation requirements, clear signage is required, as are clear divisions between the private consultation or examination room, delivery room, patient's room, and toilet. In many instances, the social franchise program creates the basic blueprint to guide the construction or renovation of the clinic so that it meets the standards. They also play a role in supervising the actual construction of the facility.

Technical assistance in understanding accreditation processes and requirements

The franchise programs demystify the accreditation process to the franchisees, and become experts on PhilHealth in the process.

PSPI administrators explained that the Field Team Members, under the supervision of the Brand Manager and the Portfolio Projects Officer, explain the requirements for PhilHealth accreditation to franchisees, assess the franchisees' existing infrastructure, identify gaps, and advise on steps to increase the likelihood of accreditation. They further noted that this sort of expertise was essential

for the franchise program to play a meaningful role as an intermediary, as requirements are complex and change periodically.

Additionally, they invite representatives from PhilHealth, the DOH and other technical experts to train franchisees on accreditation and licensing requirements.

Paperwork processing

Franchise programs also assist franchisees in filling up and processing documents for PhilHealth accreditation. They assume simple tasks such as organizing, photocopying, submitting, and notarizing documents for franchisees. Some staff members also accompany franchisees to local government offices when applying for required government-issued business permits, and to settle local accreditation-related disputes, as needed.

Facilitating agreements with partner physicians

Franchisees are required to sign a memorandum of agreement (MOA) with two referral physicians (i.e., obstetricians/gynecologists and pediatricians) in the event of complications, or for pediatric cases. As midwives are not allowed by their scope of practice to prescribe medications, partner physicians are also needed for this purpose.

The franchise programs make themselves indispensable by researching and recommending eligible referral physicians. The programs also provide a template for the MOA and edit the document based on local specifications. In some cases, franchise program staff members accompany franchisees to the meetings where the documents are signed. Franchisee respondents noted that this form of support is critical, especially in instances where the intended physician is difficult to work with, or the franchisee possesses insufficient knowledge of English to execute an agreement.

Claims and reimbursements

Once accredited, franchisees need to file claims at their local PhilHealth office in order to be paid for services rendered. Reimbursements from Philhealth may, on occasion, take several months to arrive. Thus, Philhealth financing may be associated with delayed payments and substantial business risk for franchisees. To mitigate the impact of delayed payment, the BlueStar instituted the Paluwal program. Under this program, a loan is advanced to the franchisee until the time reimbursements are processed. This program, however, has since been stopped due to lack of timely re-payment and uncertain funding.

Renewal of accreditation

Franchisees are required to renew their clinics' PhilHealth accreditation every year. Franchise programs issue reminders to ensure this occurs in a timely fashion. The franchisees then manage this process themselves, and largely credit the franchise programs with empowering them to do this. They note that the programs offered the technical assistance and personalized support that enabled them to understand and meet the paperwork requirements; and supported them to build the personal wherewithal to interface with government institutions.

Strategies used to build and support links with the NHIP

- Advocacy at the national level
- Access to capital and supplies
- Meeting minimum clinic space and layout requirements
- Technical assistance in understanding accreditation processes and requirements
- Paperwork processing
- Facilitating agreements with partner physicians
- Claims and reimbursements
- Reminders for renewal of accreditation

The substantial technical and other assistance offered by the programs has paid off in terms of high rates of accreditation among franchisees. BSP however observes that the remaining unaccredited franchisee clinics, which are by and large less well equipped and operate in rented facilities, may be the most difficult to support through the process. They note that unless the clinics are relocated to areas with higher foot traffic, they will not earn enough to finance their own upgrades.

WFMC's membership has not grown in recent years, and their support for accreditation of new franchisees has thus stalled. Substantial donor funds exited the program in 2004, and in the absence of a revenue-generating business model, few efforts at network growth were made subsequently.

Understanding the value proposition: To the franchisee and the franchisor

Franchisors incentivize healthcare providers to become franchisees by convincing them that they will derive benefits from membership in the franchise network such as increased client volume, revenue, or reputation; or access to trainings, equipment or medical commodities. It is plausible that the substantial support offered to franchisees to become accredited may also be viewed as a benefit of participation, and may support franchisors to not only recruit additional members, but also retain them for the long term. Linkages with the national health insurance program may also offer additional advantages to the franchisors themselves, such as recognition and financing from the public sector.

We therefore originally sought to understand how the franchise programs' support for accreditation affected their value proposition in the eyes of franchisees. We however found that franchisees did not differentiate between routine support services provided by the franchise programs, and the additional support offered for accreditation. Therefore, we describe below the benefits the franchisees report they derive from participation in the franchise program and the national health insurance program. We also explain how the franchisors think their efforts to support accreditation of franchisees affects their value proposition, and if this translates into financial returns for them.

The franchisee perspective: Benefits of participating in the franchise and receiving accreditation support

1. Branding and reputation

Accredited franchisees prominently display franchise brand signage adjacent to, or together with, Philhealth signage. The signs are bright yellow, and are posted in prominent places, indicating the availability of branded health services that are financed by the NHIP. Franchisees pointed out that the WFMC and BSP brands are well known and respected in their communities. They further noted that the franchise brands are associated with good quality services and products. As one midwife noted, "every time I go to gatherings and they hear that I am a BlueStar member, they know. 'She's a BlueStar member so her clinic looks like this and like that and these are the services she provides...quality.'"

The reputation conveyed by the signage may be a key incentive for the franchisees to sustain membership over the long term. As one midwife noted, "Actually I'm thinking about leaving the franchise, because this year I think we need to sign another franchise agreement. But then again, I want to...still the name. Because we are identified as the WFMC."

Given the plethora of midwives in the market, brand name and prestige may be the factor that sets franchisees apart. Longstanding and new franchisees both noted that the signage continues to offer reputation support.



The brightly colored BlueStar sign sits directly above the sign indicating that the midwife accepts Philhealth beneficiaries. Both are visible from a distance.

2. Networking, personal and professional support, and empowerment

Midwives participating in the franchise networks expressed an appreciation for the value of participation in a collegial franchise network. This is not surprising, given the long history and popularity of midwife networks in the Philippines. They also expressed how important the networks are as a tool for empowering franchisees. They described the franchise networks as a source of community, family, and camaraderie.

They further noted that the franchise networks have empowered them to engage with government institutions, and to speak on their own behalf within the franchise programs themselves. In the case of WFMC, this activism is engendered by a governance structure that includes opportunities for midwives to take an active role in determining the direction of the franchise program.

This level of empowerment has translated into the ability to seek re-accreditation without significant support from the franchise programs. Some franchisees noted they were empowered to the degree that they no longer needed hand-holding from the franchise program. However, they continued to stay on out of loyalty and affection for the program and its founders.

3. Increase in and certainty of client load and revenue

Compensation under Philhealth for the provision of MCP and NCP is considered 'full cost,' which means that all costs incurred by the midwife while providing these

services are fully covered by the health insurance payments. PhilHealth reimbursements for MCP and NCP can reach up to 9,750 PHP (219 USD), excluding taxes and other deductions. This amount tends to be considerably higher than OOP charges to clients for the provision of the same services.

Midwives also noted that Philhealth payments for the MCP and NCP are more reliable than OOP payments, as clients who pay out-of-pocket may default or pay less than they owe. They view this as a tremendous business advantage of being accredited as a Philhealth provider.

Payments by Philhealth for the provision of MCP and NCP services have given rise to a phenomenon known as ‘millionaire midwives.’ These are midwives that have financially benefited from participation in the national health insurance program, and have, in many instances, used this money to expand operations, hire other midwives, and bring family members into the profession. Both franchise programs include millionaire midwives, and the members acknowledge the franchise programs made this level of financial success possible.

As one midwife noted, “Because when you’re on your own, you think you can manage? No. There are a lot of government [requirements] that you have to comply with. It’s really different when you have an NGO that assists you... When you’re part of the franchise, you have back up, there will be someone who will guide and support you.”

Philhealth payments were therefore seen as a critical source of revenue for the midwives. Midwives also reported they felt more of an incentive to help enroll the uninsured into Philhealth, as payments from Philhealth were considerably more desirable than OOPs.

The franchise programs have not yet used these success stories to market themselves to prospective recruits, but they see an opportunity. As noted by a franchise program administrator when asked if his marketing strategy currently includes any references to Philhealth, “Now. In the beginning it wasn’t. In the beginning the vision was just to establish the franchise, and to make them financially sustainable, but with the looming financial sustainability through social health insurance, certainly it’s a value proposition to the midwives.”

4. Ongoing access to trainings and technical support

The trainings and updates the midwives receive are a key incentive for remaining in the franchise networks. One franchisee sees the trainings as a way to cultivate innovation, which she thinks is necessary to succeed in a competitive market. Another franchisee pointed out that the trainings and updates, some of which are required

by the DOH or PhilHealth, are expensive and difficult to access on one’s own. As she points out, “When you’re alone, your training will not be the same. You will need to penetrate the other organizations to get the same training and you need to pay.”

Both WFMC and BSP program administrators agree that the technical assistance they provide to franchisees regarding PhilHealth accreditation is important in reinforcing the attractiveness of the franchise program to existing and prospective franchisees. As a PSPI representative expressed, “Without the expertise that PSPI has in terms of PhilHealth accreditation processes, we wouldn’t be attractive to new midwives, and the current midwives wouldn’t value staying in the system.”

Aside from PhilHealth-related support, franchise program personnel are also available for general technical support and guidance, which franchisees value as well. Franchise program staff members are approachable, even taking calls or answering text messages during non-business hours.

Technical support provided by the franchise programs is partially reimbursed by franchisees, or may be covered under salaries, cross-subsidized by general operating budgets, or uncompensated altogether. These activities may however be tied to a substantial benefit to the franchisor: increased program loyalty.

The franchisor perspective: Benefits of offering technical support for accreditation

1. Franchise loyalty and membership retention

Franchisees attributed their current level of professional, personal, and business success to the technical assistance and support they received from the franchise program, and their subsequent participation in PhilHealth. As a result, some mentioned that they cannot imagine leaving the franchise network because they want to stay loyal to their respective franchise programs. There is also a deep sense of personal debt (*utang na loob*) and gratitude (*pasasalamat*) among the franchisees. As one franchisee observed, “We also don’t want to detach from [the franchise] because we owe them everything and they’re the ones who gave us a better life, to be successful midwives, to become respected in the community. I must be crazy if I think about leaving BlueStar. They helped you to be successful, to be respected, to have your own business, and then you just leave them? I haven’t thought about being a traitor to them.”

This sense of loyalty may balance out some of the costs (to the franchisee) of participating in the network. As one franchisee noted, “It’s like you don’t have gratitude that

they gave you so much and then when the contract ends you leave them. And they don't demand a lot. You just have to send your output through text every week. And then someone comes here—the field manager—every quarter and they look at our records. That's it! And still you leave?"

While loyalty may be seen as a rough approximation of franchisee satisfaction, it is not the only factor determining membership retention. Franchise programs continually strive to remain valuable to the franchisees by finding innovative ways to support them, and risk network attrition if they are unable to demonstrate that value. Thus, while some respondents expressed loyalty, a sense of personal debt, and gratitude towards their franchise programs, some franchisees also hinted at their misgivings and frustrations when faced with unsatisfactory program management practices.

In the early 2000s, WFMC changed its organizational structure. They decentralized operations management from one Manila-based franchisor to several local area franchisors. The local area franchisors, each with their own unique histories as previously independent NGOs, implemented the franchise program variably. In some regions, this has meant a downscaling of technical support services. This has prompted some midwives in the WFMC franchise to re-consider their membership in the network. As one midwife said, "there is a lot of competition out there. If the NGOs [local area franchisors] don't take care of the midwives, what will happen? They will just do their own practice. They will not follow the standards of our foundation, our NGO, and the DOH. That's why it [the decentralization of administration] really hurts me."

Franchise programs, having aligned membership requirements with accreditation requirements, also front-load a good deal of their support to midwives. Therefore a lot of the value that midwives expect to get from participating in the franchise network is realized early on. Some respondents observed that they were unsure if the franchise networks had anything left to offer them, and this would influence their decisions about whether or not to renew their franchise contracts.

2. Recognition among policy makers

Because of their active regional engagement with PhilHealth and the DOH (on behalf of individual franchisees), BSP reports they are known by the agencies. As a PSPI representative explained "It has given us space within their minds. You talk about BlueStar, they know what BlueStar

is about. They know what BlueStar represents. So it's a brand itself. In the regional offices of PhilHealth, in the central office, for that matter."

WFMC, with a longer historical presence in the country, also explained that their early national-level policy work continues to give them credibility in the eyes of PhilHealth and the DOH. As one WFMC area franchisor explained, "There are so many conferences we are invited to. They recognize [our NGO] and the WFMC as partners in health. So we are part of the referral system. We are part of the technical working group—on the upper levels."

The franchisors note that the relationships they have cultivated with the DOH and Philhealth have benefited midwives in tangible ways. They report playing a key role in influencing decisions on compensation rates for the MCP, and that they have been able to negotiate (on behalf of midwives) more lenient timelines to institute new DOH licensing requirements. As PSPI notes, "In the beginning, we had engaged them (the DOH) in licensing. In fact, we were instrumental in defining the size of the clinic area, the birthing area, to 50 square meters. In the beginning, they were setting the requirement at 150 square meters. We have a stake there, because none of our midwives would have met that requirement, except one or two."

The franchisee perspective: benefits of participating in the franchise program and receiving accreditation support

- Branding and reputation
- Networking and personal and professional support
- Increase in and certainty of client load and revenue
- Ongoing access to trainings and technical support

The franchisor perspective: benefits of offering technical support for accreditation

- Franchisee loyalty and member retention
- Recognition among policymakers

Lessons learned

Both programs have deftly capitalized on policy developments to link their programs with the NHIP. In some instances, they spurred those policy developments. In the process, both have empowered and enriched midwives,^a built a reputation for quality healthcare, reduced OOP outlays by clients, and expanded the range of health services and commodities available at the clinics owned by franchisees. They have also earned the loyalty of midwives, their willingness to comply with standards and technical and facility requirements, and a place at the policy-making table. There are important lessons to learn from their experiences.

1. Alignment of franchise membership requirements with NHIP requirements raised the bar for entry for midwives. It increased the odds that franchisees would get successfully accredited; it may have also disincentivized prospective franchisees from joining the franchise networks, due to prohibitive costs associated with compliance. This double-edged sword can be wielded by franchise programs to become significant players in the social health insurance sphere; it can also limit network membership to the middle-class or wealthy.

“You see, midwives before had very low set up standards—like area, layout of clinics and so forth. There were a lot of midwives—that when we standardized our procedures—like clinic spaces, layout and everything to comply with Philhealth standards—so, a lot of them no longer wanted to continue because of the cost involved. This happens when the clinic space is rented.”

– *Franchisor*

a. The majority of WFCM midwives have invested their own funds from overseas earnings into capital investments. BlueStar, which initially did not require midwives to own their clinics, now requires it. Both programs have shifted from a model that favored greater financial risk-sharing into one that places the risk primarily on the midwives.

Questions to consider

1. In its pursuit of sustainability, is enrichment of franchisees an important goal of the social franchise program?

If so, this is important to articulate as a goal, as it can inform how the social franchise program is implemented, who it recruits, and the structure of its membership fee payments.

2. Is it important for poorer midwives to be engaged constructively within the franchise network?

This will depend on the goals of the social franchise. If the goal is to raise the quality of services offered by local healthcare providers, this may be an important consideration. Some franchise programs have attempted to develop tiers of network providers, each with different franchise entry criteria and strategies for engagement.

Other groups are experimenting with different approaches to quality improvement and accreditation among healthcare providers with low access to capital.

Additional reading

- The World Health Partners model uses a tiered approach to provider engagement: ananya.org.in/stories-and-lessons/332-upgrading-healthcare-from-informal-providers
- Read about PharmAccess Group’s approach to quality improvement among healthcare providers with low access to capital: pharmaccess.org

2. Plans for long-term financial viability of the programs were initially developed with the idea that substantial donor funding would be available for the long term. This led to decisions that prioritized goals like equitable use of healthcare services and franchisee profitability. For instance, both programs have invested substantially in supporting their franchisees to upgrade and get accredited; both have recruited midwives in far-flung and remote regions with low business potential; and both have created quality assurance and monitoring systems that are costly, but highly beneficial to the program.

However, revenue from membership and annual fees has been insufficient to finance the work of the franchise programs. Also, neither program has been able to translate their support for NHIP accreditation into revenue for themselves.

Therefore, once substantial donor funds exited from WFMC, it was forced to revisit these earlier decisions and re-structure its model. Under the newer, less costly model, management is de-centralized, and operating budgets are largely financed by the NGOs that took on management of each local network. This results in variable implementation of the program's standards.

BlueStar has had to scale back the types of support it offers midwives and raise the bar to entry. As it contemplates the exit of major donor funds in the coming years, the program is considering how best to balance its commitment to equity and its commitment to financial sustainability for the franchisee and itself.

“That’s a tricky situation right now. Unless we find another grant to support us through a certain period of time, then we will find it difficult to directly support the franchised midwives. So the only solution there is to find a sustainable solution of financing our activities for the franchise—with the revenue coming from the midwives themselves... It means that either we are able to leverage existing grants to create some commercial viability around the franchise, or without that, to restrict the franchise to members that can support the franchise. In other words, eliminate the drag.”

– *Franchisor*

Questions to consider

1. Instead of using donor funds as a primary source of revenue, how can these funds be invested strategically to build business models with revenue-generating potential?

Discussions from the October 2014 Global Conference on Social Franchising pointed the way to some approaches to channeling donor funding strategically: possibilities included the channeling of donor funds toward testing, experimentation and evaluation of new approaches to financing and delivery of care; also, donor money may be used as a catalyst for leveraging public funds.

2. How can programs leverage their linkages with social health insurance programs to support their operating costs?

Social franchise programs may need to consider how to make themselves indispensable in transactions between franchisees and the third party payor. For instance, BlueStar is considering how to formalize its role as an intermediary between franchisees and Philhealth. One option they are considering is to submit all claims on behalf of franchisees, and subtract a small percentage from the reimbursements.

3. If financial returns are likely to be unsatisfactory given the program’s focus on reaching the hard-to-reach or investing heavily in quality support to franchisees, how can programs quantify their value in terms of ‘public health returns’?

The Social Franchising Metrics Working Group recommends the use of five public health goal posts: a demonstration of cost-effectiveness, health impact, quality, equity, and increased use.

Further demonstration of value in these areas may support franchise programs as they state their case for continued investment by donors and others.

Additional reading

- The conference report: sf4health.org/conferences/2014-conference
- The Global Health Group investigated different strategies used by eight programs to maximize options for sustainability: sf4health.org/research-evidence/reports-and-case-studies
- Tools to measure performance for equity and health impact: sf4health.org/measuring-performance/metrics-working-group

3. In the effort to ensure franchisees can get accredited, both programs have front-loaded a good deal of their support to the clinics. This support has come in the form of clinical and business guidance, and access to equipment and capital, among other things. Once provided with this support, members stay on out of loyalty, and to retain access to technical updates, personal and professional support, and the reputation signified by the signage. They report that their revenue has increased two to three-fold due to participation in the NHIP, but are still hesitant to pay larger fees for access to ongoing services provided by the franchise programs.

“It has given us pride, an image, a new way of working with a new group of private midwives who are not under our direct employ. We are gaining experience. We are gaining expertise. There are challenges, and we are meeting them as they come. Certainly one of the challenges is making money out of the entire thing, making money for PSPI.”

–Franchisor

Questions to consider

1. Can franchisees be incentivized to pay higher membership fees, fees based on a percentage of profits, or to pay for services rendered?

Programs note that midwives resist changes in the fee structure once it is imposed. As noted above, BlueStar is considering how to be remunerated automatically from health insurance payouts to franchisees. Given the complexity of claims processing and health insurance-related procedures, franchisees may increasingly be able to capitalize on their role as a navigator and intermediary on behalf of individual midwives. Other programs have attempted to make themselves indispensable to franchisees’ ongoing business success by giving them access to profitable socially marketed commodities and retail goods, so long as they remain within the network.

2. Can the local health or social health insurance agencies finance any of the work that is being done by the franchise programs?

The franchise programs may need to align their programs, or their technical support or training activities with policies that would enable them to be financed by these public agencies. For instance, medical institutions that pass Philhealth-specified certifications can qualify as training centers for midwives. These centers are paid by Philhealth for the provision of training services. Franchise programs will need to assess opportunities like these for how well they fit with the program’s mission, and will need to remain flexible in order to embrace business opportunities like these.

Additionally, franchise programs need to be visible to policy-makers. Engagement at the local level, while highly effective for ensuring franchisees meet local accreditation stipulations and create the right local partnerships, may be insufficient for raising the profile of social franchise programs and bringing them to the attention of the people that control national or regional health budgets.

4. Both programs have placed an emphasis on building the capacity of franchisees to financially manage successful businesses, and to deliver high quality care. Thus, some franchisees report they may no longer

need hand-holding from the program, and may not feel the need to renew membership in coming years.

Question to consider

1. What are the pros and cons of ‘graduating’ successful midwives from the programs?

Midwives that have exited a franchise network can no longer be quality-monitored, nor can they contribute to its revenues or the service statistics reported by the franchise program. ‘Scale’ is an important concept within social franchising. It is thought to lead to greater revenue potential with incrementally less investments; it is also the metric by which donors and policy-makers may judge the programs.

When and if to release franchisees from the network is a question faced by many programs. There is no simple

answer. A few programs have opted to graduate successful franchisees; a few others have created different levels of franchise membership for franchisees that no longer feel the need to engage as heavily with the franchise network.

When assessed from a local health systems perspective, some programs may find that their former franchisees are contributing to sustainable changes in the performance of the system, and that continued participation in the network is not needed. This is however a very difficult metric to gauge success by.

Conclusion

The Philippines has a huge reserve of midwives, and they are eligible to be compensated for the provision of services to Philhealth beneficiaries. The country is also rapidly expanding its national health insurance program to cover the entire population. Franchise programs have reacted to these opportunities to produce programs that have the potential to support the achievement of Millennium Development Goal 5, a priority of the current Health Secretary.

While few other countries can boast of the convergence of so many factors that could support the growth and financing of social franchising programs, the lessons from this country can inform work in others.

- Where social health insurance policies are under development, programs can execute the studies and supply the voices that can inform those policies.
- When a window of opportunity opens up in national or regional social health insurance policies, programs can react swiftly to leverage those opportunities.

- Where the capital and technical know-how for accreditation of private sector healthcare providers is absent, programs can play the role of facilitator—either on behalf of the public health system or the healthcare workers. In the process, they can build the value proposition of the program.

Linking providers with the NHIP has proven to be a costly endeavor on the part of franchise programs, and they have been unable to translate this service into a stream of revenue. Both have been forced to make critical decisions regarding whether and how to continue this form of support to franchisees. On the same token, both have also transformed the lives of midwives, reduced the crushing burden of OOPs on clients, and improved the quality of health services they receive. Additional studies on the contributions of these interventions toward strengthening the health system would be well worth it.^b

b. Katy Backes Kozhimannil and colleagues conducted an assessment of WFMC's effects on pre-natal service utilization. Reference: Kozhimannil K.B., Valera M.R., Adams A.S., Ross-Degnan D. The Population-Level Impacts Of A National Health Insurance Program And Franchise Midwife Clinics On Achievement Of Prenatal And Delivery Care Standards In The Philippines. *Health Policy* 2009; 92(1): 55–64.

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Appendix: PhilHealth accreditation

In order to receive PhilHealth reimbursements for health-care services and products rendered, medical professionals including physicians, dentists, and midwives and their clinics need to be accredited by PhilHealth. PhilHealth accreditation is a voluntary process wherein “the qualifications and capabilities of health care providers are verified in accordance with the guidelines, standards and procedures set by the [Philippine Health Insurance or PhilHealth] Corporation.”⁵⁰

According to PhilHealth, accreditation serves two purposes, namely (1) it allows health care professionals to participate in the NHIP and (2) it assures that the healthcare services provided by health professionals are “of the desired and expected quality.”⁵⁰ While accreditation has been associated with improved service quality and standardization of services in other industries, these outcomes have yet to be documented in Philippine healthcare.⁵¹ A 2008 modeling study found that PhilHealth accreditation of public and private providers influences quality of care, but it alone does not promote high quality care.⁵² An analysis of trend data from the NDHS showed that the expansion of PhilHealth accreditation was associated with increases in achievement of minimal standards for prenatal care among women in the Philippines.⁵³

There are two types of PhilHealth accreditation—one for professional providers and another for health facilities (also called institutional providers). Each type of accreditation has its own processes, requirements, and deadlines/timelines. Both types of accreditation are required in order for private sector midwives to receive PhilHealth reimbursements for the MCP and NCP.

Professional accreditation refers to the accreditation of healthcare professionals such as physicians (general practitioners and medical specialists), dentists, and midwives.^{54, 55} In 2011, PhilHealth accredited 10,773 general practitioners, 12,701 medical specialists, 201 dentists, and 522 midwives.²⁴ The following requirements are for the professional accreditation of midwives.

Initial accreditation or reaccreditation

1. **Accomplished PhilHealth application form**
2. **Notarized Warranties of Accreditation**
3. **Photo of applicant**
4. **Photocopy of midwife professional license**
5. **Proof of payment** of required PhilHealth premium contribution
6. **Accreditation fee** (500 PHP or 11 USD)
7. **Photocopy of tax identification card**
8. **Certificate of good standing** from one of two professional organization of midwives in the Philippines (i.e., Integrated Midwives Association of the Philippines and Philippine League of Government and Private Midwives)
9. **Evidence of competency on the expanded functions of midwives** (not required for graduates from school year 1995 and onwards)
10. **Memorandum of agreement** with any of the following as referral for complicated obstetric and pediatric cases:
 - a. Accredited partner physicians (obstetricians and pediatricians)
 - b. Interlocal health zone which allows sharing of human resource
 - c. DOH-certified basic or comprehensive emergency obstetric and newborn care network

Renewal of accreditation

1. **Certificate of good standing** from one of two professional organization of midwives in the Philippines
2. **Memorandum of agreement** with any of the following:
 - a. Accredited partner physicians
 - b. Interlocal health zone
 - c. DOH-certified basic and comprehensive emergency obstetric and newborn care network

Institutional accreditation refers to the accreditation of healthcare facilities such as hospitals, ambulatory surgical clinics, freestanding clinics, rural health units and health centers, maternity care clinics, and TB DOTS clinics.^{53, 54} The following requirements are for the institutional accreditation of maternity care clinics that wish to receive MCP and NCP reimbursements.

Service capabilities

(list of services that accredited clinics must be equipped to provide)

1. **Prenatal care**
2. **Normal birth**
3. **Newborn care including newborn screening**
4. **Health education** (provision of materials and posters related to MNCH, natural and artificial family planning methods, and breastfeeding)
5. **Postpartum care**

Technical standards

(refers to the space and infrastructure requirements, supplies, tools, instruments, and equipment that the clinic must have)

1. **General Infrastructure**—facility signage, lighting and water supply, and adequate space and divisions among consultation/examination room, delivery room, patient rooms, and bathroom
2. **Basic Consultation and Delivery Room Equipment**—essential delivery room equipment (e.g., delivery table, Kelly pad, weighing scales, and oxygen tank), tools (e.g., suction apparatus, bag valve masks,

blood pressure meter, and stethoscope), and storage containers (e.g., covered containers for cotton and receptacles for used cotton balls and gauze)

3. **Standard Supplies**—essential medical supplies (e.g., IV set, IV tubing, disposable syringes, absorbable suture with needle, cotton balls, gauze, surgical caps and mask, cone mask for baby, and thermometer), antiseptic supplies (e.g., isopropyl alcohol), and essential drugs and vaccines (e.g., tetanus toxoid, Vitamin K, erythromycin, and xylocaine/lidocaine)
4. **Records Management**—admissions registry with monthly summary, patient clinical records, and referral forms
5. **Available Transport Vehicle**—may be facility-owned or contracted out
6. **Human Resource**—at least one PhilHealth accredited professional provider, full-time or on-call clinic aide, on-call partner physicians or professional provider, and all personnel must be PhilHealth members with updated premium contributions
7. **Quality Assurance Activities**—list of quality assurance and improvement activities for initial and renewal of accreditation (e.g., administration of satisfaction surveys to patients and staff, submission of annual morbidity and mortality data, report on referrals made, compliance to monitoring and evaluation activities of PhilHealth, etc.)

The Global Health Group

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

The GHG studies a variety of innovative delivery platforms that leverage the strengths of the private sector to achieve public health goals.

More information about this case study and social franchising in general can be found at SF4Health.org.

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