

Innovations in primary health care: considerations for National Health Insurance

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South Africa is undertaking major reforms in its health sector to prepare for the introduction of financing reforms under National Health Insurance (NHI). Central to this effort is improving the quality of primary healthcare services. With the work of the Office of Health Standards and Compliance (OHSC) having commenced, standards are being used to assess services, stimulate improvements and overcome the current inequities in access to high-quality care. The National Department of Health is establishing excellence in the health sector through a number of initiatives, and one of these – the “Ideal Clinic” initiative – has been designed to respond directly to the problems around quality of services, ascertained through OHSC inspections.

At this time of change, opportunities arise for innovation and experimentation in strengthening services and there is considerable experience in other countries that is of interest to South Africa. Concepts and approaches being used in the private sector may also be of use in speeding up the process by which quality of care is improved. Of particular interest is experience with social franchising, which applies a set of standards to a network of healthcare providers, to provide socially beneficial health services under a common franchise brand. This chapter concludes that the financing reforms under NHI, and the initial work of the OHSC, provide the context for more experimentation with regard to different approaches to expanding quality primary care services. The lessons from other countries, such as the application of social franchising concepts, are experiences from which South Africa can learn.

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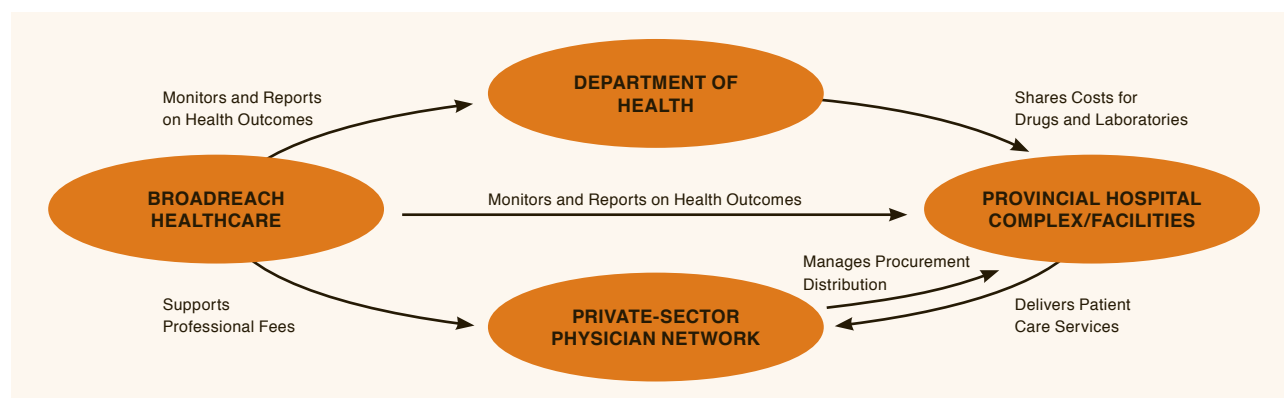
Introduction

The challenges in the South African health sector are well documented and acknowledged in the National Development Plan,¹ the Green Paper on National Health Insurance (NHI)² and other literature.³⁻⁵ Improving the quality of services is central to health sector reforms in South Africa. In 2012, the National Department of Health (NDoH) completed a baseline audit of all 3 880 public sector facilities in all nine provinces using standardised measurement tools.⁵ This included detailed assessments of Primary Health Care (PHC) facilities and provided the evidence for the changes required to improve the quality of services. In response to the findings, a nationally co-ordinated approach has emerged to develop a more efficient response to problems in facilities (the “Ideal Clinic” initiative). The primary aim is to systematically improve the quality of services in public sector PHC facilities, but in future this approach could also be used to set standards for public sector contracting of private sector services. In addition, the mock inspections^a of the Office of Standards Compliance (OSC) began in 2013. The OHSC, now formally launched in early 2014, provides a regulatory environment that will encourage innovations to improve the quality of health services in both public and private health sectors.⁶ Many other countries are exploring various mechanisms for improving universal access to high-quality, affordable health services.^{7,8} One such approach is social franchising of health services, which involves providing incentives for the roll-out of services of standardised quality as part of a broader set of changes in the health sector. This chapter provides a summary of South Africa’s experience with social franchising and recent efforts to scale up comprehensive quality services in primary care settings – the Ideal Clinic initiative. The chapter then reviews the current national and international literature on social franchising and discusses possible lessons for South Africa

Early experience of social franchising in South Africa

There is a considerable body of literature on contracting private providers to improve health services in South Africa.⁹⁻¹¹ South Africa is at an early stage with regard to considering “social franchise” approaches in the health sector. There is a limited number of innovations and lessons that may be of use for informing current efforts to improve PHC. One example is the current franchising of HIV and tuberculosis (TB) services through private general practitioners (GPs). In operation since 2005, this initiative involves a network of private sector GPs who are trained in HIV and TB management to support public-sector patients, operating in compliance with national government guidelines.¹² This was set up with the aim of increasing the capacity of the public sector health system to meet the demand for HIV care and treatment, while also adhering to national standards in clinical care. The initiative is mainly focused in urban areas, with 80% of funding coming from government and the rest from donor contributions. GPs are provided with training, mentoring and a monitoring system that includes quality of service and patient drug pick-ups, and are paid on a capitated fee system. All patients and treatment supporters must pass a comprehensive education programme with case managers monitoring adherence to patient drug pick-ups and visits to patients when problems arise¹³ (see Figure 1). An evaluation comparing the initiative with the standard public sector model showed similar outcomes with lower costs due to fewer patient visits. With the move to minimising required patient visits in the national programme, the evaluation concluded that this model could ease the burden on the public sector without increasing costs.¹⁴

Figure 1: The BroadReach public-private partnership for HIV care



Source: BroadReach, 2012.¹³

a Mock Inspections were used to train new OHSC inspectors and to develop and refine tools and procedures.

Another example of a form of “social franchising” that provides useful lessons is that used for reproductive health services in South Africa. Since 1993, Marie Stopes South Africa (MSSA), a subsidiary of Marie Stopes International (MSI), has provided termination of pregnancy and post-abortion services and other reproductive health services in 19 clinics across the country.¹⁵ MSSA has been working with government since 2007 and the MSI projects were recently evaluated in two provinces where their services were funded by the public sector.¹⁶ The evaluation noted that services responded to reproductive health needs, were provided efficiently, and were of high quality. Services were mainly provided in urban areas, although the rural districts included in the study did have higher overall utilisation of services when compared with other rural districts. The review concluded that this form of outsourcing yielded increased accessibility and use of termination of pregnancy services. The intervention entailed two different types of relationships with the public sector, one with district management and one directly with public health facilities. The evaluation concluded that the contracts with the district management constituted the more efficient model, requiring less administration. The review noted that contracting relationships had evolved over time and needed to become formalised in line with standard government procedures if scaling up were to be considered.

Improving quality in primary health care – the Ideal Clinic project

The NDoH has been developing various strategies to respond to the current deficiencies in the quality of PHC services. At the centre of this effort is the development of Ideal Clinics. These aim to provide a community-based, comprehensive range of integrated

diagnostic, curative, preventive, promotive, rehabilitative and palliative services. This forms a hub within the larger PHC team that will ensure continuity of care over time, as well as across services, and if successful, will empower and bring more accountability to the local community (see Figure 2). The Ideal Clinic will focus on the local community but will also interact with the wider District Health System and the District Clinical Specialist Teams to improve their impact locally.

The initiative was launched in 2013 in an effort to speed up the strengthening of public sector clinics. It was clear that a number of major bottlenecks had to be removed. An early innovation was to use an action learning process with the aim of developing a systematic method of change in preparation for the financing reforms under the NHI.

The Ideal Clinic will provide services to communities in different settings. Central to the delivery of integrated, patient-centred care is the use of up-to-date clinical guidelines and protocols. The initiative has adopted the integrated clinical guidelines developed under the “Primary Health Care 101” initiative, which aims to equip nurses and clinicians to diagnose and manage common conditions at primary level.¹⁷ Ten clinics were chosen across different settings in four provinces to undertake a study on how to strengthen facilities and the services they provide. For each clinic, a nurse-doctor team was engaged to work with the clinic staff and the sub-district and district managers. The process was overseen by the National and Provincial Departments of Health. All the elements for developing a high-quality service were defined, using all available national guidance and standards. The various obstacles to improving on these elements were identified, and mechanisms were identified to address them.

Figure 2: Graphic representation of the Ideal Clinic

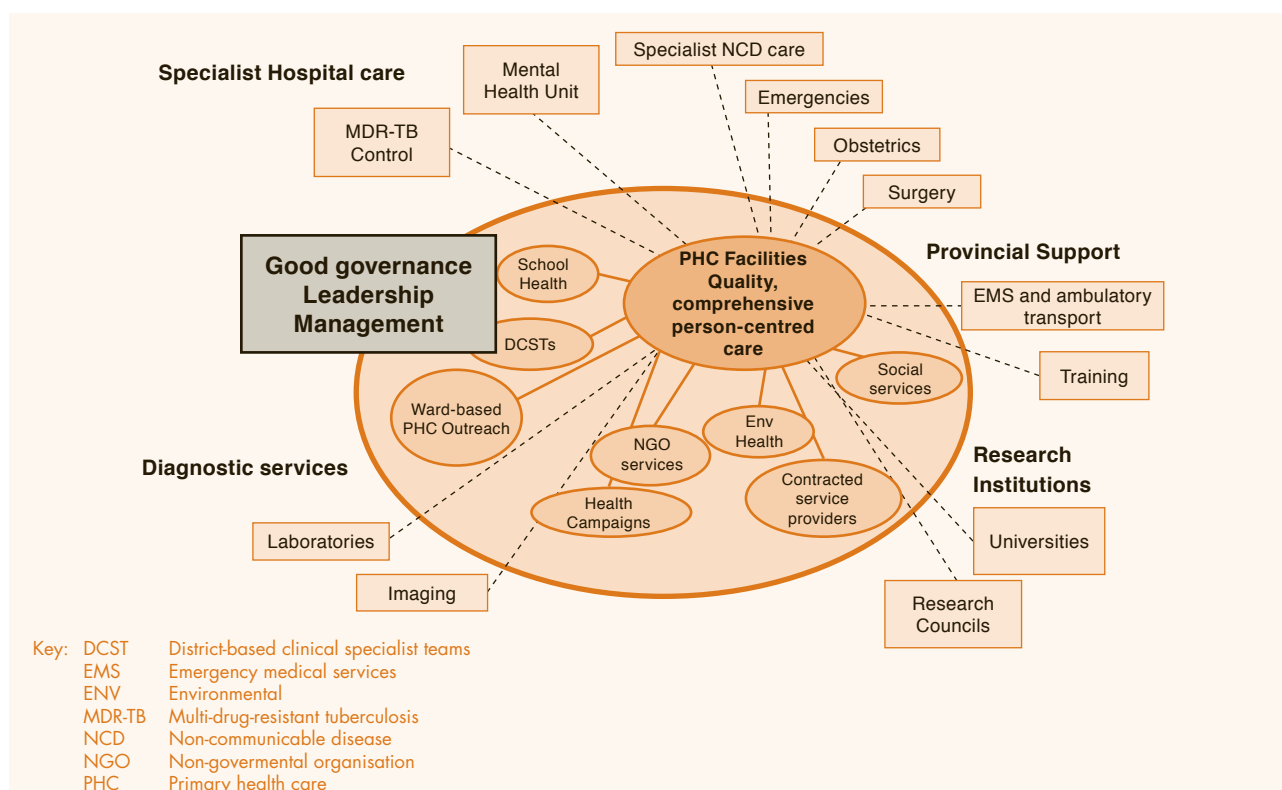


Table 1: Components National Core Standards and for establishing Ideal Clinic standards

National Core Standards Domains	DASHBOARD	
	Ideal Clinic Component	Sub-Component*
Domain 1: Patient Rights	Administration	1. Signage, Branding and Core Values
		2. Service Organisation
		3. Finance and Supply Chain Management
Domain 2: Patient Safety – Clinical Governance and Clinical Care	Clinical Guidelines and ICSM	4. Clinical Service Integration
	Availability of a Doctor	5. Clinical Management
Domain 3: Clinical Support Services	Medicines, Supplies and Laboratory Services	6. Doctor Services
		7. Medicines and Supplies
Domain 6: Operational Management	Staffing and Professional Standards	8. Laboratory Services
Domain 1: Patient Rights		9. Staffing
Domain 7: Facilities and infrastructure	Infrastructure and Support Services	10. Professional Standards
Domain 3: Clinical Support Services		11. Adequate Infrastructure and Maintenance
Domain 6: Operational Management		12. Bulk and Waste Services
Domain 7: Facilities and Infrastructure		13. Support Services – Housekeeping
		14. Essential Equipment and Furnishing
		15. Security
Domain 4: Public Health	Health Information Management	16. Information and Communication Technology Infrastructure and Hardware
		17. District Health Information System and Registers
		18. Data Cleaning and Use
	Communication	19. Computerisation of PHC Patient Information Systems
		20. Community Engagement
		21. Health Promotion and MindSet
Domain 2: Patient Safety – Clinical Governance and Clinical Care	District Health System	22. District Health System Support
		23. Patient Transport and Emergency Medical Services
Domain 5: Leadership and Corporate Governance	Partners and Stakeholders	24. Engagement
		25. Agreements

* Each sub-component has several “elements” (not included here) against which specific questions (or criteria) have been defined to help guide improvements.

In total, almost 200 elements have been defined that are specific prerequisites for a clinic to function optimally (see Table 1).

These have been classified into 26 sub-components within 10 components, namely:

- > Administration
- > Clinical guidelines and integrated clinical services management (ICSM)
- > Medicines, supplies and laboratory services
- > Staffing and professional standards
- > Availability of a doctor
- > Environment, infrastructure and equipment
- > Health information management
- > Communications
- > District health systems
- > Partnerships and stakeholders

This process has been used to help facilities develop quality improvement plans, clarifying the changes that can be brought about from within the clinic, and what requires action at higher levels of management. The nurse-doctor teams have continued to engage with the 10 clinics and have developed a set of instruments that can now be used to facilitate and monitor the process on a wider scale. The efforts are being scaled up alongside other efforts to strengthen district and facility performance, such as improving delegation of authority and more decentralised forms of management where capacity allows this. The baselines for the development of the Ideal Clinics were set by the audit of all public health facilities completed in 2012.⁵ Since then, two systems for monitoring progress have been established: the internal system overseen by the NDoH, and the mock inspections performed by staff involved in setting up the OHSC prior to its launch in 2014. These monitoring arrangements have been operating in collaboration to ensure that future inspections and future responses are aligned and lead to improvements in the quality of services provided.

The internal NDoH monitoring system for the Ideal Clinic

The system for internal monitoring of the Ideal Clinics uses a simple tool covering the standards for each of the 200 elements in the 10 components. The tool is based on a set of questions or criteria for assessing the element, linked to a red/amber/green system of grading the response. There has been continuous monitoring of progress involving NDoH “nurse-doctor” teams working closely with district and provincial managers. This has shown overall improvements, and where improvements have been slow or, in a few areas, reversed, the monitoring tool has allowed for corrective action to be undertaken early.

Inspections of the Office for Health Standards Compliance

All of the 10 Ideal Clinic study sites have been subject to mock inspections in the run-up to establishing the OHSC. This has provided an opportunity for the OHSC and NDoH to calibrate their monitoring systems. It has also helped facilities to prepare mechanisms and approaches for building compliance with the OHSC standards. The inspections make assessments against the National Core Standards and the six domains of quality. All 10 clinics have had baseline audits, but only five of the clinics have completed more than one

inspection, the results of which are shown in Table 2. The results of the previous baseline audit (using different methodologies from OSC) are also included, with adjustments to allow comparison. As can be seen, the results are that overall, four out of five clinics improved, with two clinics showing improvements across all domains. One clinic’s scores deteriorated. The waiting-time scores all improved, but the scores for infection prevention and control and for medicines were mixed. This provides an example of the type of information that will increasingly be available for all national health facilities as the OHSC inspectors proceed with their work.

The lessons from these study clinics will now be used to scale up the approach, building in more rigorous learning and evaluation. The scale-up will eventually be conducted across all public sector PHC services in South Africa, starting with the 11 districts that are being prepared for the introduction of NHI. Resources to implement this have been committed by the NDoH and Treasury.

Given the intention of rapidly going to scale, the NDoH has been undertaking various consultations to consider what lessons could be learned from other sectors, including the private sector and other countries. The initial learning from social franchising is summarised below and is followed by a discussion on how this concept and approach might be of use in scaling up the Ideal Clinic initiative.

Table 2: Baseline audit and OSC scores by quality domain

Clinic	Data (BA = Baseline Audit)	Availability of medicines and supplies	Cleanliness	Improve patient safety and security	Infection prevention and control	Positive and caring attitudes	Waiting times	Aggregate Score
		%	%	%	%	%	%	%
Clinic 1	BA	92	24	48	57	72	53	57
	Sep-13	67	46	36	44	57	80	49
	Nov-13	99	92	73	71	78	100	82
Clinic 2	BA	95	67	60	93	97	87	78
	Aug-13	69	37	45	47	67	64	52
	Nov-13	90	69	82	88	72	100	83
Clinic 3	BA	58	77	33	52	43	86	49
	Mar-13	76	67	55	75	59	60	63
	Aug-13	37	69	53	59	54	73	54
Clinic 4	BA	57	60	39	40	80	40	46
	Mar-13	80	55	56	82	61	50	64
	Sep-13	43	50	60	67	61	90	59
	Nov-13	40	83	73	85	68	82	70
Clinic 5	BA	44	50	23	29	38	38	31
	Sep-13	37	40	44	57	41	18	42
	Nov-13	41	66	50	50	27	73	49

Final OSC score compared to first OSC score	
	Improved (>5%)
	Worsen (>5%)
	No change

Social franchising in health service provision

Social franchising of health services is seen as having the potential to transform key aspects of health service delivery.¹⁸ Social franchising involves the application of business franchise concepts for community and social benefits. It provides an attractive addition to the available tools for leveraging existing resources, offering a system for standardising the outputs from a heterogeneous group of practitioners. The global literature focuses on how social franchising has been used to work with the non-government providers who are outside public health programming and where there are concerns about quality of care and non-adherence to national standards and guidelines. However, in the South African context, the relevance is how such an approach could be used in both the public and private sectors, using the national standards of the OHSC and the guidelines and protocols that are being used for the Ideal Clinic project. A social franchise has four primary goals¹⁹ all of relevance to South Africa. These are to improve:

- access, by increasing the number of service delivery points (providers) and healthcare services offered;
- cost-effectiveness, by providing services at an equal or lower cost to other service delivery options;
- quality, by ensuring that the services provided adhere to quality standards and improve on the pre-existing level of quality; and
- equity, by serving all population groups, focusing on those most in need.

A franchise is a contractual arrangement between a health service provider and a franchisee organisation. Franchisees are trained in standardised practices for which prices are predefined and all benefit from advertising of the logo or franchise name. In return, franchisees may be required to comply with minimum service utilisation and quality standards and pay a membership fee to the franchisor. Providers are monitored by the franchise organisation, which in the context of public health is generally a government or donor-sponsored NGO that subsidises the network.

The Global Health Group defines a social franchise as a network of healthcare providers that are linked through agreements to provide socially beneficial health services under a common franchise brand.^{20,21} A franchisor manages the brand and oversees the administration of the programme.

The concept of franchising for health services is similar to franchises in business. A franchisor develops a successful way to provide the health services, and other franchisees copy the model. However, each franchisee is required to follow the original model. There are usually specific training programmes, protocols and standards to follow, monitoring, and a brand name or logo which identifies that the provider is part of a franchise. In social franchising, belonging to a network is an essential element and in this network the co-ordinator (franchisor) has the mandate to harmonise the network and ensure consistency among the franchisees (health service providers). The elements that typify a social franchising package are:

- training (e.g. in clinical procedures, service management);
- protocols used for management (e.g. for antenatal care, childhood diarrhoea);

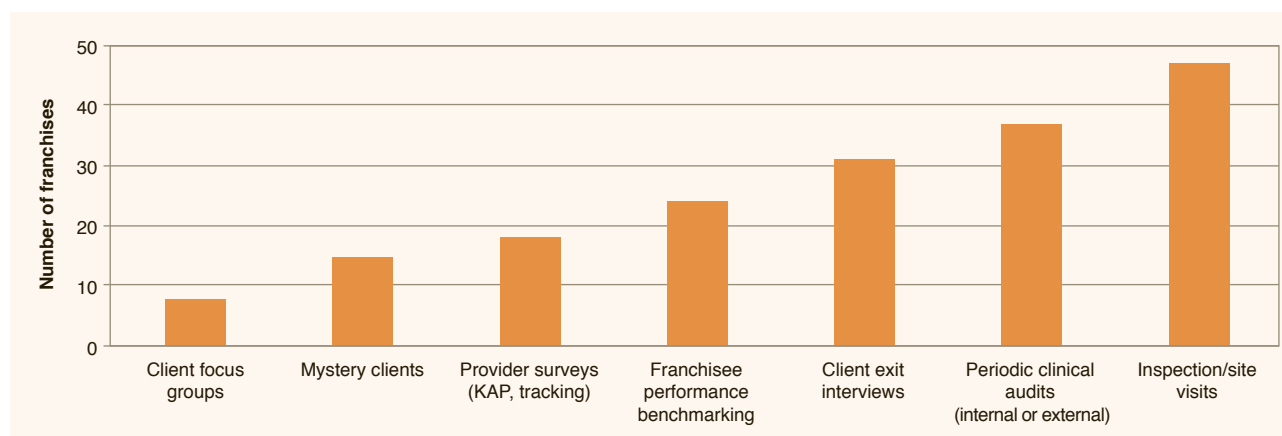
- standardisation of supplies and services (e.g. birthing kits, HIV/TB tests);
- branding (e.g. standardised display of health promotion material, use of a logo on signs, products, or garments);
- monitoring (e.g. quarterly reports to franchisor, reviews); and
- network membership (e.g. more than one franchisee in the organisation).

As a method of organising unstructured service providers, franchising is attractive because it integrates within one system all of the interventions that have been shown to have some effect individually, namely training, oversight, performance-based incentives, accreditation and certification, vouchers or other external payment schemes, ongoing support relationships and monitoring.

Different models of quality assurance are used in social franchises. An international study of “high-performing” social franchises provides lessons for the OHSC and the Ideal Clinic initiative in South Africa, and identifies the capacities and mechanisms that may be required as these efforts go to scale.²² The study concluded that successful social franchises conceive of quality assurance not as an independent activity, but rather as a goal that is incorporated into all areas of franchise operations. The successful franchisor has usually adopted a quality assurance (QA) framework that includes areas such as recruitment of the franchisee, training, monitoring of provider performance, monitoring of client experience and the provision of feedback. The most common QA mechanism entailed inspections, site visits and clinical audits (see Figure 3). The report noted that the use of “client feedback” was least well-developed, which reflected their conclusion that many franchises were not using the latest knowledge on quality improvement techniques.

Globally, social franchising has been most commonly used for family planning services in low- and middle-income countries. However, the recent review performed by the Global Health Group showed a wide range of other services included in the 52 initiatives that they identified in 35 middle- and low-income countries. These included services for sexual and reproductive health, maternal and child health, HIV, TB and malaria. In this survey, 80% of the social franchises were located in South Asia with only about 6% in Africa. The context varied enormously, and direct comparisons are difficult; however, the case studies do show the range of services provided in very different settings. Three are provided here, one from Rwanda and Kenya (The Health Store Foundation²³), one from Vietnam, a public sector social franchising initiative in Vietnam (Tinh chi em, “Sisterhood”) and the third from Ghana (Health Keepers²⁴).

Figure 3: Quality assurance activities as reported by 50 global social franchises



Source: Schlein et al., 2013.²²

The Health Store Foundation "Child and Family Wellness" Shops, Kenya and Rwanda

Basic facts:

- ❖ Target clientele: low income, children/youth, caregivers of children under 5, people living with HIV and AIDS, men, women
- ❖ Location of outlets: 10% urban and 90% rural
- ❖ Payment sources: In Kenya, 100% out of pocket; in Rwanda, some out-of-pocket payment but main payer is prevalent community-based health insurance schemes
- ❖ Number of clients served per year: 400 000

Background: Since opening its first outlets in 2000, The Health Store Foundation® has developed a network of franchised medical clinics and drug shops now totalling 71 locations serving approximately 33 000 patients and customers per month in Kenya and Rwanda. Clinics are owned by nurses and drug shops are owned by community health workers (CHWs).

Service details: Malaria testing and treatment, TB referrals, oral contraceptives, male condoms, injectable contraceptives, water purification, vitamins, long-lasting insecticide-treated nets, net retreatment, ante-natal counselling, HIV testing, etc.

Quality assurance highlights: Each franchisee is trained on the Child and Family Wellness (CFW) system and is contractually obligated to follow the CFW system; if they fail to comply, their franchisee rights are revoked; this is a powerful incentive that ensures the maintenance of basic clinical and business standards across the CFW network.

Community health workers: Some CHWs are paid on commission, and some receive salaries paid by the franchisee. They provide outreach services, over-the-counter sales, health education services, marketing and referrals to CFW or the government.

Demand-side financing: The programme plans to develop a subsidised third-party payment mechanism in Kenya. In Rwanda, the prevalent community health insurance scheme ("Mutuelles de Sante") is reimbursing CFW outlets for care provided to patients.

Operational research: The 2011 Harvard Business School case study focused on Health Store's internal discussions surrounding the possibility of making a transition to using a for-profit operating entity in Kenya to carry out the CFW business in Kenya, and the potential operational and fundraising implications of such a decision.

Successes: Serving approximately 400 000 people per year in Kenya; signing a formal agreement with the Minister of Health in Rwanda; solicitation of advice on operations from major franchise industry leaders; bridging franchise expertise with global health expertise and targeting both at the CFW network.

Challenges: Establishing a business format franchise in an environment with little exposure to business format franchising.

Future plans: Introduce vaccines and basic laboratories to two new CFW clinics in Kenya; improve the delivery cycle in Kenya including using phone orders and M-PESA payments; develop business plan and launch the first wave of new-style CFW clinics in Kenya under new for-profit entity; continue expanding CFW network in Rwanda under Public-Private Partnership with the Ministry of Health.

Tinh chi em (“Sisterhood”), Vietnam

Basic facts:

- ❖ Target clientele: Low income, migrants/refugees, men, women
- ❖ Location of outlets: 10% urban and 90% rural
- ❖ Payment sources: 10% out of pocket, 50% insurance, 40% government reimbursement
- ❖ Number of clients served per year: 887 412

Background: “Tinh chi em” is the first government-run social franchise model in Vietnam. With technical assistance from MSI Vietnam (MSIVN), the provincial Department of Health (franchisor) formed and operates the model at community health stations (franchisee). Currently the EU, Atlantic Philanthropies, MSI-UK and the government of Vietnam are matching resources to support the government social franchise network.

Service details: Oral contraceptives, female condoms, injectables, Copper T, sterilisation, emergency contraception, counselling on family planning, sexually transmitted infections testing and treatment, medical and surgical abortion, breast and cervical cancer screening, antenatal care, labour and delivery, postnatal care, and counselling on reproductive health.

Quality assurance highlights: As MSIVNs work in partnership with the public health system, there is strong involvement from the government side at provincial, district and community levels in the franchisees’ activities. Monthly reports on service provision prepared by the franchisees are submitted to the district health centres for verification before sending to MSIVN. Monitoring occurs through two channels – provincial master trainers as trained by MSIVN, and MSIVN project staff. Findings are discussed together with service providers immediately after every monitoring visit in order to gain a common understanding about strengths and areas for improvement. Points given to every franchisee at the two last monitoring visits are presented at quarterly meetings.

Community health workers: Brand ambassadors are selected from the community. They receive a monthly allowance to participate in the project (to cover transportation costs). Incentives are also provided based on referrals (about US\$5 per month).

Demand-side financing: A voucher scheme provides reimbursement for transport.

Successes: Strong partnership with local authorities; training on cervical cancer screening, emergency preparedness, basic management; skills for the head of franchisees; Refresher training on service quality, demand generation, monitoring and evaluation for provincial master trainers.

Challenges: Lack of approval mechanism for the health staff working at the (government) franchised commune health stations to collect fees from clients; the voucher scheme is new, and it took time for it to work correctly; delay in re-construction of some government health stations caused launch delay.

Health Keepers, Ghana

Basic facts:

- ❖ Target clientele: low income, children/youth, sex workers and clients, men, women
- ❖ Location of outlets: 10% urban and 90% rural
- ❖ Payment sources: 100% out of pocket
- ❖ Number of clients served per year: 520 000

Background: The “Health Keepers” network brings innovative and sustainable self-help market-based solutions to the fight against disease, chronic hunger and poverty. The programme integrates private sector business approaches to serve a public health need by addressing the bottleneck in the delivery of health products and information, and offering a smart business opportunity for local entrepreneurial women. The programme is based on a network of women known as Health Keepers. Health Keepers go from door-to-door to sell reproductive health products and offer advice on their proper use, and provide health information and linkages to referral points.

Service details: Oral contraceptives and condoms

Quality assurance highlights: The network provides feedback to franchisees and refresher trainings. Quality is evaluated based on the number of community-based women who are trained, sales, and “Couple Years Protected”. A Community Impact Assessment tool assesses quality.

Community health workers (CHWs): CHWs earn income from door-to-door sales of health protection products.

Successes: Expanded geographically, added youth and adolescents as target groups; initiated micro-savings as a strategy for addressing attrition and a product financing mechanism for the Health Keepers.

Challenges: Balancing the social and commercial goals of the programme; ensuring regular monitoring and supervision to bring about the needed behaviour change; inadequate funding.

Future plans: Introduction of zinc tablets for diarrhoea case management (oral rehydration salts plus Zinc tablets); peer-to-peer distribution of oral contraceptives and condoms in tertiary institutions.

What is the evidence that social franchising is effective?

The literature is generally positive about social franchising but until recently there were mixed views among researchers, mainly due to the lack of rigorous evaluations.²⁵ Context and local details around implementation seemed to account for many of the differences in previous research. If a social franchising service is properly targeted at poorer and disadvantaged groups, it is likely to improve on inequities in service delivery.²⁶ Recently, there have been a number of more rigorous assessments of social franchising as an intervention to improve access to and quality of health services. One review included 23 studies that focused on reproductive health services;²⁷ results varied widely, but social franchising was positively associated with increased client volume and client satisfaction. The review result was mixed regarding the impacts on utilisation and health, and was negative in terms of cost-effectiveness and equity. In Myanmar, a cross-sectional study showed that social franchising improved the knowledge retained by community health workers for dealing with malaria.²⁸ Another study on the same franchise showed that women chose franchised health service providers because of their perceived higher quality associated with the availability of effective, affordable drugs. A pro-poor focus was achieved in urban areas in terms of TB services, but less so in rural areas.²⁹ In Vietnam, a social franchising initiative focusing on nutritional counselling based in government primary care facilities showed improvements in clinic infrastructure and knowledge.³⁰ A study in Pakistan assessed the use of vouchers for expensive forms of contraception, with positive results. The study concluded that there were a number of different aspects key to the project's success: generating demand through counselling, overcoming financial constraints by offering vouchers, training, and accreditation, branding of the service providers, and ensuring uninterrupted supplies.³¹

A common criticism of social franchises centres on their rather simple measures of performance. Most define success through the numbers of users and facilities, rather than in measuring health outcomes and health impact. Efforts are being made to change this so that impact measures can be used to assess impact across different services.³²⁻³⁴ Innovative techniques such as using the "observed simulated patient" could be explored.³⁵ Performance should also focus on the ability of programmes to reach the poorest and those most in need, as serving these groups is often the rationale for setting up social franchising programmes. However, reaching the poor can be difficult and requires constant monitoring in all social franchises.³⁶

Are these experiences of use for scaling up Ideal Clinics?

Underlying all of these experiences are some common principles. All the examples of social franchising demonstrate some system of accountability for delivering results and have increased autonomy for local decision-making. There was a need to ensure sufficient capacity to implement new ways of working, and transparency to monitor results. The combination of more accountability, adherence to standards and adapting services to local needs improves the responsiveness and efficiency of health services. However, these social franchising initiatives may not have brought about change on their own, and often are part of a wider set of initiatives that contributed to changing or strengthening the health system.

Whilst the international case studies are of interest, the contexts in all these other countries are very different, and it is notable that social franchises that are part of an international network have to customise their approach to the specific country in which a programme is being implemented. This signifies the need to be consistent with national policies, regulations and management arrangements being introduced with the move to NHI. Such an initiative would also need to be manageable within existing capacities, given that decentralised contracting is already proving difficult with the capacities currently available. The studies also show success with specific programmes and services with specific outcomes, whereas the Ideal Clinic initiative is a comprehensive service that is currently driven by standards that are largely input-based.

Any such model in South Africa would need its own terminology. For example, the local Department of Health would be the "franchisor" co-ordinating the network of providers of "branded" services. The OHSC would undertake the independent verification of the quality assurance efforts and outcomes, and would assess whether clinics retain their Ideal Clinic "brand". Moreover, the Ideal Clinic initiative, with its focus on quality improvement, is an innovation in itself and may develop its own terminology and approaches based on experience. Innovations may also be required in other areas, such as building on the experience of using incentives to improve rural coverage of health services.³⁷

Are there any risks?

The advantage of going to scale quickly through a social franchising approach would have to be linked to the considerable investment into management capacity required to set up and oversee such an arrangement. However, there are potential risks that could result in failure of scaling up if these were not addressed. Some key risks are as follows:

- **Evidence:** The review of international evidence shows that any expansion of existing initiatives would need to be accompanied by rigorous evaluation and "implementation science" as recommended by the World Health Organization,³⁸ and there is a risk that these areas do not receive the required attention by researchers and their sponsors in South Africa.
- **Stakeholders:** Health workers working in primary health care would be those most affected by the types of changes envisaged here and could be resistant to change. They would need to be involved in the design process from the outset so that they could help shape the changes. Reforms that are centrally driven should not undermine local management and innovation, and should maintain a balance between local and central accountability.³⁹
- **Management capacity:** The public sector has to have the capacity to take on change. This has long been recognised as a major constraint in developing more effective relationships between, for example, "purchasers" and "providers" of services.⁴⁰
- **Monitoring:** Regular monitoring is crucial, and without this, new innovations could lead to scaling up of low quality services.⁴¹
- **Equity:** Innovative reforms often only provide more services for those who are relatively well served. Any innovation aimed at expanding healthcare services in South Africa would have to

specify the need to reach under-served rural areas for example, preferably using workers drawn from local communities.

Conclusion

The launch of the Office of Health Standards Compliance provides an environment in which monitoring and improving on quality standards in both the public and private sectors should stimulate more innovative approaches to overcoming local problems. This will need to be linked to more accountability, locally to users and centrally for adherence to standards, and more delegation of authority. This requires sufficient management capacity and more efficient support systems, for example around procurement, medicines and supplies, and information systems.

Health systems evolve over time and there is a growing consensus globally that major changes in any health sector require local evidence to be developed on what works, and what does not. Empirical evidence relating to a specific situation should guide decision-making in that situation.^{38,42} This in turn requires effective collaboration between all stakeholders (users, health workers, managers, researchers and policy-makers). In some situations where there are different options to be explored, it is possible to design different approaches to allow for a comparison of progress and outcomes. A number of methodologies can be utilised for quality improvement, such as the Plan-Do-Study-Act cycles and Participatory Action Research. The way forward is to debate the options, create the space for innovation and learning, and keep a close watch on quality, access, equity and costs.

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