

**MANAGEMENT SCIENCES FOR HEALTH  
SEAM 2001 CONFERENCE: TARGETING IMPROVED ACCESS  
TAPE NO. 2, November 27, 2001**

**DR. DENIS BROUN**

The Potential of Franchising Essential Drugs Outlets

*(Denis Broun, Principal Program Associate and Global Liaison Coordinator, Management Sciences for Health [MSH] Europe)*

MODERATOR: Dr. Denis Broun is currently the head of the new MSH Europe office in Ferny-Voltaire, France, as well as the Principal Program Associate managing both the franchising and Geneva-based technical collaboration work under CPM [Center for Pharmaceutical Management]. Formerly, Denis was Director of the WHO [World Health Organization] Department of Resource Mobilization. Prior to that, he was the Chief of Health at UNICEF [United Nations Children's Fund], and prior to that, he was Senior Health Specialist at the World Bank in charge of vaccines and pharmaceuticals. He's the rare case, an MD with a master's in economics. So he sees both sides of the coin.

BROUN: I had the impression that it was a coin that had more than two sides. I'm going to talk about something a bit more technical to some extent, which is the specific issue of franchising. *[slide 1]* What we're trying to address in franchising is looking at some of the major issues that we have in the pharmaceutical sector, both in the public sector and the private sector. We know that we have major problems that we have to address. I have put a list here. *[slide 2]* They are a bit of a caricature, of course. Anyone could object to any of these items.

But on the whole, we have a real problem, especially in the private sector, on the price of drugs, on the fact that it's only or mostly the rich who are served, that dispensing is not done appropriately, that generic substitution is done the wrong way, and that there is little respect for regulations, especially in developing countries.

So what is the issue here? We think that franchising can help in distributing essential drugs. *[slide 3]* And it's possible to address some of the issues I just listed. The idea would be that the franchise would be a mechanism that would harness the incentives of the private sector and drug distribution toward meeting public health goals.

I'm going to give you a definition that is not exactly the official one. *[slide 4]* I will get back to the official one later. But this is what I'm going to develop and explain regarding how things work for essential drugs. The franchise will be a network of privately owned facilities operating under one single brand, with a uniform operating model. That means that everyone works in the same way, with close supervision and monitoring so that the level of service provided is always high and predictably high. People will have the same level of service anywhere they go, and will be using economies of scale.

Because it's a franchise, it's something that for the private entrepreneur seems to be a safer way to develop business than an individual company. The failure rates, especially in the United States where it is pretty tough to start your own business, are extremely different. People who start a franchise have only a 2 percent failure rate after three years versus 80 percent for individual enterprises.

**MANAGEMENT SCIENCES FOR HEALTH**  
**SEAM 2001 CONFERENCE: TARGETING IMPROVED ACCESS**  
**TAPE NO. 2, November 27, 2001**

It's definitely much more constrained; people lose their freedom when they're working a franchise. But it gives the power of a group where people work in the same way and have the same interests and the same approaches. And franchise means also systematic training.

So now let's get into the official definitions. *[slide 5]* Sometimes people have a mistaken view of a franchise versus a network or a chain. First, the franchise is a contractual relationship between a franchisor and each individual entrepreneur who operates under the franchise. So there has to be a contract.

Second, the operation of the system that the franchisor has is defined. *[slide 6]* The franchisees don't have freedom to do what they want. They accept and adhere to the system. Third, they work under a brand, and this brand is the same for everyone. Finally, there is a financial relationship between the franchisee and the franchisor, and when this relationship doesn't exist, it's not called a franchise. So one of the things one has to understand is that a public sector franchise is not something that is usually possible. It has to be in the private sector with an economic relationship, a financial relationship.

Next, some terminology. *[slide 7]* The franchise is the overall system. It's also the brand. You say McDonald's is the brand of the franchise, and you call it the franchise as well. The franchisee is the person who operates the outlet. The franchisor is the one who manages the whole system. You have intermediary situations where you have master franchisees. I'm not going to develop this explanation any longer as it complicates things for nothing.

Typically, a franchisor would have a system at headquarters where the policy is defined, where things happen. *[slide 8]* Then the franchisor would have a region, which can be in a health care district or country, whatever the franchisor decides is a region. There are supervisors—people who monitor, supervise, and support the business. And then these people interact with the outlets. But each outlet has a contract with the franchisor.

Let me go back to define what a franchise is and explain what this means for the essential drugs model of franchising. It is a privately owned facility. *[slide 9]* We are speaking of franchisees distributing essential drugs and having a direct incentive to the success of the distribution because they make their living off it. These people have locations and opening hours that are convenient to the public. Because otherwise, they don't get customers and they don't make money. So clearly, when we looked at the question of accommodation, the question of geographical success, et cetera, it is what is needed there.

A franchisee who sticks out as someone who is losing customers and is definitely not good for the money—it's not good for the confidence customers may have. So this is also something that has to be done well. One thing that we have seen, especially in the scheme that I will show you later, is that franchisees who operate on a limited list of essential

**MANAGEMENT SCIENCES FOR HEALTH**  
**SEAM 2001 CONFERENCE: TARGETING IMPROVED ACCESS**  
**TAPE NO. 2, November 27, 2001**

drugs have little money and need to be supported to open their franchise. What is useful is to either provide loans or access to micro-credit so that they are able to invest in their franchise. This is not any different than it is in the United States, where there are specific mechanisms for people to invest and buy franchises.

What is the single brand in this case? *[slide 10]* Well, I mean, it's using the fact that in general, and unfortunately, people prefer branded products to products under generic names. So let's use the brand of the franchise rather than a complex set of brand names. Operating under a single brand is also an opportunity to do communications under one single name. We have seen how this works for social marketing. You have all seen such programs. It's also what makes advertising much easier.

This is one of the strong aspects of franchises: when McDonald's makes an advertisement, thousands of outlets benefit from it. It's easy also to repackage drugs and use logos and brand names for recognition by the customers. It's something that strengthens the brand and strengthens the faithfulness of the customer to the system. And finally, the brand is a privilege and if people do not abide by the rules of the franchise, they can lose access to the brand.

When speaking of a single operational model, we mean that all the shops look the same. *[slide 11]* They have the same organization, the same display, and the same system of management. They also have a systematized and standardized list of products, a core list. In any country, you may find differences in epidemiology from one region to another and in the needs of the population from one region to another, so while you must have a standardized core, you may have some small variations. This is allowed actually even in other franchises. McDonald's would have chicken in some areas. They would have pork in some other area, but not in Israel, for instance.

Service orientation is something that is provided by the essential franchise. It's enforcing good dispensing practice, and this is something that a franchise can do that is difficult to do otherwise. Definitely the same management system—the same system for reporting sales, for monitoring patients, for managing staff, for refilling; the same ledgers. And then one thing that can be done in a franchise, which is usually not done, is that you can have all the prices displayed. There is no surprise. Of course, if you have hyperinflation, it may be difficult.

Now, one of the problems we have with regulations in many developing countries is that they exist on paper but are not enforced. With a franchise, they are enforced, and there is muscle behind the regulations, behind the supervision. *[slide 12]* People can lose their business. So there's a big difference between supervision under the franchise business and under the public sector.

Drug outlets are inspected. They are monitored. This is why there is a regional facility that does the supervision. There's a central quality-control system. This is something that can be operated in a franchise that cannot be operated in single pharmacies or single

**MANAGEMENT SCIENCES FOR HEALTH**  
**SEAM 2001 CONFERENCE: TARGETING IMPROVED ACCESS**  
**TAPE NO. 2, November 27, 2001**

outlets. It would be far too costly. And also, only the drugs that have been agreed on, from the sources that have been agreed upon, are sold in the franchise. You cannot have spurious or fake drugs because the business depends on the central procurement of the franchise.

There are sanctions, and they are real. The level of service that you want to arrive at actually is very close to the goal of the supervision. *[slide 13]* You want to get into more than just selling drugs, but really getting a public health value added. That means the service that goes with it. Patients are helped in their language. They have product names. Franchisees have to take the time to give the information on dosages and side effects. There is patient information recorded. This is something that is essential. In Kenya, for instance, each patient contact is recorded, and this creates a database that is extremely useful for public health in general—when you remember that most of the first contacts with the health system are made through drug shops in most developing countries.

The franchise organizes the interaction of the health system—that means the public sector—with the local health authorities. It is possible to do things that outlets operating in isolation couldn't do, like participation in large public health initiatives. And this had been the case in Kenya, for instance, where we speak of de-worming, which has been provided.

Economies of scale is something that is possible to do in any network. *[slide 14]* The franchise is one example. Procurement is another—vendor agreements where you have contracts for the organization of logistics to deliver drugs to the various outlets. With pharmaceutical benefit management systems, it's much easier to contract with insurance companies or with large private sector companies for delivering pharmaceutical care when you have a network of franchise facilities than when you operate alone. Information technology is definitely easier when it's shared. In specific packaging, when you are a single pharmacy, you are not going to package a new brand. When you have a franchise, you can do that using economies of scale.

It is expensive to train people and to develop specific training mechanisms. *[slide 15]* However, you can do that if you are going to use the training several times. Otherwise, it's not a cost that can be easily swallowed. You can have sophisticated logistics. You can also gather statistics that make sense in public health when you have the whole network, and these contribute to public health programs.

A couple of things are important because one wonders what is possible to achieve in a franchise that cannot be achieved elsewhere. And why should people stay there? And there's one thing that is interesting—when you have this rigid system of supervision and monitoring, what is the change process? McDonald's is a good example. It takes three years to get a new sandwich on the market. So it is true a franchise is something that reacts at an appropriate pace, which is a rather slow one. But it's generally safer in the drug sector. The initiative can come from just about anyone; any franchisee can say, "Hey, why don't we distribute this product?" *[slide 16]* But the final word is always with

**MANAGEMENT SCIENCES FOR HEALTH**  
**SEAM 2001 CONFERENCE: TARGETING IMPROVED ACCESS**  
**TAPE NO. 2, November 27, 2001**

the franchisor, who decides if this is going to get into the procurement mechanism, if it's indeed going to be distributed. Changes cannot be implemented by franchisees in isolation. This would be contrary to the franchise rules. But once the change has been done, then it's undertaken by all. Think of change in standard treatment guidelines, which is so difficult. When you have trained people district by district, they go back to their old habits if you don't give them booster shots of training, and in a franchise, it's much easier. Once you have your training done, then people implement it, all of them. And the whole network gets into this system. So the change process for a franchise is rather useful in essential drugs.

Why should people join a franchise? We have found that access to training is something that is a very strong incentive. Most of the people who distribute drugs have no training or very little training. Providing them with high-level training, giving them the possibility to be a service and not only sell drugs, is something they value.

Second, being sure that the drugs are high quality—actually, even with questionable ethics, people are not often happy distributing fake drugs. I mean, if they are sure that the drugs they are going to distribute are of good quality, on the whole, they prefer it. We have found that in several countries, small outlets for drugs had no access to logistics. That means people take a bus, walk, whatever, bike, go to the capital, go around to the various wholesalers, try to buy some drugs and take them back. It's an extremely inefficient way of supplying your store. So if you can have logistics that work, it's definitely a very important asset.

Getting support for management, being able to know how your stock would be managed and how you count your stock, having access to credit because you have credibility for it on record—all this is something the franchise can provide that you don't get otherwise. And surprisingly maybe, although I describe it as something a bit dictatorial, supervision is considered a very strong plus. In Kenya, it's not only supervision. It's also boosting the morale. These people who distribute drugs are alone. And having people who come and help answer their questions, et cetera, is something that is highly valued.

Another question is, why stay in a franchise? *[slide 17]* Once you have been trained on a network and have your clientele, why should you stay in it? After all, some people might say, "Well, I have taken advantage of it. I might get out." What is important is despite all the constraints, business grows, and it grows better and actually survives better than other businesses, and they know it. The fact that franchises provide some safety in business is something important.

The population recognizes a brand. The service is valued. It is recognized that in the population in general, people are happy to be recognized in their community. Something that supervision provides is answers. When people have problems, they can try to find their own solutions, or they can rely on the support they have in the franchise. And this is something they like. *[slide 18]*

**MANAGEMENT SCIENCES FOR HEALTH**  
**SEAM 2001 CONFERENCE: TARGETING IMPROVED ACCESS**  
**TAPE NO. 2, November 27, 2001**

And in the end, losing the brand is very costly. When you start losing access to the cheap, high-quality drugs, start losing access to the logistics, and when you no longer have management support when you're in trouble because you have forgotten to buy something or you have overexpended, then you see that the costs can be much, much worse than the small advantages you would get by getting out. And this is something that is a rather strong incentive.

This is not purely speculative. There has been a use of franchising in the drug sector. *[slide 19]* Cry for the World (CFW) Foundation [now the Sustainable Healthcare Enterprise Foundation] has a network of franchises in Kenya that MSH supports. I'm going to show you some elements of it. But it also exists in branded brands. The Medicine Shoppe in the United States has a very large franchise that has expanded to other countries. I think they're in the Philippines. They're in Malaysia. They're in Taiwan. And they lately have come into poor countries like India. Medipharm in Korea has 1,200 outlets. It's one of the largest franchises in Asia. But it has gone beyond that. In family planning supplies, you have the Green Star Network, although it's not exactly a franchise because there is no payment of a franchise fee. And there have been a lot of other experiments to use franchises for distributing family planning supplies and reproductive health supplies. There have been other initiatives. I think of the ones in Mexico and various African countries with various successes. I think FriendlyCare by far is the one that's done the best. In a large way, one of the main problems with a franchise is cash flow. You have to be very careful when you start it to have the cash flow.

The CFW shops in Kenya are all alike, all the same brand, painted the same way—small shops, but serving the needs of the population. *[slide 20]* Now, what do we know about financing so far—for a limited list of 25 to 85 drugs, more or less? *[slide 21]* And we're speaking here of things that are not managed by a pharmacist. The investment including the first stock, including all the painting, display, et cetera, is about \$1,500. It actually can be a little less. Each outlet becomes profitable in less than two or three years. What does that mean, less than two to three years? It depends on how much people had to borrow. The amount they have to reimburse is one of the major burdens on their profitability. If they didn't have to borrow a lot, if they had a rather cheaper investment, they are profitable in less than two years. In three years, they're all able to make it.

What is important is having this whole network with headquarters and regional facilities. This is more difficult and expensive. What we have found is that the way to get into balance is to have a large number of outlets. Because each outlet pays a franchise fee, your costs for logistics and supervision get divided when you get more outlets. When you have 100 or 200 outlets operating, costs go down. Once again, it depends on the size of your headquarters. It depends on the expenses you have there. Normally, you arrive at financial sustainability within five years.

What are the limitations of franchises? *[slide 22]* They are not the answer to every problem. First, when you have a limited drug inventory, you have a limited list of drugs, and this limited list is a regulation by the government. Most people don't respect it. I

**MANAGEMENT SCIENCES FOR HEALTH**  
**SEAM 2001 CONFERENCE: TARGETING IMPROVED ACCESS**  
**TAPE NO. 2, November 27, 2001**

mean, in Ghana, we had interesting findings: antibiotics in about any chemical shop, although they are not supposed to distribute them. When you are operating a franchise, you are highly visible. You have an interaction with the government, and you have to respect the law. So, one of the problems is indeed that you have a smaller list of drugs than you would want to really cover public health needs. This is one of the limitations, and it's important to know it. What we're doing in Kenya with CFW is trying to see how, instead of having people with very little training, community health workers can distribute drugs. We could do that with nurses. And this is the next step—nurses having a much larger list of drugs than they can handle.

On the affordability side, you distribute essential drugs, generic form, procured through central procurement tenders. So you have cheap prices, but it's not the cheapest possible price. You have to have a level of margin that guarantees that your shop is going to survive. You cannot sell the franchise to people who are going to go bankrupt because the margin they are making is too small. So you don't have rock-bottom prices. You don't have free drugs. This is one of the limitations. The fifth quintile, the people with no cash available, people who are living in absolute poverty have to be supported by other financing mechanisms. And what is impressive with the franchise is, because of its very strong record keeping, it can be a partner with any government or insurance scheme because it can provide justifications for every expense. But it cannot finance the drugs for the poorest.

Another limit is due to geographic accessibility. People have to have a population base that allows the shop to work. If you have 300 people around a small pharmacy shop, there's no way you can have enough business. You need 1,500, 2,000, 3,000. It depends on your list of drugs and the population base to be sustainable. It doesn't work for extremely scattered populations in remote areas, so there another type of system is necessary.

And finally, you say you should have good dispensing. You should have appropriate use. Sometimes it's not exactly what the population wants. It's true you have populations saying, "Hey, I want injections." And you say, "It's not what is appropriate." Or they say, "I want to buy one tablet of Fansidar because I can't pay for three." But this is not what should be sold, so sometimes you are not doing exactly what the population would want. It's part of the educational role, but it's true you're losing some sales to it.

This is an example of a CFW shop. *[slide 23]* A couple of features are interesting in the layout of CFW shops. The patient sits in front of the manager. There's no counter. There's no barrier. It's kind of a respectful relationship and kind of an equal-to-equal relationship, which people value quite a lot. All of the drugs are displayed.

What is really important is that franchisees have to keep books of every encounter. What's important is the notation of the \$30 to \$40 a month left after the drugs are bought, the loan has been repaid, and so on. This is what the franchisee's net income is, and this is what allows the franchisee to live and live well. He or she is considered a person with

**MANAGEMENT SCIENCES FOR HEALTH**  
**SEAM 2001 CONFERENCE: TARGETING IMPROVED ACCESS**  
**TAPE NO. 2, November 27, 2001**

some notoriety in the village, someone who thinks that they are doing well. It's important that people relate the income that they can expect to the population where they're living. This has been one of the major obstacles we have had with some pharmacists who expect some type of Western income in southern countries. And this is one of the reasons why these franchises can do so well if they're adapted to what people need and what they can pay for.

MODERATOR: It looks like we have actually 10, 15 minutes for questions or comments before a break is scheduled. I'll just start off with one comment myself actually. When we were talking about limitations, there was no limitation mentioned for quality, but I'd like to propose one. In fact, as Denis pointed out, having monitoring and supervision is the only way this franchise works. The only thing that holds it together is effective monitoring, supervision, and enforcement of rules. The fact of the matter is that the burden gets higher, the more outlets you have and the more expenses you incur. So I think this is still an experiment, and it remains to be seen whether one can actually enforce franchise rules and standards in a network of any real size such as this. It's one of the things we're hoping to investigate.

Q: I am Dr. Louis Teulières from the French Pharmaceutical Industry Association. My question is about the relationship and negotiation you may have had with the pharmaceutical industry, because branded generics are more often used. And I wonder, during your negotiations with the generic manufacturers, did they accept or are they accepting very easily to see the brand name disappear? Or do they find some kind of advantage in participating to serve some quintiles of the market you were mentioning. So I would like to hear how it worked. What is your experience with that?

And do you—a second question and that's all. One of the public health benefits or good actions you could make is perhaps training the people in prescribing generic or DCI [*dénominations communes internationales*] drugs. I'm sorry if I say it in the wrong way. But did you participate in such action, also? Thank you.

BROUN: Well, Louis, it's embarrassing, as it was in the UN sometimes—you take a question from a Frenchman in English and you have to answer in English as well. And I know that if the French ambassador were here, we would be in trouble, both of us. There are two answers. In negotiation with the pharmaceutical industry, you have two things. First is in Kenya, where we use a central procurement agency to buy drugs by tender or we use pharmaceutical companies operating in Kenya that participate in these standards. So it's one of the ways in which we do not have to negotiate directly. Now, it doesn't mean there is no direct negotiation. There is indeed a negotiation in which several manufacturers who operate in Kenya—they are local manufacturers that have pretty high-quality drugs, although not always the highest level. The negotiation with them has not meant the disappearance of the brand. It's manufactured for CFW with the logo by Cosmos. I mean, people still have to have their brand there. It is still their responsibility that the quality of the drug is assured. So their brand does not disappear. It is, I think, what Jim would call cobranding, although it's not exactly the same thing.

**MANAGEMENT SCIENCES FOR HEALTH**  
**SEAM 2001 CONFERENCE: TARGETING IMPROVED ACCESS**  
**TAPE NO. 2, November 27, 2001**

Training of prescribers—indeed, this is something important. We are talking here of a very limited list of drugs. I mean, I think it's 25 drugs. And you have to see also that most people come to these outlets without a prescription. It's usually the first line of contact with health care. But we have prescriptions that have to be bought in the CFW stores in Kenya, and these prescriptions have been given in the public sector in general, because unfortunately access to drugs in the public sector is pretty limited in Kenya. And they are under generic names. There has been quite a lot of work on that. In general, they tend to prescribe generics, but there's still a very long way to go there. As you know, when there is the authorization to substitute product, the dispenser must have full knowledge of the equivalences, and it's not always the case. So indeed, helping prescribers to prescribe generics is something important.

Q: Thank you. Al Bartlett from USAID. First, I would say that I certainly applaud both of these presentations and these efforts. I think that they represent the sort of attempt to operationalize what was written in *World Health Report 2000* of a health system that includes both public and private sector components, but that isn't that easy to operationalize. So we need to learn a lot from them. That said, two questions—one for either or both Denis and Jaime Galvez Tan, and the second one for Denis. First, both of you talked about a three- to five-year time lag to profitability. And it could, looking at some of the current practices, even be longer. That's a relatively long time. And I take it that in the developing world venture capital is not that easy to come by. So the implications of that for implementing these approaches at scale seem to me implications that would fall on some sort of subsidy or indemnification, either from donors or from governments themselves. And I wonder how you think that would play out as these experiments attempt to scale up.

Second, for Denis, particularly when you're talking about Kenya, and your last comments just made it even clearer, in many cases the drug provider is the first point of contact because the public sector is skipped because they don't have drugs. That makes them de facto health care providers, and I wonder what the implications of that are because you're not talking about them as health care providers. You're talking about them as drug providers, but they're really care providers. And what does that imply? Again, in terms of regulatory and medical, public health factors.

GALVEZ TAN: Yes, regarding the three- to five-year lag for profitability, in my discussion with several businesspeople, it depends on the business. And it looks like some businesses in the Philippines, even restaurants or hotels or resorts or similar things or even transportation, they really take that long for a full recovery of investment. What I'm trying to say is this comes from large businesses and they're willing to wait five years for the full recovery. But, of course, in the meantime, the operational aspects are there. Not all businesses want immediate return. There are several categories of that. As you were saying, there will be a need because it's a public health good—technically, a subsidy from the donors. And this is where we have to convince donors to maintain that type of support. Now, in business parlance, I found out that our bankers were talking

**MANAGEMENT SCIENCES FOR HEALTH  
SEAM 2001 CONFERENCE: TARGETING IMPROVED ACCESS  
TAPE NO. 2, November 27, 2001**

about accumulated losses, and the accumulated losses are really what you're unable to generate. Therefore, that is actually the subsidy. And in business parlance, what businesses do is, of course, borrow money or cough up more capital in that case. But in this particular case, if you do have a donor, of course, that's the distinct advantage that one would have.

One thing I found out right before coming here: because I'm involved in other NGO [nongovernmental organization] business enterprises, I've talked with our development banks in the Philippines. We have development banks, the Land Bank, things like that. And in fact, they do give a lot of soft loans: low interest rates and a minimum of 10 to 12 years to pay. So in a sense, given the time latitude of 10 to 12 years to pay, particularly for social development or those with public externalities, even our development banks have become more or less adjusted to these types of enterprises right now.

MODERATOR: But in the case of FriendlyCare, in fact there was a very generous subsidy from USAID, I believe.

GALVEZ TAN: For our first two years, just to tell about FriendlyCare, we got US\$7 million for two years of operation, which is really what I would call it if I had a group of 10 businesspeople willing to invest \$7 million. This is just like what I promised them.

BROUN: Yes, there's another side of the onset to that, where you can get these type of franchises to become profitable much faster. You just have to target the richer clients. But, you know, here you're looking at something that is not for profit. If you want to make a profit, you can do it very fast. But you want to make it not for profit, and you still want each of the outlets to be profitable. So this is why it's most important to make sure that your outlets are going to be alive and they are going to thrive under the system that allows them to give drugs to people who need them.

As for your hypothesis, indeed you need subsidy. Because if you don't have it, you will cater to the richer instead of serving your target population. I mean, what we have looked at is accumulated negative cash flow, so it must be very close to what you call community of losses. And this is what has to be financed. This is the gap that has to be financed. It may vary if you have to provide soft loans to your franchises to help them open their shop. If you don't have to, then, of course, this problem is less. Even if the loans are reimbursed, you have to get the money first. So all these elements come into the making of the business plan. But it's true you have to start with someone.

On the second question, yes, indeed. These franchisees are first-line health operators or health providers. The training they receive is for that. I mean, they are trained to recognize symptoms and use standard treatment guidelines. And they just actually operationalize what is happening in the health centers of the government. It is not optimal, but it's what the population requires.

MODERATOR: Are you operating under the radar of the health system at this point?

**MANAGEMENT SCIENCES FOR HEALTH**  
**SEAM 2001 CONFERENCE: TARGETING IMPROVED ACCESS**  
**TAPE NO. 2, November 27, 2001**

BROUN: Always, yes. I mean, all the facilities are inspected by the district health officer.

MODERATOR: No, not under the radar, under the supervision.

BROUN: But it's sometimes under the gun.

Q: Hi, my name is Carlos Carrazana with the Summa Foundation. I think my questions were answered. They're mostly along the line of sustainability. Have you seen any of these franchisee networks being established with direct access to the commercial markets with our donor, with our subsidy? And if not, what—from your experience, what happens when the donor pulls out or when the subsidy pulls out? Are the interventions usually sustainable? And finally, are the franchise fees a percentage of sales or a flat fee?

BROUN: Flat. I mean, basically, you can answer for yourself. In the case that we're looking at, it's a percentage of the turnover—a couple of percent of the turnover. It's 2 to 5 percent. It's not something that is critical for breaking even for the franchise. But it's something that is essential to make sure that this relationship stays together and remains strong. I don't have any experience of these franchises being completely weaned from donors just because there's no franchise of this type where we have a five-year history yet. We have studies of franchising and especially, I think, of franchising in reproductive health in Mexico.

MODERATOR: Right. Green Star, PROSALUD in Bolivia, that type.

BROUN: Yes. PROSALUD is an example of something that works decently well and I don't think gets a lot of donor support any longer. But Green Star is not really a franchise. And one has to be a little careful about it. What happens when the financing stops, I don't know. In that case, the only thing we can do is a serious study. And it really looks like this is something that gets completely sustained once the donor monies are finished—that's all we can say at this stage.

Q: Hi, I'm Josiano Gomes Chaves from the Ministry of Health of Brazil. Now, I have a question for both of you. How can the franchise headquarters resist the pressure of the outlet managers if they get together to change certain technical procedures that are not attractive from a commercial point of view?

BROUN: When you have one that is a problem, close it up. I mean, two franchisees had to be closed up. And actually what's important is not so much that it was a decision by the headquarters. It was a decision that was supported by everyone in the network because they knew that people who were not abiding by the rules were weakening the whole network and then weakening the brand. So, the only thing that could go wrong is if you have a riot of all of your managers. But then you should change jobs. I mean, I agree.

MODERATOR: Since we don't want people to not get their medications, is there an

**MANAGEMENT SCIENCES FOR HEALTH**  
**SEAM 2001 CONFERENCE: TARGETING IMPROVED ACCESS**  
**TAPE NO. 2, November 27, 2001**

option of the franchisor stepping in and running the franchise?

BROUN: Yes, indeed, this is a possibility. We are getting into complex considerations. Most franchises have a kind of a mixture of privately owned outlets that are franchisees and company-owned outlets that they run by themselves and that can be run temporarily. So a franchisee can be run temporarily by the franchisor until a better candidate has been found.

MODERATOR: Thank you to both of you. I think that's two really good examples of a response to the question. How do you help households get the best value for money? And clearly, what's there is better than their other alternatives. One question that I have is whether the brand is well branded. The words come with baggage. "Franchise" comes with some baggage. And we, in the whole area of WTO [World Trade Organization] work, spent a year with confusion. Opportunity arose for using the word in loopholes, and nobody wanted loopholes. Once we rebranded and provided provisions and safeguards, everybody said, "Oh, we want safeguards." I knew we were moving ahead when the industry people started calling parallel imports a safeguard.

The reason why this comes up is that people do react to "franchise." We were in a roundtable about six weeks ago with the Secretary General and several companies, and we were writing the communiqué. The concept of franchising had come up, and the communiqué said "franchise." Koffi Annan said, "Can you find another word?"

I think if we want to sell this idea, we need to think a little bit about it. Because I think it comes with good baggage for some people and not good baggage for other people. So it's a good concept, and let's maybe think about the branding.

GALVEZ TAN: On this one, I'd like to share something when I left the WHO and explained that I was going to work on this franchise, and they said, "Oh." That's really interesting. Because I have speechwriters who put this franchise thing in my speeches, and I always remove it because I don't think they know what they're talking about. And indeed, it was the case. And this person was a very prudent person to remove the word. It is indeed something that comes with baggage, but I don't think that it should have a negative connotation. And actually, having more of these experiences coming up and having a decent analysis of them—then we will have people using "franchise" with a positive connotation, even when it's not positive, and that's going to be even worse.

MODERATOR: Okay. We'll watch the speeches.

Q: Sauwakon, Chulalongkorn University in Thailand. I have an idea to share about the issue of sustainability when the donors withdraw from supporting the franchise. While they're in health insurance financing, is the community financing going to health insurance? I think several years down the road, this may be one of the ways that needs to be explored when one franchise serves a community. If the relationship is built and the satisfaction of the customers in that area is served for the service around the area, then I

**MANAGEMENT SCIENCES FOR HEALTH  
SEAM 2001 CONFERENCE: TARGETING IMPROVED ACCESS  
TAPE NO. 2, November 27, 2001**

think there is a possibility to draw from the community itself to make the franchise attainable.

But what we have learned from the presentation is that we look within the system itself, the franchise, for how to supervise and monitor and the benefits of that. But I think one of the things that needs to be explored is the relationship of the franchise, the service provider, the drug providers, with the community. There are several issues that if we think of beforehand, we may be able to gather information at the beginning. Then we may come up with a good conclusion for the sustainability. Thank you.

GALVEZ TAN: Yes, thank you for sharing that. Actually, that is already happening in one of our clinics. But when we talk about community, we're not talking about 100 percent geographical. So I talk of a community around the clinic. For example, there are tricycle or pedicab drivers, around 8,000 of them. They become members of a community health financing. There are also a 2,000-member female garment workers group and around 1,000 market vendors. So that constitutes the community. Still not 100 percent. But there are now community health insurance schemes within their own organization, and right now the partnership of the franchise is really with these community groups and therefore is expanding the market.

MODERATOR: I think both are very interesting and important concepts, especially the direct example of similar things in other countries. So the business of health care for the poor cannot be compared with the business of the pharmaceutical industry, not even with the hotel industry. We have to remember that.

So your hope of recovering the money if you serve the poor along with the rich, if it is equitable, there is no chance. That is what the global experience is. And I think we should not try to do that either, for obvious reasons that we have heard this morning. In Bangladesh, we have similar examples of those who provide quality care and other things heavily subsidized by the donors. Also, in our brochures, you will find that your support is slightly better than the government but nowhere compared to the private industry. Private industry is working 14, 15, 16 hours; the public sector maybe 7, 8 hours; NGOs, 8 to 10 hours.

So this is the thing I think we have to remember—the only thing I can think of why you should invest money for health care. The only example that I can think of is the priest who would be happy if he finds that Sunday Mass is full of people. It's not whether they are going to have it or not. But it's full of people.

Similarly, in health care, if we find enough poor people are coming, then we should be happy. Why do we have to pay back the money? That should come either from the state taxes or the UN donations and other things. When we talk about the poor, all of a sudden we bring up the issue of sustainability. What is the sustainability of this conference? Can you think of all the money that we are spending here? No. But for a bigger cause, this spending money has got an investment value. I think we should think of this in that light.

**MANAGEMENT SCIENCES FOR HEALTH**  
**SEAM 2001 CONFERENCE: TARGETING IMPROVED ACCESS**  
**TAPE NO. 2, November 27, 2001**

I personally have experience for the franchise in trying to give health care for the poor. It's always difficult to reach the poor in any country. If a greater number of the poor can be recruited, your recovery rate will be higher, even despite low charges.

In my almost 28 years of experience trying to help the poor in the rural areas of Bangladesh, in some areas we are providing for almost a million people. That's the best we can do. In an urban area, we have had a program for three years. The bank is on my back. They say, "Hey, when are you going to give the money back?" We are not recovering 50 percent. But in an urban area, we have done a little better than in the rural areas because even the poor have a little bit of money. The only answer I have is when the rich man pays back the money, I will pay you back the money.

My last thing on the franchise. Denis and I have talked about it a long time. It's a very good concept. Again, I bring the idea that, depending on the marketing and the education of the masses, somebody else has to pay for it. But the franchise will never recover the money. So if we are practical and pragmatic, it's a good concept we can try. Thank you.

BROUN: There are a number of variations on this concept. Among them are the community health centers that I used to work in before I got involved in international health; the centers are funded by a combination of fee for services, subsidies, contracts with government for public health services, and a whole variety of funding sources. So I think we're going to be looking at a lot of options in the countries where we're working to see how these things can work and be sustained.