Facing Challenges and Opportunities for Franchised Rural Health Services
A PSI/Myanmar Case Study

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From evidence to action

Introduction

Dr. Min Zaw, Director of the Health Services Department of Population Services International, Myanmar (PSI/Myanmar), sat still, deep in thought at the head of the conference room table in PSI's Yangon office. Deputy Country Director David Valentine had recently informed him of a new funding opportunity: a large American donor was offering support for the expansion of program activities for market-based healthcare delivery in rural areas. This funding could be the perfect fit for an idea that Dr. Min Zaw and his team had been considering for some time: a network of for-profit health entrepreneurs who would travel door-to-door selling a variety of health-related products and referring patients to PSI's existing network of peri-urban clinics.

However, PSI/Myanmar already had a rural network of voluntary health workers, and while it was doing well at targeting rural populations for referrals and basic services, it did not fit the new donor's criteria of prioritizing a sustainable model, and in fact the existing rural network was quite expensive to operate. Dr. Min Zaw knew that pursuing this new funding would mean making a commitment to transition the existing rural network into a completely new for-profit model. While he envisioned doing this eventually, making a decision to do so immediately was not without its risks. Though much of his team was in favor of seizing this opportunity and making the transition, others were concerned about the unknowns: the real costs of managing a supply chain for new commodities, potential quality declines, and the resulting implications for health impact. Dr. Min Zaw needed to make a decision immediately to meet the quickly approaching proposal deadline.

1. WHO and UNICEF

Background

Myanmar's health statistics are among the worst in Southeast Asia. The estimated maternal mortality ratio is 320 per 100,000 live births – higher than almost all of its Southeast Asian neighbors.[1] Despite rapidly improving economic development in urban centers, health services – particularly for the 66% of the population living in rural areas – remain woefully inadequate. Infectious diseases are a major burden and national infrastructure at all levels is antiquated, inadequate, or nonexistent. Additionally, private, out-of-pocket payments make up 87% of all health expenditures in the country.

Population services international (PSI) is a US-based nongovernmental, nonreligious organization focused on applying market-oriented mechanisms to ensure the delivery of affordable, high-quality goods and services for healthcare conditions of public health priority. PSI generally focuses on the "near poor," who have well understood challenges in accessing healthcare, but who have some disposable income, which makes them a viable target for PSI's market-based approaches to healthcare delivery. The goods and services that PSI supports are often subsidized by outside donor agencies, but their in-country delivery and oversight systems are funded by end-user payments. The result is a healthcare transaction that is desired by the patient and profitable for the final provider of care, herself a shopkeeper, pharmacist, or doctor.

PSI/Myanmar began operating in 1995 with just a few employees. It was focused primarily on social marketing of HIV prevention products and later expanded to family planning commodities. In addition to its main Yangon office, there are now eight regional offices nationwide.

Social Marketing in the global health context refers to the application of commercial marketing strategies to promote public health-related behavioral goals. These strategies usually involve the marketing of commodities (such as condoms and bed nets) and the implementation of behavioral communication campaigns.

In a growing number of countries, PSI has implemented programs to deliver comprehensive medical care to disadvantaged populations through private sector providers. This model of organizing, training, branding, and supporting existing private

practitioners to deliver high quality, low cost care is known as "social franchising." It is a system that applies the well-established structures of commercial franchising – the standardization of processes organized through the mutually beneficial contractual relationship between a franchisor and individually owned franchisees – to social problems. PSI began using the social franchising model during the mid-1990's in Pakistan, where they built the Greenstar social franchise, an organization that had great success expanding family planning programs throughout the country.

Social franchising is now regarded as an effective way of rapidly growing the number of delivery points supplying the poor with vital health services. Social franchising today is the fastest growing market-based intervention in the world being used to provide health care services in developing countries. PSI is at the forefront of applying the social franchising method and developing new and innovative improvements and extensions to its core model.

The Sun Quality Health Social Franchise

In 1999, the Director of PSI/Myanmar's Reproductive Health Department Dr. Nyo Nyo Min and a colleague traveled to Pakistan to learn from Greenstar, which had rapidly scaled-up and was delivering family planning services to thousands of women annually. Upon returning to Myanmar, Dr. Nyo Nyo Min designed PSI/Myanmar not only to emulate Greenstar's model for market expansion but also to build an extensive system of quality monitoring procedures. In 2001, with funding from the Packard Foundation, PSI/Myanmar launched the Sun Quality Health (SQH) franchise – named to reflect a deliberate focus on quality services.

Initially, urban and peri-urban private providers that joined the SQH network delivered clinical family-planning services: IUDs, injections, oral contraceptive pills, and a host of consultations and non-clinical commodities. Starting in 2003, PSI/Myanmar began to add a number of non-family planning services to SQH's portfolio, first with malaria treatment and STIs. Since then, TB screening and care, pneumonia and diarrhea management, and HIV-AIDS care and treatment have all been added to the clinical service delivery mix.

In keeping with Dr. Nyo Nyo Min's goal to provide high quality services, the first franchisees invited to join the SQH network were licensed General Practitioners (GPs) serving low-income populations with pre-existing clinics in urban and peri-urban areas. PSI/Myanmar initially recruited 57 GPs in three geographical areas to join the SQH network. Most of these providers were already offering a wide

variety of health services, but did not necessarily have access to, nor could they afford to stock high quality products. In a market survey conducted by Dr. Nyo Nyo Min, she found the market was flooded with low quality products, such as birth control pills dubbed "Chinese pink pills" that contained dangerously high amounts of estrogen – an estimated 100 times the necessary dose. To address the issue of substandard health products, PSI/Myanmar focused on distributing reproductive health commodities and services to the participating franchisees. The products – starting in 2001 with condoms, pills, and injectable contraceptives – were high quality, branded and subsidized to be both affordable and to compete with the low quality alternatives on the market.

Providers who joined the network participated in a three-day training program and were visited monthly by Franchise Officers who collected patient record data, checked commodity supplies, and provided support and feedback. The clinics kept a similar appearance to what they had before they were franchised, and were allowed to stay unbranded in addition to new SQH branding. PSI/Myanmar provided a SQH sign, and clinics stocked branded commodities and displayed PSI/Myanmar branded informational materials. Clinics were two or three room spaces, with at least one private examining room. Some clinics consisted of a single doctor, while others employed a clinical assistant to help with reproductive health counseling, sterilizing, preparing for procedures, and collecting payments.

SQH providers were not paid a salary by PSI/Myanmar, but earned a profit by charging affordable, set fees for PSI products and consultation services. These prices were set by the PSI/Myanmar main office and were designed to produce a reasonable profit for the provider. Many providers continued to offer non-PSI/Myanmar commodities and services, such as treatment of respiratory infections, which allowed them to generate additional profits. The rise in clientele due to PSI/Myanmar referrals was also expected to generate additional income for SQH providers.

In 2003, Guy Stallworthy joined PSI/Myanmar as Country Director. Enthusiastic about the franchising program, he restructured the office to create a franchising department and stated an ambitious goal of one million consults per year by 2008. Dr. Nyo Nyo Min started rapidly expanding the number of providers and integrating more services. In 2003, SQH integrated treatment for malaria and STIs into the franchising portfolio. In 2004 they integrated TB into franchises, in 2006 they added Water guard, and in 2007 they added pneumonia care.

By the end of 2007, the network had 797 SQH clinics in urban centers across the country. The franchise model had proven successful in providing a spectrum of reproductive health services along with an array of disease treatment services for STIs, malaria, pneumonia and diarrhea. In terms of clients served and health impact units, SQH clinics were reaching and exceeding expected targets for increased healthcare access in Myanmar.

The Goals of Social Franchising:

- **Quality**: Clinical and structural aspects of service provided by individual private providers. Measurement and monitoring strategies often include checklists, training requirements, patient surveys and ensuring drug quality.
- **Cost-effectiveness**: More health impact for less money. This is often measured by cost per health impact unit or DALY averted.
- **Equity**: More poor people get access to treatment
- Health impact: Measurable impact in treating disease and saving and improving lives.
- **Health Market Expansion**: Providing a service to those in need that would not otherwise be supplied by the existing health system.

Expanding to Rural Areas: The Creation of Sun Primary Health

By early 2008, Sun Quality Health was poised to expand services to new areas and increase the number of clients served each year. The challenge was that 66% of the Myanmar population lived in rural areas, far from SQH clinics, and the worst health conditions were there. Dr. Nyo Nyo Min and her Deputy Director at the time, Dr. Min Zaw, wanted to find a way to address this need and donors were beginning to take notice of the need for rural service provision as well. While it was recognized that PSI/Myanmar could invest in creating new Sun Quality Health clinics in urban and peri-urban areas – areas that were not yet saturated – the decision was made to rise to the challenge of expanding access to services to rural areas.

Expansion of full clinics to rural areas using the existing SQH model was not feasible because of the lack of doctors located in rural areas. In addition, the urban-based

clinics suffered a rural knowledge gap: even people living in rural areas who were close enough to travel to a SQH clinic for needed treatments seldom did so, because the laws preventing direct advertising in Myanmar limited knowledge about the clinics to an area within close proximity to the clinic. Dr. Nyo Nyo Min and her team explored ideas for how to reach these rural areas – they would need to find a way to provide basic services in areas with no doctors or clinics, as well as facilitate referrals to SQH clinics for more complex treatments.

The approach that Dr. Nyo Nyo Min preferred was to create a network of auxiliary midwives and volunteer community health workers who had received some kind of training from the government, but who did not have steady employment or commodities to sell. Coming from a public health perspective, Dr. Nyo Nyo Min felt that these health workers had the trust and the networks in their villages and that with some additional training from PSI/Myanmar, they could become a reliable first point of care in their communities. While the government had discontinued support for this network of volunteers, PSI/Myanmar could capitalize on their existing experience to create a robust rural network that would feed referrals into SQH clinics.

As this idea was under consideration, in May 2008, Cyclone Nargis – one of the deadliest cyclones in reported history – struck Myanmar and claimed the lives of an estimated 140,000 people. To address the health crisis that followed, PSI/Myanmar immediately began recruiting and training 200 volunteer community health workers and auxiliary midwives in areas affected by the Cyclone. Sun Primary Health (SPH) was quickly established as a second tier the Sun Quality Health Franchise.

The Structure of Sun Primary Health

SPH providers were (and continue to be) recruited and trained by Field Leaders to provide a variety of health services to people in their villages and even nearby villages. They provide counseling on reproductive health; malaria testing using rapid diagnostic tests and effective artemisinin-based combination therapies; they sell PSI/Myanmar branded health products such as condoms and pills; and they refer clients to SQH for IUDs and injectables, TB and pneumonia testing and treatment. Most SPH providers will see clients in their homes, and also travel for visits in clients' homes. SPH providers make only a few cents profit on each of the highly subsidized products they sell, with referrals to SQH being a large and important part of their contribution to health impact goals. Because of this, PSI/Myanmar pays providers a performance-based incentive for treatment and referrals, based on a point system

that is weighted by treatment area. As of early 2012, they could earn up to 25,000 Kyat (~31 USD) per month for the care they provide, which includes referrals to SQH. See tables 1 and 2.

SPH providers meet regularly with Field Leaders: salaried employees of PSI/Myanmar, often residing in a township and overseeing the SPH providers in surrounding villages. They meet with each provider once a month to collect information on the patients they have treated and referred, pay any incentives that are due, and provide some advice and follow-up training. Health Services Officers, based at HQ or regional offices, monitor and supervise a portfolio of SQH clinics and Field Leaders. They check the work of Field Leaders, assist in incentive payouts, ensure drug supplies, and help resolve any issues that are being encountered in the field.

Sun Network Success and Challenges

Throughout the past decade, the Sun network continued to add new services to its healthcare platform: in 2008 additional long term reproductive health services were added (SQH), in 2009 oral rehydration salts for diarrhea (SQH & SPH), and in 2010 they introduced rapid diagnostic tests for malaria. By the end of 2011, the Sun network included about 1300 SQH doctors and around 1000 SPH rural health workers, and Dr. Min Zaw, who had assumed the role of Director following Dr. Nyo Nyo Min's retirement, began to reflect on their greatest successes and challenges.

One concern was the high operational cost of SPH. While The SUN network's overall health impact in Myanmar had steadily increased between 2007 and 2011, SPH's costs per health impact unit (HIU) were increasing as the second tier network expanded. The cost per unit had reached a low of $62 in 2007, but had jumped back up to $82 by 2009. Meanwhile the total health impact achieved per PSI/Myanmar Franchising unit staff member had decreased (see Table 3). This was disappointing, but expected given the costs inherent to working in rural areas – the hiring of additional supervisory staff, increased travel and monitoring costs, and incentive payouts. Because SPH providers were paid only modest incentives, their attrition rate was high, increasing PSI/Myanmar's recruiting and training costs.

Productivity was also a concern. In the SPH network, some providers were very effective at providing treatment and referrals, while others were not. Nearly 80 percent of the health impact was generated by 20 percent of the SPH providers. It was expensive to monitor and collect data from so many providers who were not generating results. With these concerns in mind, Dr. Min Zaw wondered at what

point in the SPH program could they expect to gain efficiencies and see the health impact cost decrease again, if this could be expected at all.

Paying large incentives and monitoring costs was uncharacteristic of the PSI Social Franchising model, and many of the Health Services staff – particularly Dr. Min Zaw and Deputy Country Director David Valentine – began to think that there must be way to create greater efficiency in the Sun network while still serving rural populations in Myanmar.

Externalities and Opportunities: Reinventing Sun Primary Health

Even before this current funding opportunity, external pressures had already led PSHI/Myanmar's leadership to reconsider the role of SPH in the SUN network. In early 2012 the government announced that it was ready to sign a formal operating agreement with PSI. However, the government qualified this by allowing PSI clearance to operate only in 216 of Myanmar's 325 townships. Of those 216 townships, SPH had only been operating in 12. The government's message was clear: they were not thrilled with SPH's active role in developing rural provider networks, preferring the "hands-off" approach of SQH. Thus, in many parts of the country, SPH would be forced to shut down, at least temporarily. Faced with the high costs of supporting the SPH program and the new government regulations, creative alternatives were needed to find new ways to provide services to rural populations.

Back when SPH was first created, the PSI/Myanmar team had discussed other options for how to reach the rural population. One idea had been to pursue a social marketing model: recruit existing small retail/drug shops or entrepreneurs to sell PSI/Myanmar products, such as contraceptives and antimalarials, and create a financial incentive for them to refer complicated cases to the nearest SQH clinic. These providers would self-select as those motivated to sell a wide variety of products, and PSI would simply supply them with additional subsidized products from which they could sell at an affordable price, but still generate a modest profit. Thinking along these same lines, PSI/Myanmar leadership now envisioned a broader network of existing retail outlets and individual retail sellers – akin to the well-known commercial Avon model. The recruited retailers would sell PSI commodities, but would also offer an array of other commodities in small packages, such as soap, toothpaste, shampoo and sanitary pads, which would be useful to clients but also attract additional income and provide a reason for frequent visits to clients. A similar approach had been implemented elsewhere, such as LivingGoods in Uganda, often

referred to as "micro-franchising." A key difference in this model to that of the existing SPH network would be PSI's role as a supplier of commodities, and a reduced need for the complex structure of monitoring and incentives required by community health workers.

With this alternative model, PSI/Myanmar could expect modest impacts in family planning, diarrhea, clean water, and malaria prevention. Additionally, with providers now motivated to visit clients in their communities at regular intervals, a stronger SUN network referral and counseling network could be developed. Because these entrepreneurs would have a more diverse array of products to sell, incentives from PSI would not be necessary. With fewer oversight needs, field staffing could be streamlined to avoid redundancy and to save money. The biggest challenges would be establishing a reliable supply chain to reach rural providers and finding a way to ensure that referrals to the SUN network continued and increased.

Decision time

Now, sitting in that conference room, it was decision time. Dr. Min Zaw turned the questions over in his head and composed a list of pros and cons for the micro-franchising model:

Would the savings on Field Leaders be greater than the costs to manage this more extensive supply chain? What level of quality could they expect without Field Leaders? Would patients with the greatest health need be the ones to receive attention in the new profit-driven model? How would the volume of treatment in each disease area shift and how would referrals for difficult cases be managed? And if there really was demand for these products and they were not difficult to supply, why hadn't the private sector worked out a solution already? Why do we think PSI will do a better job at distributing these products – and should PSI/Myanmar even be in the business of selling soap? Is this a justifiable use of donor subsidies?

If they did ultimately decide to implement this new micro-franchising model, other pragmatic operation questions arose as well. Should these recruits be existing small shops, or should they be traveling freelance sellers who could move between communities? How should PSI/Myanmar balance its interest in pursuing a business-oriented model focused on sustainability, versus an emphasis on quality healthcare, which might arguably involve a more programmatic (SPH-style) approach?

Min Zaw set out to think through the issues and unknowns, jotting down a list of these questions and others, as well as a table of pros and cons for each model, on the yellow-pad in front of him (see Table 4).

With the government MOU signed, and political changes opening Myanmar to the outside world, new opportunities for funding were available, but there were other NGOs now competing for support, and if PSI couldn't propose a convincing way to reach rural populations in need of healthcare using private-market methods, another organization would. This funding program would be a great opportunity to boost PSI/Myanmar's rural healthcare operations, but it was an all or nothing decision: Dr. Min Zaw had to choose between either going after the funding for micro-franchising or continuing with the tried and true SPH model – PSI/Myanmar could not justifiably operate two parallel rural networks.

The American Donors had been in town for a week talking to all the candidate organizations. These donors had been to the field and knew both the SQH and the SPH programs. Tomorrow afternoon PSI/Myanmar had an opportunity to make a final presentation and had to decide whether to propose micro-franchising or try to make a pitch for continued funding of SPH. Dr. Min Zaw had to present his proposal to PSI/Myanmar leadership first thing in the morning.

As the office emptied, Dr. Min Zaw kept going over his list of issues again and again. Finally, as the evening lights illuminated Shwedagon Pagoda in the window behind him, Dr. Min Zaw made his decision and began setting out his argument.

Table 1: Points allocated for each service delivered by a SPH provider; used to calculate bonus payments each month

Treatment Area	Points/Unit
Suspected TB case referral	10
Registered TB case	20
RH referral	20
Pill sale	2
Condom sale	2
Malaria RDT tested	5
Treated with ACT	5
Pneumonia treated	10
OraSel Kit	2
Any other referral	5

Table 2: Incentive structure and payments from PSI to SPH providers

* No more than 60 points can come from one treatment area

Total Points/month in all treatment areas combined *	Incentive	Percentage of SPH providers who achieved this incentive level during the first quarter of 2010
>= 75	15,000 kyat	20%
>= 100	20,000 kyat	33%
>= 125	25,000 kyat	26%

Table 3: SQH and SPH providers, PSI Field Officers, and Health Impact Units 2001–2010

	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Number of SQH	73	124	331	467	559	707	797	879	1006	1169
Number of SPH	-	-	-	-	-	-	-	137	741	858
Field Officers	2	5	9	13	16	19	23	42	65	57
Total Health Impact Units (HIU)	119	665	3,732	14,338	28,508	45,578	52,415	5,6408	81,848	31,905
Total HIUs/ Field Officer	60	133	415	1,103	1,782	2,399	2,279	1,343	1,259	560

Table 4: Min Zaw's blank pros and cons table by category for SPH and micro-franchising models

	Sun Primary Health		Micro-franchising	
	Pros	Cons	Pros	Cons
PSI/Myanmar staff costs				
PSI/Myanmar supply chain costs				
Quality of service/ care				
Health impact				
Government cooperation				
Referrals to SQH clinics				
Logistics/ operational considerations				
Other factors				

Figure 1: The Social Franchising Model

Social Franchises *are private clinical provider networks that receive training, branding and technical support by the Franchisor organization, and in turn agree to quality, pricing and other healthcare service standards.*

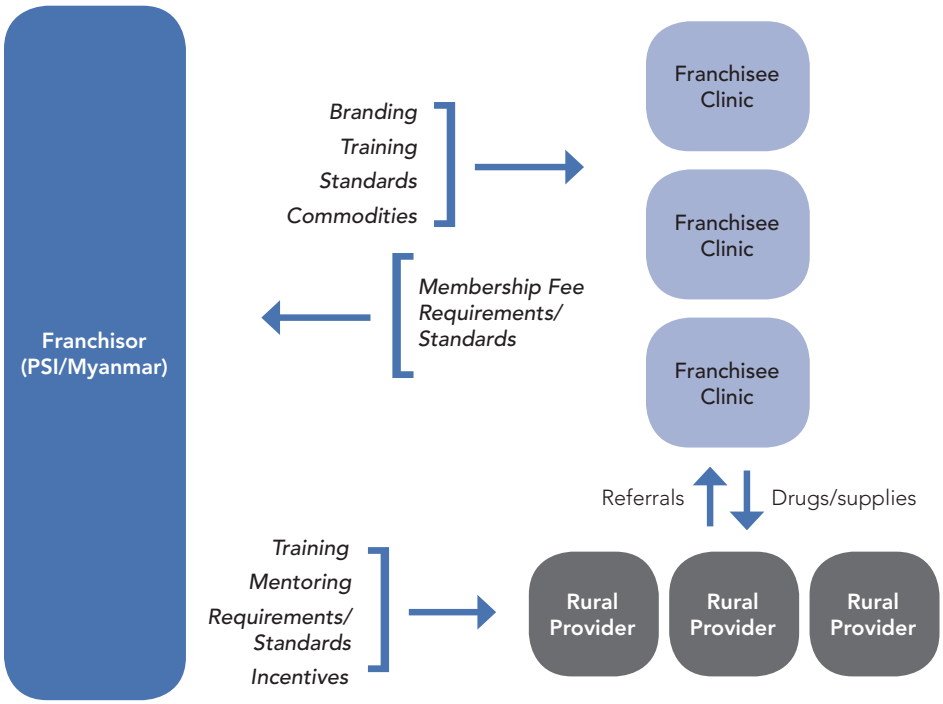
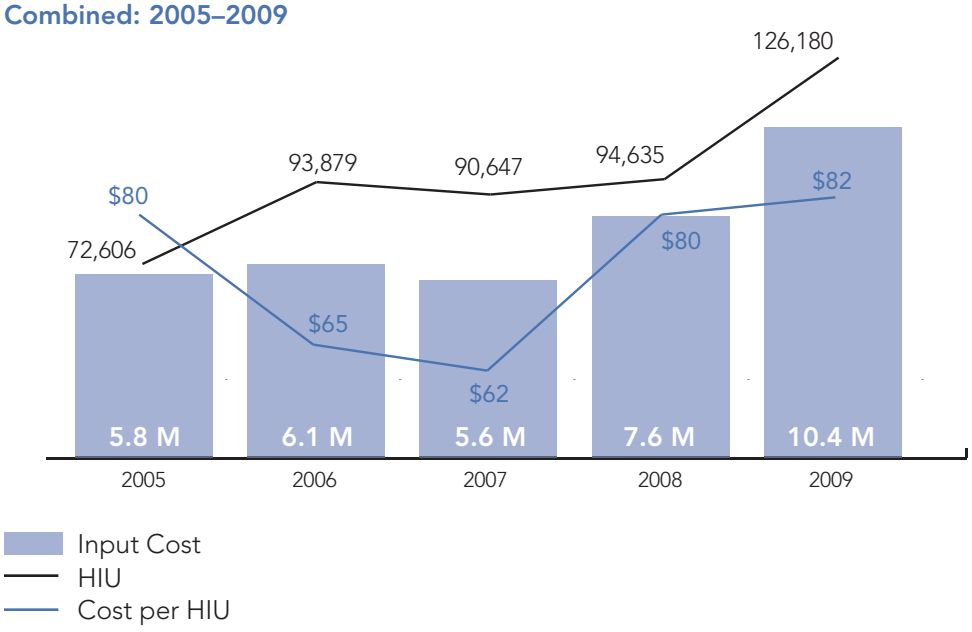


Figure 2: Program Cost and Cost Per Health Impact Unit, SQH and SPH Combined: 2005–2009



Questions

1. Complete Dr. Min Zaw's list of pros and cons (table 4).

2. Should Dr. Min Zaw apply for funding to immediately create the Micro-franchising program and begin to replace the SPH program with this more commercial model? On what grounds should he make this decision?

If yes:

A. Summarize the argument he should make to PSI/Myanmar Country Director first thing in the morning.

B. Who should be the target recruits for the program?

C. What should or should not be on the list of goods supplied to micro-franchi sees? Should there be any requirements or quotas for what they purchase and/or sell?

D. How would you design the incentive structure to motivate sellers to refer clients to SQH clinics for TB, IUDs and other issues currently addressed by SQH providers?

E. What level of quality is it reasonable to expect from the Micro-franchising recruits? Should there be quality-related incentives or penalties involved?

If no:

A. Summarize the argument Dr. Min Zaw should make to PSI/Myanmar Country Director first thing in the morning.

B. What changes could Dr. Min Zaw make to create more efficiency and lower monitoring costs in the SPH program?