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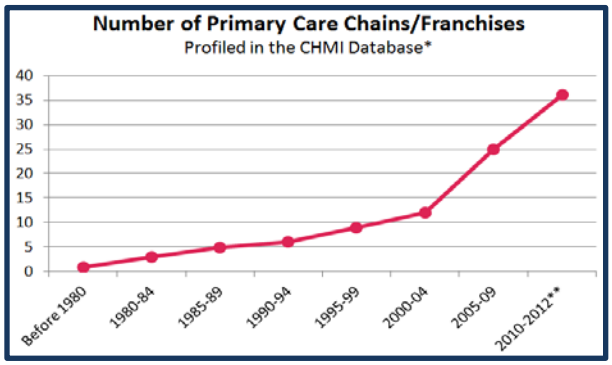
DATABASE AT A GLANCE: PRIMARY CARE CHAINS AND FRANCHISES

In low- and middle-income countries (LMICs), primary care has traditionally been provided by governments or charitable organizations running individual clinics. However, many governments have historically failed to meet the needs of the majority of their population in this regard, and the charity-run clinics, while playing a crucial role, are often constricted by fluctuating funding. Therefore, over the past 10 years (see graph below), LMICs have seen a large growth in the number private organizations (both for-profit and non-profit) that are striving to provide accessible, affordable and high-quality care for the poor, while simultaneously making a profit and/or achieving sustainability.

Many of these private health providers have taken the form of clinic chains or franchises because these models offer the advantages of being able to spread overhead costs, share managerial resources, standardize processes that improve the quality of care, and create a reputation using common branding that allows for the generation of additional revenue through increased volumes and premiums.



**Primary care chains franchises by year*

Landscape of Primary Care Chains and Franchises

CHMI has identified approximately 37 of these primary care chains and franchises spread fairly evenly in different regions around the world, with the exception of India, which has 15 such programs. Note that five of these programs would primarily be considered pharmacies (this doesn't include general primary care programs that have associated pharmacies); we have nevertheless decided to include them here, as many patients skip doctors and go straight to the pharmacists for medication. Many pharmacists act as primary care providers and diagnose patients. In fact, this became such an issue for Mi Farmacita Nacional, a pharmacy chain in Mexico, that they ended up formally integrating a primary care component into many of their pharmacies.

Just over three-fourths of the identified programs are chains, and the remainder are franchises. As a

**Distribution of primary care chains and franchises by country*

refresher, both franchises and chains consist of clinics operating under the same brand where services are standardized by a central organizer. Franchises however are operator-owned, whereas operators of clinics in chains are paid employees of the central organization. The smaller number of franchises that focus on general primary care contrasts with the large number of franchises identified by CHMI that focus on one specific area of health (which are out of the scope of this analysis), such as the more than 50 franchises focusing on family planning and reproductive health.

Most of these franchises and chains are for-profit (25, or around two-thirds), while 10 are not-for-profit, one is a public-private partnership, and one is unidentified. The larger number of for-profits is representative of the growing trend of entrepreneurs tapping into the market at the bottom of the pyramid as a viable source of revenue.

The programs have a range of geographic foci, but most are focused on urban and/or peri-urban areas (20), with a smaller number focused on all geographies or focused exclusively on rural areas (9 and 7 programs, respectively). For these models, which generally require high volumes to off-set their small-profit margins, urban and peri-urban areas represent logical locations for clinics. However, going forward, it will be important to find more models that can successfully reach the underserved populations in rural and geographically remote areas.

The size of these general primary care programs ranges greatly from those that have only 1 clinic (or are just on the cusp of launching) to others that have tens or even hundreds of clinics. Several of the pharmacy chains have thousands of outlets.

Innovative Business Models

As mentioned above, providing accessible, affordable and quality care to the poor while still achieving profit or sustainability can be a huge challenge. To overcome this, a number of chains and franchises are employing innovative new models that are helping them to raise the quality of care while lowering their costs. These trends include:

Telemedicine

Several organizations, such as World Health Partners in India, use information communication technology to connect qualified doctors in cities with rural patients. This allows these franchises and chains to better access remote populations without the trouble and high costs of employing a full-time doctor in rural areas.

Hybrid Business Models

Between work and other daily activities, the poor in LMICs are very busy and visiting a clinic for a checkup can be a hassle. Therefore, some programs have started selling other non-health-related goods so that the patients can kill two birds with one stone. For example, Sehat First in Pakistan includes a general store in all of its clinics so that patients can pick up other items and groceries when visiting the doctor. Similarly, E Health Point in India sells clean water at its clinics. In these ways, these programs are both able to increase patient volume and subsidize clinic costs with revenue from these other items.

Membership Schemes

Another way to help ensure foot traffic and constant revenue is member schemes. By employing such a system, programs can avoid major month-to-month fluctuations of revenue and thereby better plan their budgets. With Primedic, a chain in Mexico, patients pay a membership fee and receive access to unlimited primary care consultations with specialists in internal medicine, pediatrics, OB/GYN and family medicine.

Hub and Spoke Models

To increase their reach into communities, some organizations have begun employing tiered systems of clinics, where clinics are linked by efficient referral systems, thus allowing them to have more clinics without the cost of fully stocking every clinic with every resource and service. For example, in the Carego Livewell chain in Kenya, "hub" clinics are managed by a fully qualified medical doctor, and also contain a pharmacy and diagnostic laboratory, while "spoke" clinics are run by clinical officers and registered nurses and are electronically linked to the hub clinics to facilitate communication and referrals.

Electronic Medical Records (EMRs)

EMRs are becoming increasingly common as they are recognized as a useful tool to save staff time, avoid errors, and generally organize information. Nation Wide Primary Healthcare Services in India utilizes a cloud-based EMR that also includes reminder services to make sure that future appointments and other details aren't forgotten.

Developments in Primary Care Chains and Franchises

Primary care chains and franchises are cropping up all over the world and showing increasing promise in their ability to deliver quality care to the poor at an affordable price. Nevertheless, few (if any) programs seem to have perfected the model, so success will depend on continued experimentation with the business models mentioned above and other innovations.