LARCS AND PM IN SOCIAL FRANCHISING: *TOWARD AN UNDERSTANDING OF SUCCESS*

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May 19, 2014

LA/PM Community of Practice Technical Consultation

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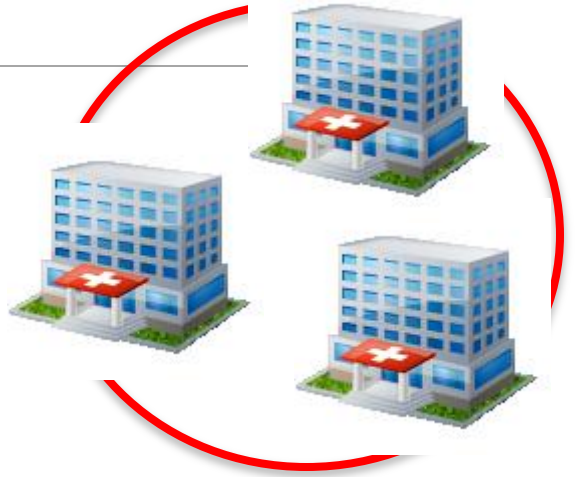
Outline

- Defining success
  - Metrics Working Group perspective
- What is known about franchising?
  - Overview of research
- Evidence of success
  - Scale of LARC and PM work

Social Franchising

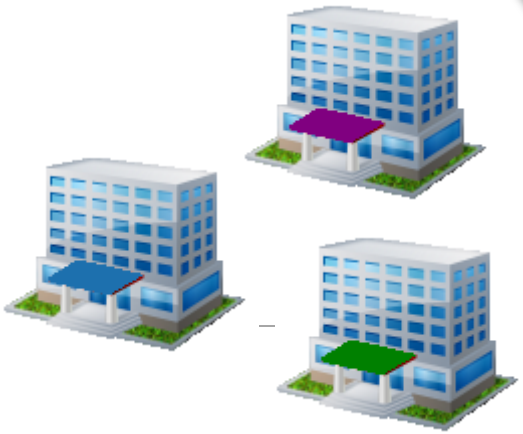


Branding

Training

Standards

Commodities



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Social Franchising - Goals

Health Impact	Improving population health
Quality	Ensuring adherence to clinical standards for client care
Cost-Effectiveness	Providing services at equal or lower cost to alternatives
Equity	Enabling the poorest to access services
Market Expansion	Delivering services that would not otherwise be provided

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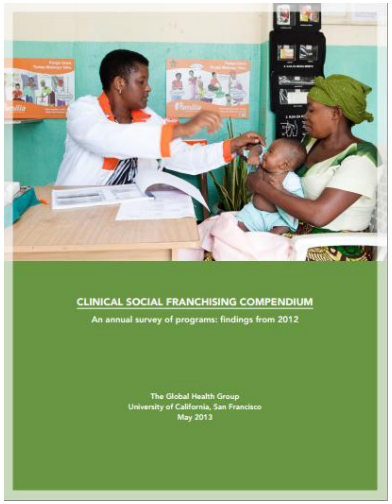
What We Do

- **Purpose of the group**
  - Standardize, systematize (and simplify, where possible) metrics for performance in key areas of social franchising with a focus on health services
  - Develop technical assistance materials to support programs to put metrics into practice
- **Goals**
  - Evaluate the effectiveness of social franchising by making comparisons across key metrics
  - Provide evidence for management-level decision making
- **Audience**
  - Primary: social franchisors, bilateral donors
  - Secondary: social franchisors to-be, multi-lateral donors, policy makers



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Health Impact

- **Goal:** Improve population health
- **Definition:** A summary of health benefits resulting from avoiding a disease or unintended pregnancy
- **Metric:** DALYs averted
- **Tools:**
  - PSI is adjusting DALY calculator for use in 2014 – will be posted to www.sf4health.org

HEALTH IMPACT

improving population health

Metric: Disability-Adjusted Life Years (DALYs) averted

Purpose of this briefing note: This is a call to action for all social franchise programs to measure health impact using a standardized measurement approach.

Intended audience: Individuals who implement, research, fund or partner with social franchise programs that provide health services.

BACKGROUND

Social franchising is a model for organizing networks of private providers that deliver quality-monitored health services known to improve health or avert disease or disability. There are at least 74 social franchises offering health services in 40 countries.

There is a tested and robust approach to health impact measurement that can inform decision making processes. The Social Franchising Metrics Working Group presents this approach in this document.

Health impact is one of five essential goals put forward by the Social Franchising Metrics Working Group. To learn more, visit SF4health.org

Why measure health impact?
Measuring health impact makes it possible for a program to know if it has achieved what it set out to do: improve population health.

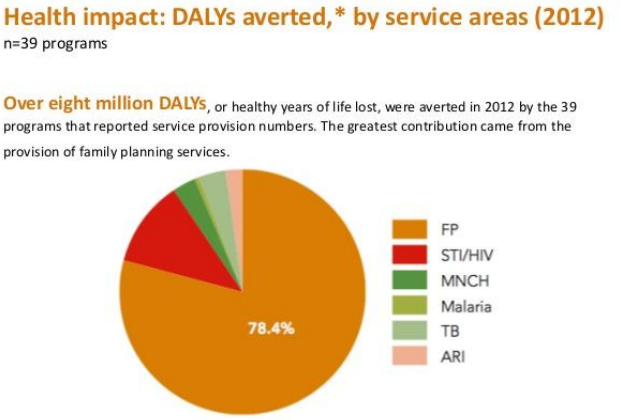
Outputs like clients served and services used are often measured and tracked by programs. However, clients served does not tell the broader story of how many clients successfully completed services. Services used does not take into account the varying degrees of health benefits provided by different types of health services and commodities. Health impact measurement is a more robust way of estimating the public health value of a program. Measuring health impact is also an important precursor for understanding the cost-effectiveness of a program.

Why measure health impact using a standardized metric?
Consistent use of the same metric will permit comparison across years, and across programs. This type of analysis can lead to better programmatic decision making.

How can health impact be measured?
Most programs maintain records of how many health services (including referrals and diagnostic tests) and commodities are provided in a given year. These statistics can be run through a mathematical model, which attaches a country-specific coefficient (or estimate of health impact per unit of intervention) to each item. Each coefficient is based on assumptions of the health benefits provided by a particular health service or commodity within a given country. Results are expressed in the form of Disability-Adjusted Life Years (DALYs) averted. This is a summary estimate of health benefits resulting from treating an illness or avoiding unplanned pregnancies or a disease. One DALY averted means that the services provided by a franchise resulted in a year of healthy life saved.

DALYs averted takes into account the wide range of services that are now offered by social franchise programs, unlike Couple Years of Protection (CYPs), which measure the impact of family planning services and commodities only.

Are there resources to support you in measuring health impact?
Yes! The Population Services International (PSI) Health Impact Calculator



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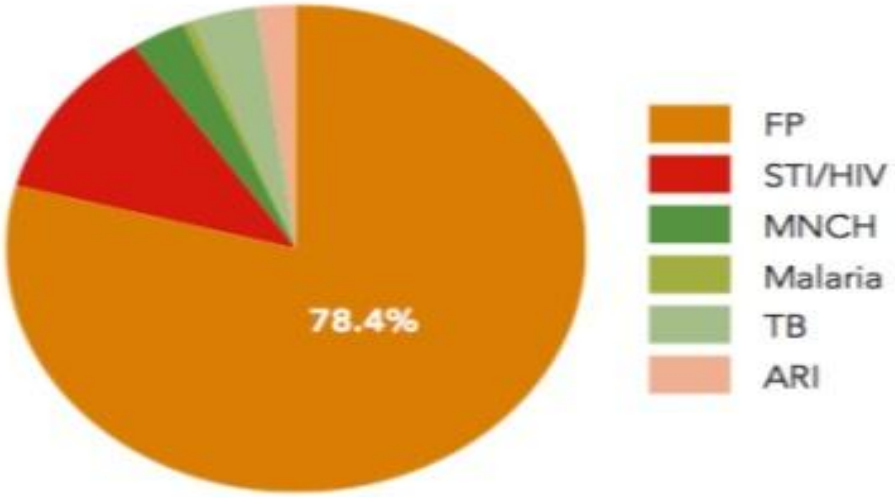
Health Impact

Health impact: DALYs averted,* by service areas (2012)

n=39 programs

Over eight million DALYs, or healthy years of life lost, were averted in 2012 by the 39 programs that reported service provision numbers. The greatest contribution came from the provision of family planning services.



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Cost-Effectiveness

- **Goal:** Provide services at equal or lower cost to the alternatives
- **Definition:** Organizational cost for delivering a service by health impact
- **Metric:** Cost/DALY
- **Tools:**
  - Costing guidance available on www.sf4health.org

COST-EFFECTIVENESS

achieving impact at an equal or lower cost to other sources of care

Metric: Cost (to the franchisor) per Disability Adjusted Life Years (DALYs) averted

Purpose of this briefing note: This is a call to action for all social franchise programs to measure cost-effectiveness using a standardized measurement approach.

Intended audience: Individuals who implement, research, fund or partner with social franchise programs that provide health services.

BACKGROUND

Social franchising is a model for organizing networks of private providers that deliver quality-monitored health services known to improve health or avert disease or disability. There are at least 74 social franchises offering health services in 40 countries.

There is no universally accepted standard measure for calculating cost. The Social Franchising Metrics Working Group responds to this need by presenting a validated and feasible approach.

Cost-effectiveness is one of five essential goals put forward by the Social Franchising Metrics Working Group. To learn more, visit SF4Health.org

Why measure cost?
Calculating the actual cost of running a social franchise program can help managers track how many resources are invested in operations over time, and with what results.

This is a departure from the commonly used method of estimating cost-effectiveness by calculating the ratio of donor contributions to program outputs. As programs decrease reliance on donor funds, this method of calculation is becoming less meaningful.

Why measure cost using a standardized metric?
Consistent use of the same metric will permit comparison across years, and across programs. This type of analysis can lead to better programmatic decision making.

How can cost be measured?
By adding up the direct and support costs of running a franchise program. This includes all costs associated with: administering a franchise program, any subsidies for health commodities, and any technical assistance or administrative support provided by a headquarters office.

Are there resources to support you in measuring cost-effectiveness?
Yes! Cost-effectiveness is calculated by dividing cost by health impact. This document provides guidance on how to calculate cost. Visit SF4Thehealth.org to learn how to calculate health impact using the metric of DALYs averted.

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Quality

- **Goal:** Ensure adherence to clinical standards for client care
- **Definition:** The ability to treat or refer clients with complications, and adherence to overall program protocols
- **Metrics:**
  - % of facilities complying with IP protocols
  - % of facilities with adequate supplies of tracer commodities
  - % of facilities with evidence of ability to treat or refer clients with complications
  - % of providers assessed yearly on adherence to national or global protocols
- **Tools**
  - 3 assessment tools developed
  - Pilot testing underway

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Equity

- **Goal:** Enable the poorest to access services
- **Definition:** The percentage of patients receiving franchised services that are within the lowest two national quintiles
- **Metric:** Wealth Index

- **Tools:**
  - Online toolkit developed
  - www.presentationofdata.com

EQUITY

enabling the poor to access services

Metric: The proportion of clients receiving franchised services who are within the lowest two national wealth quintiles

Purpose of this briefing note: This is a call to action for all social franchise programs to measure equity using a standardized measurement approach.

Intended audience: Individuals who implement, research, fund or partner with social franchise programs that provide health services.

BACKGROUND

Social franchising is a model for organizing networks of private providers that deliver quality-monitored health services known to improve health or avert disease or disability. There are at least 74 social franchises offering health services in 40 countries.

Many programs measure if their health services are reaching the poor or most vulnerable. Many are researching how to do so. The Social Franchising Metrics Working Group responds to this need by presenting a robust, validated and feasible approach to equity measurement.

Equity is one of five essential goals put forward by the inter-agency SF4Health Metrics Working Group. To learn more, visit SF4Health.org

Why measure equity?
Measuring equity makes it possible for a social franchising program to know if it is serving those most in need. In practice, this most often means the poor. While placing service-delivery points in low income neighborhoods and capping prices are critical approaches to encouraging use of health services among the poor, they do not guarantee that the poor are using the services to the degree that is anticipated. Measurement is key.

Few programs have reported on equity in the past. Now, resources for measuring equity are within reach.

Why measure equity using a standardized metric?
Consistent use of the same metric will permit comparison across years, and across programs. This type of analysis can lead to better programmatic decision making.

How can equity be measured?
The Social Franchising Metrics Working (SFMWG) advocates for the use of wealth indices adapted from the Demographic and Health Survey (DHS). The wealth indices measure equity in terms of asset ownership and household characteristics. Using DHS as the source for questions allows for rigorous analysis by sub-populations, useful comparisons within a country context, and comparisons across countries.

Are there resources to support social franchises in measuring equity?
Yes! The SFMWG has developed an Equity Measurement Toolkit, which includes guidance notes, country-specific surveys, a sampling calculator, and a pre-programmed analysis tool. This toolkit is available at SF4Health.org

Interested in learning more about the Equity Measurement Toolkit? The SFMWG will host a webinar in January 2014, free of cost. To learn more, contact SF4Health@ucsf.edu.

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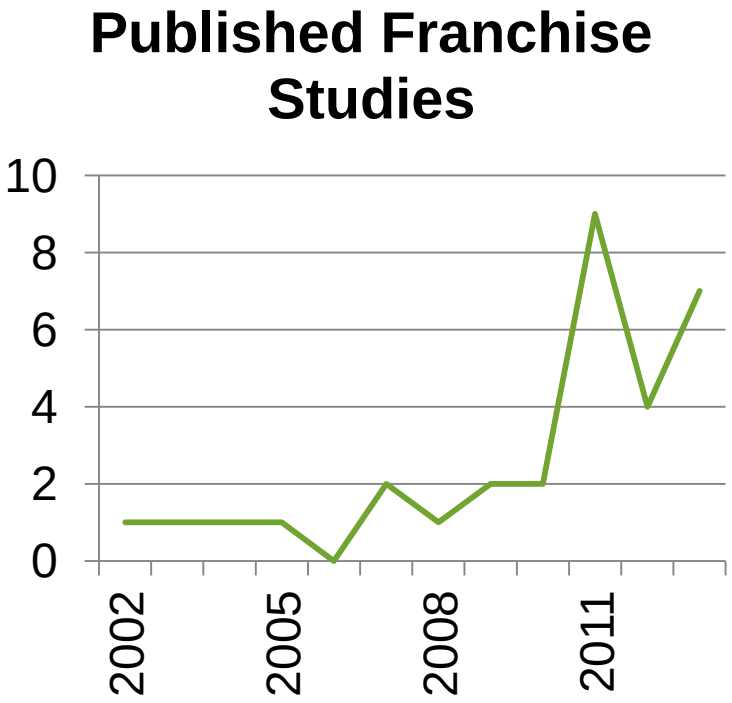
Market Expansion

- **Goal:** Increase access to high quality health care service
- **Definition:** Provide services to patients in need who would otherwise receive lower quality care, delay seeking care, or go without care (preliminary)
- **Metric:** TBD
- **Progress:**
  - Will identify and pilot metric in May 2014

Research on Social Franchising
What do we know?

Franchising Research

- Illustrative search on Pubmed
  - 49 studies with Social Franchise or Social Franchising in title or text
  - 20 studies include substantive text on franchising
- 2 systematic reviews on Social Franchising
  - 2009 Cochrane review found no eligible studies [1]
  - 2013 systematic review found 23 eligible studies [2]
- Studies to date have been primarily cross-sectional or pre-post



Graph based upon illustrative search results

1. Koehlmoos, T.P., Gazi, R., Hossain, S.S., Zaman, K. Cochrane Database of Systematic Reviews 2009
2. Beyeler, N., De La Cruz A., Montagu, D. PLoS ONE 2013

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Review of Franchising Research

- Quality measured by half of studies; only in family planning.
  - Franchised clinics in Pakistan and Ethiopia had higher quality than other private providers, but lower than government clinics.
  - No clear difference in quality of care between franchise and non-franchise in Nepal, greater range of contraceptive choice in India, Ethiopia and Pakistan.
  - Improvements in perceived quality in Vietnam and Myanmar, and in client satisfaction in Vietnam and Nepal.

- Service utilization may be higher for franchises
  - 6 studies found higher total client volume, or increases in client volume after franchising
  - Does not seem to translate into population level effects in health behaviors.

- Few studies have measured equity or cost-effectiveness
  - 3 studies find franchises to serve relatively wealthier clients, while one study in Myanmar found franchises to serve more urban poor.

Source: Beyeler, N., De La Cruz A., Montagu, D., 2013. The impact of clinical social franchising on health services in low- and middle-income countries: A systematic review. PLoS ONE 8(4): e60669.

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Outstanding Research Questions

- Does franchising improve quality provided by existing providers?
- Do franchises serve the poor, or allow for improved equity of service provision in the market?
- Does franchising increase access to services (and particularly sexual and reproductive health services) or shift use from other providers?
- Is franchising cost-effective?
- How do providers benefit from franchising?

Current Franchising Research

- AHME (African Health Markets for Equity)
  - 5 year, 3 country (Ghana, Kenya, Nigeria)
  - Partners: MSI, PSI, SFH; Grameen Foundation; IFC; PharmAccess; Medical Credit Fund; SafeCare
  - Randomized controlled trial, assessing franchising integration, credit, and accreditation
  - Externally evaluated; Main research questions:
    - How effective and cost-effective is the AHME model at improving quality of care, utilization and health outcomes
    - What is the incremental impact of the SafeCare/MCF, ICT interventions and demand-side financing interventions on quality of care, health outcomes, and provider business success

Current Franchising Research

- SIFPO funded study in Kenya with 2 components
  - Population based component is a case-control design comparing households in clusters within the catchment area of a Tunza Social Franchise to households in matched catchment areas without any franchise
    - Does access to franchising improve contraceptive use?
    - Is there any difference is socio-economic status among household seeking care at franchised and non-franchised facilities?
  - Provider component is a 1 year longitudinal study of Tunza providers and control facilities
    - Is there any difference in provider revenue, client volume and case mix among franchised and non-franchised private providers?
  - Conducted by PSI and PS/Kenya

Scale of LARC and PM Services in Franchises

Overall Scale Among Franchises

Figure 8. Health impact: disability-adjusted life years (DALYs) averted, by service areas (2012)

N=38 programs

7 million DALYs, or years of healthy life lost, were averted in 2012 by the 38 programs that reported service provision numbers. The greatest contribution came from the provision of family planning services.

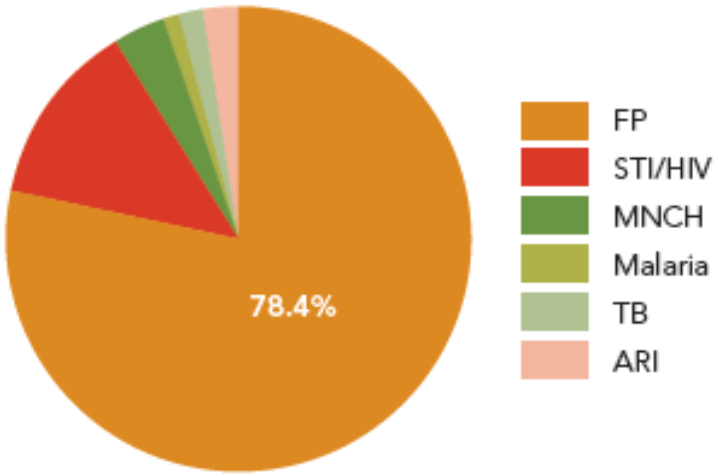
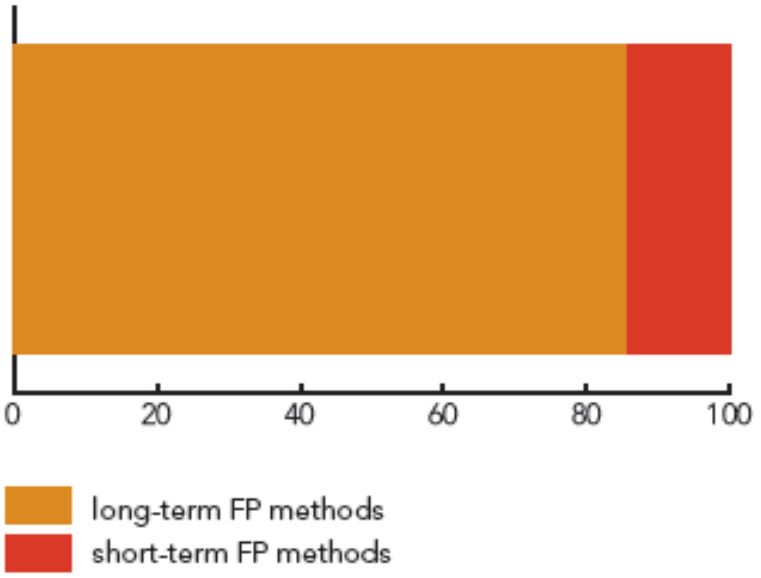


Figure 9. Proportion of FP DALYs averted attributable to long-term FP methods* (2012)

N=38 programs

Long-term family planning methods accounted for nearly 85.5% of the health impact attributable to family planning services.



Source: The Global Health Group (2013). Clinical Social Franchising Compendium: An annual survey of programs: findings from 2012

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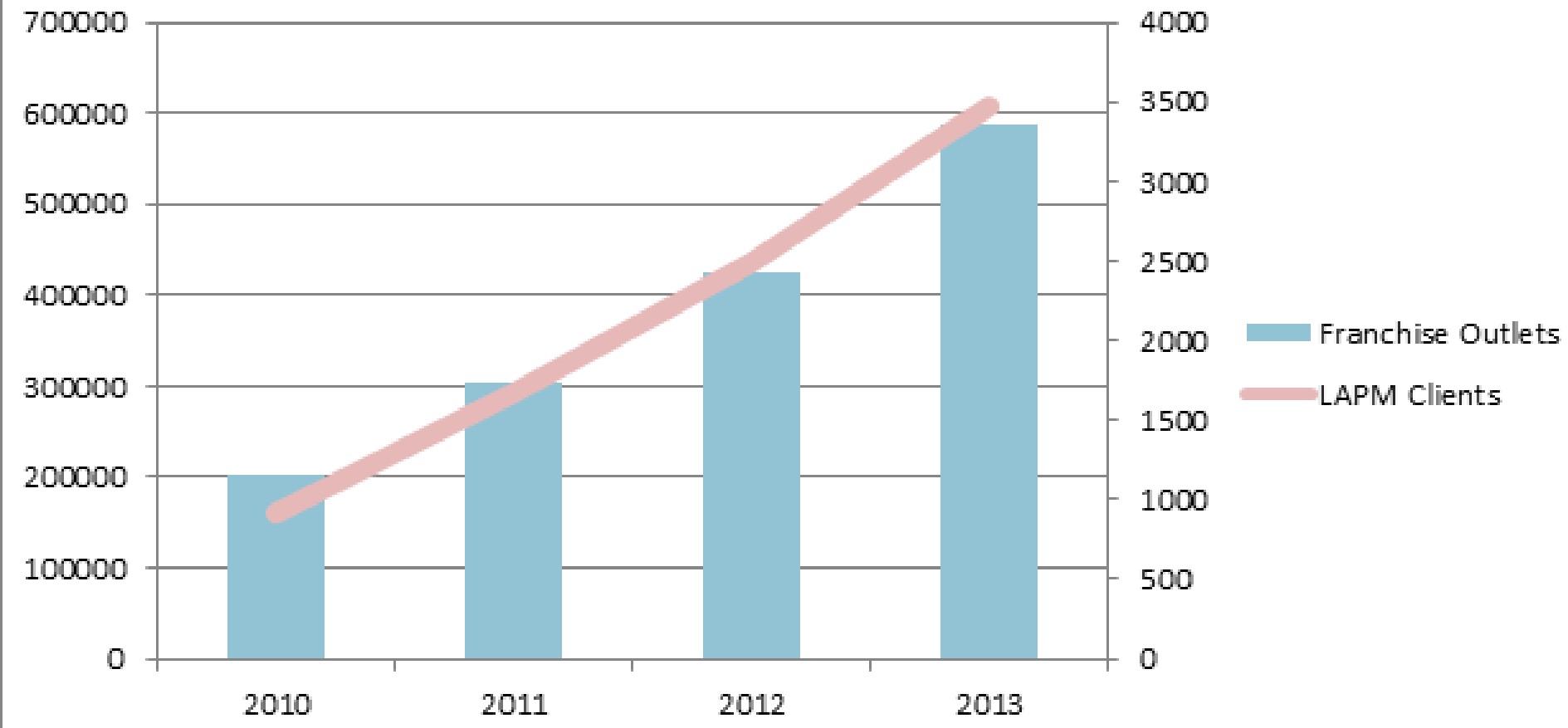
LAPM Clients in MSI Social Franchise Networks



Data specific to LAPM clients in franchised clinics

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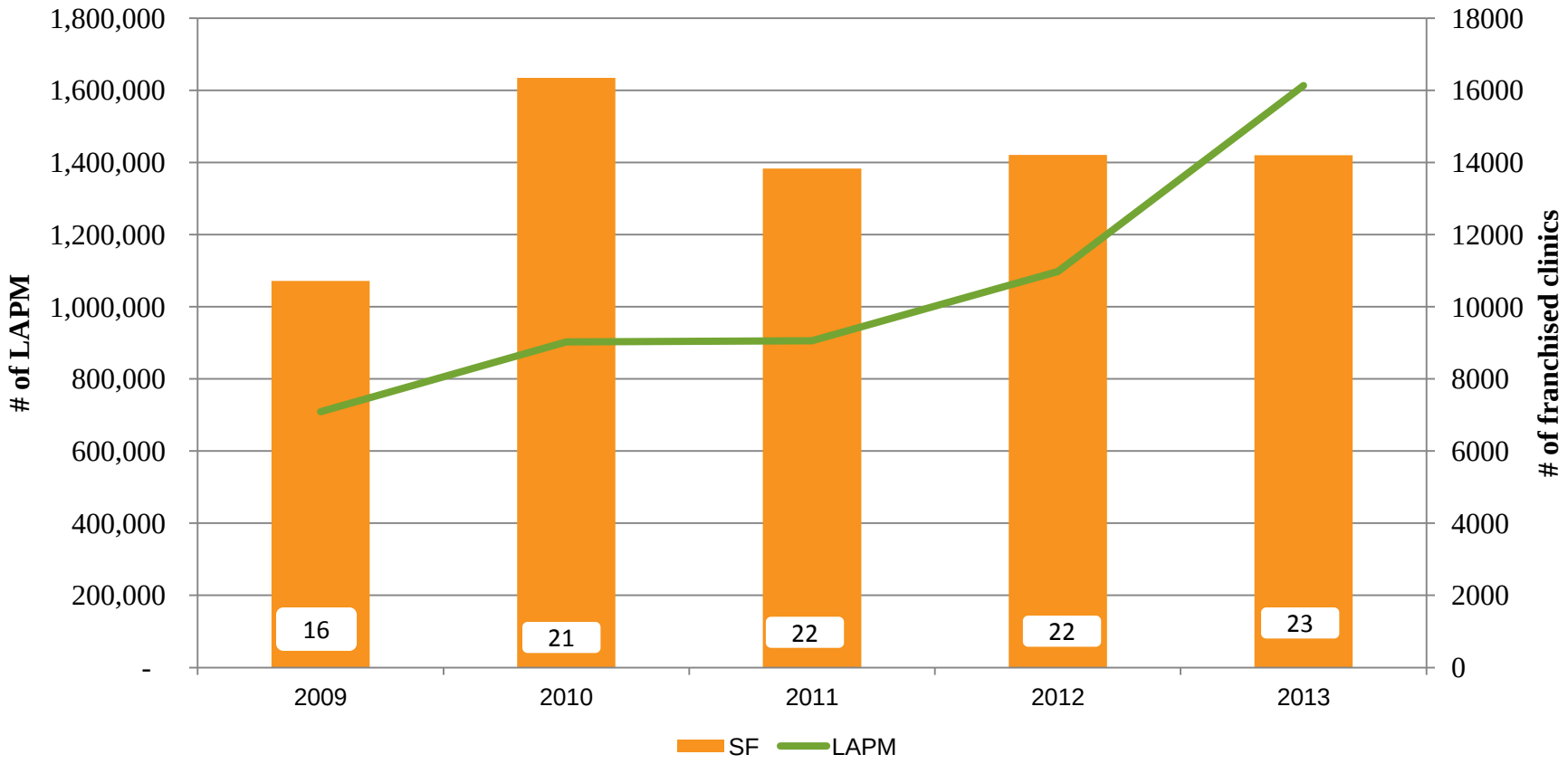
PSI's LAPM services, and franchised clinics, by year



Data for LAPM clients do not necessarily all come from franchised services, due to intricacy of PSI's data capture system.

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THANK YOU!

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