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**Market-Based  
Family Planning:  
The Enterprise Program  
Experience**

**The Enterprise  
Program**

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## FOREWORD AND ACKNOWLEDGEMENTS

This is the third and final paper in the Enterprise Program's series of activity-based studies. The first two covered work in the employment-based sector and with non-governmental organizations (NGOs). The studies explore strategies pursued and the impact of various models on privatizing family planning service delivery. They also attempt to present a thoughtful analysis of lessons learned and recommendations for future private sector programming.

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# MARKET-BASED FAMILY PLANNING: THE ENTERPRISE PROGRAM EXPERIENCE

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## Acronyms

<b>A.I.D.</b>	<b>Agency for International Development</b>
<b>ACNM</b>	<b>American College of Nurse-Midwives</b>
<b>ADOPLAFAM</b>	<b>Asociación Dominicana de Planificación Familiar</b>
<b>AIG</b>	<b>American International Group, a worldwide insurance firm</b>
<b>ALICO</b>	<b>a division of AIG</b>
<b>CEPECS</b>	<b>Centro de Estudos e Peguisas Clovis Salgado (Brazilian NGO)</b>
<b>CIMAS</b>	<b>Commercial and Industrial Medical Aid Society (Zimbabwe)</b>
<b>ESIC</b>	<b>Employees State Insurance Corporation (India)</b>
<b>GRMA</b>	<b>Ghana Registered Midwives Association</b>
<b>HIO</b>	<b>Health Insurance Organization (Egypt)</b>
<b>HMO</b>	<b>health maintenance organization</b>
<b>IEC</b>	<b>information/education/communication</b>
<b>IMA</b>	<b>Indian Medical Association</b>
<b>IUD</b>	<b>intra-uterine device</b>
<b>JIEP</b>	<b>P.T. Jakarta Industrial Estate Pulogandung</b>
<b>MEXFAM</b>	<b>Fundación Mexicana para la Planificación Familiar</b>
<b>MR</b>	<b>menstrual regulation</b>
<b>NGO</b>	<b>non-governmental organization</b>
<b>OC</b>	<b>oral contraceptive</b>
<b>PATH</b>	<b>Program for Appropriate Technology in Health</b>
<b>PLFI</b>	<b>People's Livelihood Foundation, Inc. (Philippines NGO)</b>
<b>PSMAS</b>	<b>Public Service Medical Aid Society (Zimbabwe)</b>
<b>SOMARC</b>	<b>Social Marketing for Change (A.I.D. project)</b>
<b>TDRI</b>	<b>Thailand Development Research Institute</b>
<b>TFHPF</b>	<b>Turkish Family Health and Planning Foundation</b>
<b>TIPPS</b>	<b>Technical Information on Population for the Private Sector (A.I.D. Project)</b>
<b>USAID</b>	<b>United States Agency for International Development</b>
<b>YKB</b>	<b>Yayasan Kusuma Buana (Indonesian NGO)</b>
<b>ZNFPC</b>	<b>Zimbabwe National Family Planning Council</b>

## **EXECUTIVE SUMMARY**

Over the last six years, the Enterprise Program has gained considerable experience working with market-based providers in the commercial and non-profit sectors to expand family planning service delivery. The market-based sector is made up of both for-profit and non-profit entities working in diverse settings to produce, distribute, finance or deliver health care services or products.

The goal of Enterprise's work in the market-based sector has been to develop, test, and document a number of program strategies and models, and to assess their strengths and weaknesses in terms of four impact objectives:

- creating sustainable family planning services;
- attracting family planning acceptors;
- using resources for family planning cost-effectively, and
- leveraging private sector funds for family planning investments.

This paper analyzes the experience of the Enterprise Program in working through the market-based sector to maximize these impact objectives. The paper describes projects in Brazil, Mexico, the Dominican Republic, Haiti, Ghana, Zimbabwe, Egypt, Turkey, India, Thailand, the Philippines, and Indonesia. It is important that the lessons from the Enterprise market-based experience be documented and disseminated, to inform the donor community about the opportunities and constraints of working with this very important but little understood area of the private health care sector.

There are several reasons that tapping the resources of the market-based sector offers significant opportunities for both host governments and donors to expand family planning service delivery. First, market-based providers have an inherent concern for efficiency and cost-effectiveness; given their bottom line orientation, they understand the importance of minimizing costs. Second, they are market-driven; they understand how to compete in the marketplace, how to attract and retain clients, and how to take advantage of demand. Third, those that are well established can share the donor's financial risk in starting or expanding services, if the return on their investment is sufficient. Finally, prospects for sustainability are high, because the livelihood of the market-based provider depends upon achieving it. The goal for host governments and donors, then, is to maximize these market-based resources, using appropriate strategies at a reasonable cost.

Enterprise segmented the market-based sector into five categories of settings and providers:

- Individual and group practices -- including physicians, midwives and traditional healers;

- Health service institutions -- service providers such as clinics, dispensaries and hospitals;
- Health financing institutions -- entities offering indemnity coverage and/or managed care plans, such as health maintenance organizations (HMOs) and insurance companies;
- Manufacturing industries -- producers and/or packagers of contraceptive and other health care *products*;
- Retail outlets and middlemen -- operations such as pharmacies that sell contraceptives and offer information on family planning.

To expand family planning in the private sector, Enterprise used four implementation strategies:

- Working through "apex" or "umbrella" organizations -- such as trade or professional associations or family planning agencies -- to reach a large number of service providers or retailers, who, in turn, reach a large number of acceptors;
- Developing fee-for-service clinic or "doctor franchising" arrangements to increase the accessibility and availability of family planning services;
- Developing innovative managed care or insurance arrangements to increase access to family planning;
- Developing public policy initiatives for family planning to reduce barriers to privatization and to make more cost-effective use of host government resources.

The Enterprise experience has shown that market-based models require that trade-offs be made in terms of maximizing impact objectives. For example, if the top priority is to establish a self-sustaining market-based intervention that attracts large numbers of acceptors, then working through an apex organization to reach medical personnel in private practice is an effective option. If the top priority is to leverage private sector resources, then working through a non-profit organization to establish a full-service clinic may be a better choice. Donors working in the market-based sector need to be aware of these trade-offs, and select program strategies and models to maximize specific objectives.

As demand for family planning continues to outpace the availability of public funds to provide services, it is increasingly important to identify new avenues for mobilizing private sector resources to fill the gap. The Enterprise Program's ground-breaking work in the market-based sector demonstrates its potential as an important new source of services and funds for family planning.

## **I. INTRODUCTION**

In recent years, innovative partnerships have been developed between the public and private sectors of many countries to expand the availability and accessibility of family planning services. Although the importance of the charitable work of private, non-profit family planning agencies has long been recognized, new avenues to foster private sector involvement and support for family planning are now being sought by host governments and donors alike.

For donors, the most complex and least well known entity working in the private health care sector is the market-based provider: individuals and organizations which compete in the marketplace to sell (or to finance) health care products and services. There is a wide range of market-based providers: some sell products and services directly to clients, and are individuals, such as physicians in private practice, or institutions, such as private hospitals. Other providers offer coverage plans to guarantee access to affordable health care, like insurance companies. Market-based providers may be for-profit or not-for-profit entities, but they have one feature in common: they are *in business* -- and they must realize a profit to stay in business.

The existing literature on the private health marketplace describes its importance in many countries as a provider of family planning services to certain segments of the population (largely the middle and upper classes). The potential for playing a larger role exists, although data and current experience are lacking on what kinds of broader programs actually work and at what cost, how to work with the private sector to achieve doctor or government family planning objectives efficiently, and how much of the market this sector can potentially serve.

Over the last six years, the Enterprise Program has gained considerable experience working with market-based providers in the commercial and non-profit sectors to expand family planning service delivery. As the Enterprise Program ends, it is important that the lessons from this experience be documented and disseminated as widely as possible, to inform the donor community about the opportunities and constraints of working with this important but little understood area of the private health care sector.

The goal of Enterprise's work in the market-based sector has been to develop, test, and document a number of program strategies and models, and to assess their strengths and weaknesses in terms of four impact objectives:

- Creating sustainable family planning services;
- Attracting family planning acceptors;
- Using resources for family planning cost-effectively, and
- Leveraging private sector funds for family planning investments.

In designing market-based subprojects, Enterprise selected strategies and settings where market-based providers can maximize one or more of these impact objectives. Early on, Enterprise recognized that to achieve a sustained level of success in privatizing family planning, it was important to know when the use of a market-based model was appropriate and how and under what conditions the market-based sector optimizes the Enterprise impact objectives. This paper analyzes that experience and identifies market-based strategies that have demonstrable impact on expanding family planning service delivery in the private sector.

The rest of paper is organized into four sections. Section II defines and describes the market-based sector and explores its importance in expanding family planning service delivery. Section III discusses how Enterprise identified market-based providers and how they were motivated to participate effectively in new family planning ventures. Section IV then describes specific market-based strategies and models that Enterprise developed, and analyzes them according to their potential for significant impact in terms of the objectives outlined above. A few non-Enterprise examples of market-based models are also presented to enrich the discussion. Section V, the last section, presents conclusions relating to the trade-offs required to maximize a particular objective, along with recommendations on the environments under which they can be met. The final section concludes with suggestions for further study of the market-based sector, to assist donors in private sector family planning to assess market-based work in the broader context of wide demographic impact and public policy.

## **II. THE MARKET-BASED SECTOR AND FAMILY PLANNING**

### **A. Definition of the Sector**

The market-based sector is made up of both for- and non-profit entities working in a number of settings that produce, distribute, finance, or deliver health care services or products. Market-based providers function outside the public sector, and meet their financial needs largely with earnings (and with venture capital, investments, etc.). All market-based providers seek to maximize their return on investment, and market forces determine the growth and direction of their businesses.

The market-based provider, therefore, has interests that differ from those of the public sector. The public sector is concerned with increasing family planning prevalence, protecting or expanding services to the poor and underserved, maintaining an equitable health service fee structure, and keeping expenditures under control. The market-based provider is primarily concerned with profitability, market growth, a stable business climate, and protecting market share by promoting good relations with the government and community. There may be, however, a convergence of interests as well: both the public and market-based sectors may be concerned with providing high quality services to clients, and both may be motivated by social welfare concerns. Public policies affecting health care and business operations are of concern to both the public and market-based sectors: where the public sector is concerned with instituting controls

to protect larger political, economic, and social interests, the market-based sector is concerned with reducing any legal, tax, or trade restrictions that prevent it from maximizing earnings.

The range of market-based providers is broad and the settings they are found in are quite diverse. Enterprise segmented the market-based sector into five categories of settings and providers:

- Individual and group practices -- including physicians, midwives and traditional healers;
- Health service institutions -- service providers such as clinics, dispensaries and hospitals;
- Health financing institutions -- entities offering indemnity coverage and/or pre-paid health service or "managed care" plans, such as health maintenance organizations (HMOs) and insurance companies;
- Manufacturing industries -- producers and/or packagers of contraceptive and other health care products;
- Middlemen and retail outlets -- operations such as pharmacies that sell contraceptives and offer information on family planning.

Market-based providers are found in the urban, peri-urban, and rural areas of nearly every developing country, although they are disproportionately located in urban areas. They operate in both the formal and informal economies. Countries with more active private sectors will have greater numbers of market-based operations, however, countries with less dynamic private sectors will have them as well, e.g., off-duty government personnel in private practice and traditional practitioners such as birth attendants and healers.

There are important differences between for- and non-profit market-based providers. On the for-profit side, a market-based operation may be "proprietary", that is, owned and operated by individuals or groups of service providers. After-tax profits accrue directly to these owner/managers. A for-profit operation may also be an institution owned by investors who have little or no direct involvement in managing the business. The after-tax profits ultimately accrue to these "off-site" investors through dividend distributions or increased equity. While consistently preserving a good image, a for-profit provider will emphasize earnings growth over social welfare concerns, and services and products will be offered at unsubsidized prices to clients who can afford to pay.

Non-profit market-based providers on the other hand, are generally tax-exempt entities which are chartered for a social welfare purpose. "Profits" (surplus income) are reinvested in the business, and are used to fulfill the organization's mandate -- meeting the health care needs of the community it serves. The typical non-profit provider is overseen by an unpaid board of trustees. Because the organization is a non-profit, it may have easier access to any subsidized inputs

offered by the public sector (e.g., free commodities, concessionary financing, or technical assistance). A market-based non-profit provider is not a charity, however, and it does not depend on donations; it competes in the marketplace and survives by ensuring a healthy bottom line. Any services and products offered at subsidized prices must be compensated for by surpluses generated elsewhere. In recent years, as competition has grown fierce, non-profits have become creative in diversifying their operations -- establishing for-profit subsidiaries, undertaking joint ventures, and attempting franchising arrangements. Thus the operational distinctions between non- and for-profit providers are becoming less evident. The Enterprise Program publication "Promoting NGO Sustainability: the Lessons of Enterprise" provides further discussion of the attitudes and practices of NGOs in business.

## **B. The Role of the Market-based Sector in Family Planning**

Existing data show that the magnitude of family planning services provided by the market-based sector varies greatly, both across and within regions of the developing world. A 1988 study by Lewis and Kenney<sup>1</sup> on what is referred to as the private, commercial sector found that in a sample of developing countries, the percentage of contraceptive methods obtained in this sector fell over a huge range: from less than three percent in Nepal to 100 percent in Paraguay. The study also found that due to these wide variations, there were no clear patterns of family planning use in the commercial sector among countries within specific regions. The percentage of methods provided by the commercial sector varies from three to 42 percent in Asia, eight to 50 percent in Africa, 16 to 100 percent in Latin American, and 21 to 69 percent in the Near East.

The lack of good data makes these wide differences difficult to explain. Countries with large and well established government supported family planning programs tend to have the largest share of acceptors using public services, which reflects several factors: first, that subsidized family planning programs in the public sector that are well managed will attract acceptors, and satisfied acceptors have little incentive to pay market prices for services; i.e., that a strong public sector family planning program is effective *competition* for the private sector. Second, that income levels also determine where the family planning acceptor seeks services, with higher income groups tending to obtain services in the commercial sector. Third, and just as important, that incentives or disincentives to private investment in family planning play a large role in how active the commercial sector will be. Restrictive government policies may keep the size of the commercial sector relatively small, and public sector subsidies may distort the marketplace, making the commercial sector less competitive. Thus, if the marketplace for family planning were truly "free," a very different pattern of usage might emerge.

The Lewis and Kenney study also shows that, in the majority of countries surveyed, the public sector tends to play a larger role in providing clinical methods (e.g., surgical contraception,

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<sup>1</sup> M. Lewis and G. Kenney, The Private Sector and Family Planning in Developing Countries: Its Role, Achievements and Potential (Washington, D.C.: The Urban Institute, 1988)

IUDs), while the commercial sector tends to dominate the market for supply methods (pills, condoms, etc.). This may be due in part to the higher cost of clinical methods, which, without public sector subsidies, would make these services too expensive for many lower income couples. The utilization of commercial sources for family planning is also higher in urban than in rural areas, as a larger proportion of commercial service providers are urban.

As the demand for family planning services increases and government resources for family planning become increasingly scarce, there is growing interest in shifting some of the burden of service provision from the public to the private sector. To shift this burden, host governments and outside donors are seeking ways to mobilize the resources of all segments of the private sector, including both the workplace and the marketplace. There are several reasons that tapping the resources of the market-based sector offers significant opportunities for both host governments and donors to expand family planning service delivery. First, market-based providers have an inherent concern for efficiency and cost-effectiveness; given their bottom line orientation, they understand the importance of minimizing costs. Second, they are market-driven; they understand how to compete in the marketplace, how to attract and retain clients, and how to take advantage of demand. Third, those that are well established can share the donor's financial risk in starting or expanding services, if the return on their investment is sufficient. Finally, prospects for sustainability are high, because the livelihood of the market-based provider depends upon achieving it.

### **III. ACCESSING THE MARKET-BASED SECTOR**

#### **A. Enterprise Goals and Strategies for Market-Based Programming**

The goal of Enterprise's work in the market-based sector has been to develop, test, and document program strategies and models which successfully expand family planning service delivery by mobilizing the resources of the private health care marketplace. To achieve program success, Enterprise has attempted to develop market-based strategies and program models which maximize the largest number of family planning impact objectives. That is, Enterprise maintains that market-based interventions should be designed to be sustained, to attract a large number of acceptors, to use resources cost-effectively, and to leverage private sector funds.

The implementation strategies of Enterprise market-based projects can be categorized into four groups<sup>2</sup>:

- Working through "apex" or "umbrella" organizations to reach a large number of service providers or retailers, who, in turn, reach a large number of acceptors.

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<sup>2</sup> Strategies involving contraceptive production and social marketing, which also work in the market-based sector, are not included in this study for two reasons. Enterprise had only limited experience with such approaches and the non-Enterprise implementation of these strategies has already been extensively documented.

These organizations may be professional and trade associations, family planning agencies, or cooperatives;

- Developing fee-for-service arrangements to increase the accessibility and availability of family planning services. Such arrangements include full-service clinics and "doctor franchising" programs;
- Developing innovative managed care arrangements to increase access to family planning. Exploring the feasibility of establishing health plans comprising family planning services (e.g., health maintenance organizations) and working with insurance companies to expand coverage for family planning are the primary focus of this strategy;
- Developing public policy initiatives for family planning to reduce barriers to privatization and make more cost-effective use of host government resources.

## **B. The Enterprise Marketing Approach**

Through experimentation and experience, Enterprise has developed a comprehensive approach to identifying market-based individuals and organizations with the highest impact potential, and marketing new family planning business opportunities to them. Selling possible business opportunities in family planning to market-based health concerns means convincing them that participating will meet their enlightened self-interest. The most successful market-based ventures have been those where Enterprise's intent to maximize impact objectives have coincided with the business, financial, and service interests of the private providers themselves. A critical part of market-based programming, therefore, is zeroing in on that part of the sector where this coincidence of objectives and interests is likely to occur, and then selling the market-based group or individual on the new initiative.

### **1. Identifying market-based settings and providers**

Because Enterprise has focussed on developing and testing a wide range of market-based strategies and models to demonstrate their feasibility, most market-based projects have been in countries with a varied and dynamic private sector (e.g., Thailand, Mexico). Another criterion for country selection is the *lack of* legal barriers to or restrictions on private sector operation and expansion.

After country selection, a "map" of the country's market-based sector should be developed, to identify potential settings and providers and to rate each in terms of sustainability prospects and impact potential. Guideposts on the marketing map include:

- The range and numbers of potential providers in the health service marketplace;

- The types of market-based settings where providers are found;
- Providers' revenue mix (fee-for-service, subscriber fees, national or private insurance plans, private and/or public contracts, donations, etc.);
- The size and characteristics of the health services and family planning market;
- Prospects for expanding existing markets and/or capturing new ones;
- Prices charged for family planning services in both the public and private sectors.

Additional demand-side data may also be examined, such as household expenditure on health and family planning services, current sources of health-related goods and services, and how expenditures differ for different income groups.

The most promising potential project sites are those that:

- Allow access to a maximum number of providers;
- Have the greatest number of success factors, such as:
  - an operating business (or businesses) with good performance records;
  - a competitive range of services offered or covered under pre-paid or insured schemes;
  - competitively priced services or managed care packages;
  - a sizeable untapped market for family planning, or good prospects for family planning acceptors transferring from the public sector.

The next step is to ascertain the feasibility of launching a family planning venture and to market the idea to the potential provider.

## **2. Motivating the market-based provider to participate effectively**

To market the prospective family planning venture successfully and to ensure effective joint participation during start-up and implementation, Enterprise used appraisal and marketing tools to demonstrate the viability of the family planning business opportunity and to prove that both the private providers' and the donors' interests would be satisfied. Another important motivating factor, from the private providers' perspective, were the essential inputs Enterprise offered in terms of training, materials, and technical assistance. The *four critical steps* in developing successful market-based ventures are elaborated below:

**Step One. Demonstrating that the financial interests of the provider will be satisfied, through tools such as pre-feasibility and detailed feasibility studies, business plans, market assessments, or cost-benefit analyses.**

There is always the risk that the findings generated by these assessment tools may not be persuasive enough to draw the provider into family planning service delivery. It also may be found that the requirement for start-up capital is unacceptably high to the potential donor. Thus feasibility studies and other assessment tools are essential investments. The prospects for *positive* findings are most likely when:

- Evidence exists that substantial numbers of target clients already pay for health services;
- There is a reasonably well developed private health sector that demonstrates the profitability of primary health services and/or insurance plans;
- Sufficient financial resources exist locally to share at least some of the start-up costs;
- Government policy supports privatization and encourages market-based operations;
- Local service providers and/or insurers play an active role in the study as co-sponsors, co-funders, data sources, and/or discussants.

**Step Two. Developing the provider's capacity to provide family planning in a business context, by providing technical assistance, training, and materials.**

In environments where providers are already firmly established in the health service marketplace, capacity development is a straightforward and potentially cost-efficient way to increase and maintain participation in new family planning ventures. Medical personnel in private or group practice, pharmacists, and drugstore retailers are excellent candidates for training and technical assistance. Because a large body of technical training materials already exists, this step involves relatively low-risk investments with good potential to increase service availability, especially if the following conditions are met:

- Providers are already persuaded that involvement in family planning service delivery is in their best interests;
- ~~Providers are already established in business and can easily expand their services.~~ Alternatively, there is an excess of un- or under-employed

providers (e.g., physicians, midwives, or nurses), who seek opportunities for private sector practice;

- Local, affordable support systems exist to reinforce or update training, or to provide continuing technical assistance, if needed;
- There is ample demand to support market-based family planning providers;
- There is a profit potential in extending services to underserved areas.

**Step Three. Positioning the provider in the marketplace by giving an edge over potential competitors and/or enhancing status as a family planning service provider.**

In a competitive business climate, any innovation or new service that will differentiate -- in a positive way -- one market-based provider from all other competitors is a powerful advantage. This is especially the case if the provider receives free advertising and significant exposure to enhance status or professional legitimacy. Any program that assists providers to *position* themselves better in the marketplace is a strong motivator and is especially effective when:

- There is active competition among providers for the same clientele;
- The market-based sector is growing;
- There are opportunities to link lower-prestige providers with higher-prestige institutions in the same community;
- Providers feel that status or reputation strongly influences the family planning client's choice of service provider;
- The regulatory climate permits the participation of diverse providers in family planning service delivery;
- Providers feel that participating will help them influence public policy and regulations governing various aspects of their businesses.

**Step Four. Arranging for or supplying seed capital for the start-up of a family planning venture.**

~~The amount of start-up capital required depends entirely on the nature of the business and the provider's financial history.~~ In settings where the focus is on introducing family planning through private practitioners and small clinics, the requirement for start-up capital may be relatively modest. Very often, these providers have little or no credit

history and will have difficulty obtaining loan or investment capital from commercial sources. On the other hand, a large market-based health financing institution like an insurance company or an HMO may need substantial funding to move into the family planning arena. These operations are more likely to have previous experience in obtaining commercial credit, or may have access to funding through a parent company or investor group. If concessionary financing through non-commercial (e.g., donor) sources is required, there are several conditions that enhance its appropriateness, including the following:

- Participating providers share part of the financial risk;
- An apex organization exists to manage and oversee the program, if working with a number of small practitioners and/or clinics;
- Qualified providers view family planning as an attractive investment opportunity;
- There is a large enough market for the new service to assure sufficient return on the provider's investment.

Once the "sale" was made, and a joint venture in family planning was launched with a private sector partner, the Enterprise Program conducted monitoring and evaluation activities, to ensure smooth implementation and to assess lessons learned and identify opportunities for replication.

#### **IV. DEVELOPING REPLICABLE MARKET-BASED MODELS; RESULTS AND IMPACT**

As the most difficult sector to access and in which to develop a portfolio of subprojects, most market-based subprojects were initiated only in the final years of the Enterprise Program. Moreover, some of the most interesting and innovative of Enterprise's market-based work encompass only the feasibility study or planning stage. In spite of the relatively short time frame, the Enterprise Program's experience reveals useful information about the complexities inherent in working with the market-based sector, and the true potential of this sector as a means to expand family planning service delivery.

This section explains how Enterprise secured and sustained the participation of market-based providers by:

- ~ Working through apex organizations;
- ~ Establishing fee-for-service operations;

- Developing insured or managed care plans, and
- Developing privatization policy initiatives.

Examples of market-based program models tested under each strategy are illustrated and analyzed according to their potential for achieving the four impact objectives: sustainability, attracting acceptors, cost-effectiveness, and leveraging.

**A. Strategy: Working through Apex Organizations to Reach a Large Number of Service Providers or Retailers**

**1. Settings: Individual Service Providers**

Enterprise worked through local professional associations to reach medical providers in Ghana and India. The Ghana Registered Midwives Association (GRMA) and the Indian Medical Association (IMA) teamed up with the Enterprise Program, in the former case, to strengthen the business management practices of members of the Ghanaian midwifery association, and in the latter, to upgrade the quality of oral contraceptive (OC) counselling and services offered by physicians in the Indian association. Working through the two associations (whose memberships also include public sector professionals) has the potential for widespread private sector impact: there are 600 midwives in the GRMA and 78,000 medical professionals in the IMA.

Although the types of training that were offered by Enterprise to the two associations differed, there are similarities between the two subprojects. First, the associations were targeted because of their access to large numbers of current and potential family planning clients. Second, both subprojects involved training association members as trainers and technical assistance providers to minimize the need for continuing technical support from donors. Third, most subproject start-up funds came from the Enterprise Program (and other donors), not from the associations or their membership.

The goal of the subproject with the IMA was to give selected physicians advanced training in modern spacing methods, especially in prescription of and counselling for oral contraceptives. Studies have indicated that lack of physician knowledge was preventing the pill from being more widely prescribed in India. This along with inadequate counselling on OC side effects were barriers to continued use among the younger couples that preferred a reversible family planning method. Enterprise contributed about \$72,000 to the subproject (IMA contributed about \$10,000), to develop the capacity within IMA to train member doctors in OC technology, counselling, and information/education/communication (IEC) techniques, and to implement a service demonstration project in three states.

Physician training is to continue after Enterprise with support from IMA, the Ministry of Health and Family Welfare, and USAID. The Ministry is already funding parallel training of IMA physicians in other states. IMA intends to network the program with the commercial and

industrial sectors, including pill manufacturers and distributors, and to charge fees for training and services.

The Ghana midwives subproject revealed a great deal about the potential of using this strategic model to expand family planning services. Enterprise's subproject with the GRMA (the budget for which totalled \$65,895) was part of a much larger USAID-supported effort, spearheaded by the America College of Nurse-Midwives (ACNM) to strengthen the association and to stimulate the involvement of Ghana's private sector midwives in family planning. The overall GRMA project is one of the most intensive efforts to date to increase the participation of market-based providers in a country with severely constrained public health resources and large, underserved populations. The GRMA received assistance from a number of USAID cooperating agencies; Enterprise provided training in business management. Although the trainees were already actively operating businesses (their practices or maternity homes), their management skills were weak and they were poorly positioned to manage more complex operations or to enjoy the financial benefits of an increased and more diverse clientele. Enterprise funded the development of a new business training manual specially geared to the needs and understanding of small health service providers like midwives, and sponsored nine business skills training courses for member midwives. The curriculum included business planning, marketing, costing and pricing of services, sales planning, record keeping, and staff development. The materials developed for the GRMA training were adapted at Enterprise headquarters into the publication "Basic Business Management for Small Family Planning Businesses," now available in English, French, and Spanish.

One of the main activities of the Ghana midwives program, and a major reason why midwives participated, was to help *position* registered midwives in the marketplace as family planning service providers. Though midwives have always been highly respected in the local community, many began noticing a decline in business prior to program start-up. These declines were attributed to the increasing number of physicians opening maternity clinics. Since physicians have higher status, many clients transferred their patronage to the new clinics. The GRMA program included many public relations and marketing initiatives which provided considerable publicity (e.g., recognition at public functions, distribution of unique signs and wall logos, and coverage in the local press). As a result, midwives have become respected providers of family planning services, GRMA's own image has improved, and GRMA membership has grown.

In terms of program impact, 240 midwives are new providers of family planning services in Ghana, and these services are being sustained. All program participants have incorporated family planning services as a permanent part of their businesses. The midwives are now able to manage their practices in a more businesslike manner and their profits are higher. On the average, the monthly profits of Ghana midwives increased by 15 percent after family planning services were integrated into their practices and business skills training was received, though the percentage of ~~total income earned from family planning services ranged considerably, from six to 43 percent.~~ Working with the GRMA provided clear evidence that when the financial interests of market-based providers are met, family planning service delivery will be sustained. Moreover, the documented financial returns have been an enticement for other midwives to join the program.

Family planning acceptor numbers have also met expectations: between May 1988 and September 1990, the midwives newly offering family planning attracted almost 19,000 acceptors. It is interesting to note that the midwives who received IUD-insertion training in addition to standard family planning training were particularly successful in attracting acceptors. In a two-month comparison with midwives who only received standard training, the group with IUD training attracted 107 to 836 percent more acceptors and logged 19 to 44 times as many revisits. Conditions were perfect for simultaneously increasing acceptors and filling a new market niche. By satisfying the unmet demand of the marketplace for IUDs, midwives were serving effectively as family planning providers, while also augmenting the profitability of their practices.

In terms of the cost-effectiveness of donor funds used in the Ghana midwives training program, only a rough estimate of cost per acceptor can be made. Due to the large number of cooperating agencies involved in the program, it is difficult to determine accurately the total cost of the program. A conservative estimate sets the figure at \$1.5 million, which yields a donor cost per acceptor of \$79. It is important to remember that this figure will decrease over time as program costs are amortized: financially self-sustaining midwife practices are continuing to attract acceptors without additional inputs of donor funds. That is, the donor cost per acceptor becomes smaller over time as the numerator (cost) of the equation stays constant and the denominator (acceptor numbers) grows larger. Amortization is a key concept when evaluating donor inputs to private sector programs.

## **2. Setting: Retail Outlets**

Enterprise promoted family planning service delivery through retail outlets in Thailand by working with pharmacists and non-pharmacist owners of retail drugstores. A somewhat similar effort was initiated by SOMARC in Ghana in the late 1980s as part of a social marketing project aimed at increasing prevalence by distributing subsidized contraceptives. SOMARC trained traditional chemists and pharmacists to assist potential users in selecting an appropriate contraceptive, and in identifying and avoiding side effects. The premise was that a retailer will promote and sell products (contraceptives) that are profitable. As retailers purchased contraceptives that were priced below market and then sold them at a mark-up, the project demonstrated that this premise was correct -- it was profitable to promote family planning products, and thus, retailers promoted them to clients.

The Enterprise subproject in Thailand did not involve contraceptive distribution. Since Thailand has one of the highest contraceptive prevalence rates in Asia, the objective in the Thai project was not to promote contraceptives but to reduce the increasing number of contraceptive failures from OC *misuse*. Thailand's 8,000 drugstores play a key role in OC service provision. In the private sector, they are the most important source for OCs, accounting for 61 percent of cycles provided in urban areas. Oral contraceptives, which comprise about 87 percent of a drugstore's family planning commodity sales, are sold by nearly all drugstores in the country and are available without a prescription.

In spite of the high contraceptive prevalence, there is a large and rising number of reported unwanted pregnancies, many stemming from incorrect pill use. A study done on OCs in Thailand indicated that users who purchased OCs from drugstores were the most likely to forget to take the pill. The conclusion of the study was that differences in use and compliance with respect to source most likely stemmed from differences in instruction and supervision provided. Women who purchased their pills in drugstores were unlikely to receive instruction on use and side effects unless they specifically requested it, and even then the information given was often incomplete or incorrect.

As a result of these findings, the Enterprise Program collaborated with the Program for Appropriate Technology in Health (PATH) on an initiative to upgrade the quality of oral contraceptive services delivered by drugstores in two provinces. Total funding provided by Enterprise was \$109,569. The subproject brought together the professional associations representing both pharmacists and non-pharmacist retail drugstore owners, and linked them with sources of pharmaceutical and counselling expertise at the two local university schools of pharmacy. The goal of the project was to reduce misuse of OCs by improving the quality of service delivery at retail drugstores and raising consumer awareness of correct OC use. Like the earlier activity in Ghana, the Thai model tested the hypothesis that drugstores would be interested in participating in the project because it was good for business, and that what was good for business would improve family planning service delivery in the country.

As in the apex model employed with the GRMA and the IMA, developing the subproject participants' capacity and positioning them in the marketplace were important incentives for the 260 drugstore operators to join and sustain the program. Although OCs sales are not a large part of a drugstore's business, improving the quality of the service provided to customers was seen by operators as giving them a competitive edge. If pill customers appreciated the service they were getting, they could be expected to return for other products and to refer their friends. In addition to training in OC technology, counselling, and customer service, participants received reference materials, posters, and stickers promoting proper OC use, free advertising, and special recognition.

Non-pharmacist drugstore owners who make up the vast majority of the drugstore trade in Thailand particularly benefitted from the subproject. Although successful in business, these owners have less legitimacy because they are not pharmacists. Moreover, government regulations are more restrictive on their services. By participating alongside pharmacists, both their image and status as service providers were elevated. As training was provided by prestigious local universities, their legitimacy as service providers was further enhanced. The universities also benefitted by fulfilling their mandates to participate in local social development initiatives.

A sustainable partnership between the provincial professional associations and the local universities was created to carry the program on without donor support. Discussions for joint participation in related activities, such as upgrading the quality of antibiotic counselling, are now underway, and it is anticipated that funding will come from the associations' members themselves.

Not every market-based impact objective is achieved by working with retailers. For example, this model is not strong on leveraging private sector funds for subproject start-up. However, if the primary objective is to maximize prospects for the long-term sustainability of private sector family planning, the model performs very well. Evaluation surveys conducted at the end of the subproject indicate that the drugstore operators' knowledge of OCs and proper customer counselling increased, which has resulted in higher quality contraceptive services for OC clients - and, it is hypothesized, in significant numbers of *better* family planning acceptors. The majority of drugstore operators also report that although they take much more time with family planning clients than before training, the impact has been positive on business volume overall. Because the new OC services introduced have helped most drugstores compete better in the marketplace, these services are being sustained.

#### **B. Strategy: Establishing Fee-for-Service Operations to Increase the Availability of Family Planning Services**

Two models were tested in the fee-for-service setting: small clinic franchise programs in poor communities and full-service clinics geared to middle income clients.

##### **1. Setting: Small Clinic Franchise Programs**

In Mexico and the Dominican Republic, Enterprise provided training and seed capital for private physicians to open small clinics in poor, underserved communities. Funding in both cases was channelled through non-profit NGOs, to stimulate the development of independent market-based family planning providers initially "franchised" by the NGOs. In addition to these projects, Enterprise sponsored a feasibility study in the Philippines to investigate the possibility of establishing a similar program there.

The first clinic franchising program funded by Enterprise was inaugurated in Mexico in late 1986 with MEXFAM, the family planning NGO that pioneered the approach known as "community doctors." Enterprise supported the establishment of 30 MEXFAM family planning clinics, 10 of which had a child survival component. Total funding to MEXFAM was \$329,044. Under MEXFAM's ongoing community doctors scheme, unemployed physicians are recruited, trained, and given clinic space and equipment. In addition, MEXFAM funds a local promoter and provides financial incentives for initial family planning client visits. The clinics operate on a fee-for-service basis, and subsidies from the NGO are gradually withdrawn. Physicians repay half of all start-up costs for equipment and furniture.

After repayment, the clinics are independent market-based operations, owned and managed by private physicians. The amount of time typically required to reach this stage is two years. MEXFAM is currently studying the reasons for and implications of the relatively high rate of physician turnover within the community doctors program (approximately 50%). Despite this phenomenon 28 of the 30 Enterprise-supported clinics now operate without subsidy, including six that moved from one locale to another in order to find a sufficient client base. It is

interesting to note that those with strong children's health services were much more profitable, and hence became sustainable much more quickly, than those without. From a financial standpoint, businesses providing integrated services may be a better investment.

The Enterprise doctor franchising program with ADOPLAFAM in the Dominican Republic drew on this model, but unlike MEXFAM, ADOPLAFAM was an entirely new family planning NGO, with no previous experience in doctor franchising programs. Enterprise support to the program began in late 1988 and totalled \$276,794. Due in part to ADOPLAFAM's lack of organizational experience, it is taking much longer for the forty community clinics funded by the subproject to break even and to begin loan repayments; after more than two years of operation, only ten ADOPLAFAM clinics have made payments on their loans and only three have fully repaid their debt.

As ADOPLAFAM gained experience, it experimented with different clinic seed funding arrangements, which yielded some interesting results. The first set of clinics under the subproject received initial seed funding (for salaries, rent, utilities, furniture, and equipment) as well as clinical and business training and technical assistance. These clinics were heavily subsidized for 12 months. The second set of clinics received the same kinds of assistance, but the subsidy was gradually withdrawn, beginning in month three. The third set received equipment, supervision, and training, but the physicians were required to make their own investments for other costs. This transition in funding arrangements seems to have enhanced prospects for clinic sustainability, as clinics in the last set were closer to breakeven in a shorter period of time.

Enterprise also examined the feasibility of replicating the clinic franchise model in the Philippines by commissioning a study late in 1990. The study determined the viability of establishing a franchise network of 10 rural-based clinics with recently graduated nurses in the Eastern Visayas. Although the franchise network model has excellent potential in the Philippines to reach large underserved populations, the study indicated that the need for long-term subsidies is too great, and the risk to potential investors too high for the proposed market-based venture to be viable. The reasons for this conclusion are instructive.

The study suggested that a foundation be identified to provide professional management for the clinic network fulfilling the "apex organization" role played by MEXFAM and ADOPLAFAM. However, no suitable organization existed, and a new one would have had to be created. Initial estimates showed a consistent operating loss at the foundation level, totalling \$370,000 over ten years. Clinics would require *eight years* to become profitable. Although alternative models were explored which significantly increased prospects for clinic profitability and sustainability, the program remains a risky investment with potentially long-term donor obligations. And, the payoff in terms of numbers of potential family planning acceptors remains unknown.

There are important lessons to be drawn from Enterprise's experience with the clinic franchise model. First, the opportunity to upgrade their clinical skills through high quality training and access to training in business management are a major inducement to physicians to participate in franchising schemes. Second, if the objective is to maximize prospects for clinic

sustainability, working in poor communities where only modest fees for services can be charged means accepting the fact that significant subsidies will be required until the community clinics are viable operations -- indeed, subsidized contraceptives may be required indefinitely. Serving the lower income market also means that clinic owner/operators will, in all probability, be unable to pay back the full value of any loan given for start-up -- concessionary financing and generous repayment terms will be required. Third, to increase prospects for clinic success, family planning should be integrated with other basic health services (e.g., maternal/child health) and clinic operators should share some part of the financial risk of start-up. Finally, one of the most important lessons is that for a franchise-type program to work, the availability of potential market-based providers and an existing market are not enough. An effective apex organization also must exist to implement these complex programs; otherwise, this type of market-based investment may not be a cost-effective use of donor funds.

An excellent feature of this model is that it can attract very large numbers of family planning acceptors, and be a cost-effective use of donor funds. The 30 MEXFAM clinics have attracted more than 64,000 acceptors. In spite of program delays, the ADOPLAFAM clinics have served about 11,000 new acceptors and nearly 4,000 transfer acceptors. Cost per acceptor for the MEXFAM program was less than \$2.00. Final tallies are not yet in for full life-of-project acceptor figures for the ADOPLAFAM project, so cost-per-acceptor cannot be calculated.

## **2. Setting: Full-Service Clinics**

Enterprise supported the establishment of three full-service health and family planning clinics geared to serve a middle-income market in Indonesia, Turkey, and Brazil. The clinics were designed to provide a full range of high quality, convenient, and competitive services in comfortable surroundings, to attract significant numbers of paying clientele. Although the model was applied in very different geographic and social environments, the three Enterprise-sponsored clinic subprojects had much in common.

First, all three subprojects were implemented by non-profit family planning NGOs: Yayasan Kusuma Buana (YKB) in Indonesia, the Turkish Family Health and Planning Foundation (TFHPF) in Turkey, and Centro de Estudos e Pesquisas Clovis Salgado (CEPECS) in Brazil. Second, the three clinics were designed to compete effectively in the market place for a similar target population, middle-income clients who could afford to pay the full cost of services offered. Third, all three had similar sustainability objectives: to establish profitable clinic operations that would generate revenue for the NGOs. Revenue were to be used to subsidize the charitable family planning work of these NGOs or to establish more clinics.

Unlike the for-profit market-based providers who were already in business but needed assistance to develop their *family planning* skills, these non-profit NGOs were experienced family planning organizations that needed help to sharpen their *business* skills in the full-service ambulatory care setting. YKB and CEPECS had years of family planning service delivery experience; TFHPF, while new to service delivery, was Turkey's leading family planning promotion NGO focussing on IEC work and social marketing. To compete effectively in the health service marketplace,

the NGOs had to provide a high quality, attractively packaged product: a full range of health and family planning services in a convenient, upscale location. To reap maximum profits from the new operations, the NGOs had to upgrade their financial management skills (including cost control), and learned how to package and price the new services appropriately. A great deal of attention was given to positioning the clinics in the marketplace -- location and service mix selection were critical -- and successful marketing strategies had to be developed and aggressively implemented. Enterprise played a key role in upgrading these business skills. In addition to providing seed capital for clinic start-up, Enterprise assisted the NGOs to develop their business capacity, through technical assistance in planning the new operations, financial management, service costing, pricing, and marketing.

The performance of the full-service clinic model in terms of the impact objectives differs somewhat from the franchise model. Unlike the franchise model (or the professional/trade association model), Enterprise inputs successfully leveraged private sector funds, as all three NGOs shared the financial risk of clinic start-up, averaging out to dollar-for-dollar cost sharing. This reflects an overall pattern in Enterprise's portfolio, where the non-profit providers tend to be more willing than the for-profits to co-invest.

Regarding clinic sustainability, prospects look good, as all three are, or are close to, breaking even. While CEPECS broke even after 12 months of operation, YKB and TFHPF took considerably more time than originally anticipated to reach this point: three to four years instead of the planned two to three. The YKB and CEPECS clinics are beginning to generate profits for other NGO program activities, and the TFHPF clinic covers nearly 70% of its operating costs through revenues. Aside from receiving donated or low-cost commodities, the clinics currently operate without donor subsidies.

It is important to recognize that to maximize prospects for sustainability, all three clinics had to offer more than just family planning. In fact, family planning has not proven to be a real money maker. For example, only 15 percent of YKB's clinic revenue comes from family planning. Integrating family planning with other services was a lesson YKB learned the hard way. In the mid-1980s, YKB opened 6 urban clinics in Jakarta that primarily offered family planning. These clinics consistently lost money, until the NGO procured a contract to provide parasite control to local schools. In 1986, the year before the school parasite control program began, revenue from the clinics made up only 78 percent of costs (excluding YKB's administrative overhead). By 1989, with a broader range of services, clinic income exceeded costs by 12 percent.

In terms of attracting family planning acceptors in the marketplace, the experience of the TFHPF clinic is instructive. Although the clinic was very well managed, offering high quality services in an exemplary facility, it did not meet its targets in attracting many family planning acceptors, largely because it did not offer a highly demanded service: menstrual regulation (MR). Turkey has a high rate of family planning knowledge, but a low rate of correct use of effective methods. The high demand for MR may be largely due to high failure rates. It was difficult for TFHPF to compete in a family planning marketplace that offers legal, affordable, and safe MR without also providing the service. Instead, the clinic has augmented its women's health service mix

(diagnostic, episodic/emergency, and prenatal care) to attract more clients, much as the YKB clinic added parasite control and the CEPECS clinic offered services ranging from obstetrics to urology.

**C. Strategy: Developing Insured or Managed Care Plans to Increase Access to Family Planning Services**

**1. Setting: Health Maintenance Organizations (HMOs)**

Enterprise sponsored four studies to analyze the feasibility of extending health and family planning services to low- and middle-income clientele through HMOs. The organizations proposed to implement the programs are a non-profit family planning organization in India (Sankalp Kiran), a private industrial estate in Indonesia (P.T. Jakarta Industrial Estate Pulogandung, or JIEP), a rural cooperative in the Philippines (People's Livelihood Foundation, Inc., or PLFI), and also in the Philippines, an established for-profit HMO interested in expanding into the informal sector (PhilamCare Health Systems, Inc.).

**a. Sankalp Kiran**

The feasibility study, market analysis, and business plan prepared for Sankalp Kiran examined the prospects of establishing an HMO to serve the employees and dependents of 26 large and medium sized companies in South Delhi. Although the HMO is a new concept in India, the study concluded that the concept is feasible, provided potential clients can be convinced to switch from direct payment to a pre-payment plan for health services. The analysis suggests a hybrid HMO model that incorporates both a new fixed facility and a network of independent, currently practicing physicians. In addition to a selection of pre-paid packages which offer a choice of curative and preventive services (including hospitalization), the facility is to provide services on a fee-for-service basis.

The feasibility study projects that ten to fifteen thousand clients can be enrolled in five to seven years. The market analysis advises first targeting junior and senior managers at multi-site service and manufacturing industries (companies that tend to pay more benefits). Once this group has been convinced of the HMO's advantages, (e.g., high quality and convenient services at competitive prices), their employees are to be targeted. Eventually, less affluent workers covered by the Employees State Insurance Corporation (ESIC) are to be targeted, and ESIC has already been approached by Sankalp Kiran.

The HMO is projected to be sustainable within five years, but will need considerable financing until breakeven is reached. Start-up capital required is about \$1.5 million. By the fifth year the HMO is expected to begin to generate some profits, however, for Sankalp Kiran, it is more important that the HMO meet its service objectives than generate profits; the venture need only be self-sustaining.

As the market for the new HMO is somewhat uncertain, this is a risky undertaking. Sankalp Kiran's willingness to accept some of this risk is consistent with the behavior of other non-profit NGOs that Enterprise has worked with. Sankalp Kiran is actively seeking a donor or lender to share that risk by supplying start-up capitalization.

**b. P.T. JIEP**

The JIEP HMO model proposed for an industrial estate in Jakarta differs in some respects from the one above. First, the model involves converting an existing health clinic on the estate to an HMO, whereas in South Delhi there is no existing facility to build upon, only a network of independent physicians.

Second, being on an industrial estate of over 260 employers with a "captive" population of 30,000 workers (plus dependents in the estate community), the market is accessible and easily identified. The study shows the availability of an adequate market among estate industries and the community (10,000 clients are projected to be enrolled by year five, and 15,000 by year ten).

Being in a middle income area, it also shows that some workers would be willing and able to pay a reasonable premium, that others would pay on a fee-for-service basis, and that the JIEP HMO operation would be self-sustaining and profitable within three years. Start-up costs for the JIEP HMO are budgeted at \$344,000, considerably less than for the Sankalp Kiran HMO. The projected financial statement for the JIEP HMO shows a profit in year three of almost \$26,000. The costs and profitability prospects are so attractive that local financing from a commercial bank, combined with equity investments from JIEP, an investor group, and a local private medical group will be adequate to cover capital requirements. After seven years, the loan should be repaid, the initial investment recovered, and almost \$100,000 should remain in profits. The Enterprise-sponsored feasibility study (which cost \$30,000), indicates the power of a modest donor investment to leverage considerable investments in family planning by the local private sector. The public sector measure of cost-effectiveness in family planning is usually defined in terms of acceptors; however, it can also be argued that a public dollar which generates \$10 in local private investment, as is the case here, is cost-effective as well.

Like the Sankalp Kiran HMO model, no projections were made of numbers of potential *family planning* acceptors. Family planning acceptors are not separately or specifically targeted. Although preventive services like family planning are essential to good health and cost control, to position itself in the marketplace and be competitive, the HMO must provide and advertise a full range of affordable *curative and preventive* services. In fact, another JIEP study will be done to include hospitalization. It was originally thought that hospitalization should be kept out of JIEP's pre-paid package options, because it would drive costs and the fee structure up; however, a review of the study has led to the conclusion that for the JIEP HMO to succeed in attracting large numbers of enrollees, hospitalization must be included.

**c. PhilamCare Health Systems, Inc.**

The two HMO models proposed for the Philippines are interesting for their innovative features and the elements of risk they incorporate. One involves an established for-profit HMO, PhilamCare Health Systems, Inc., which is interested in expanding into the informal sector by providing services to the Pasay Metro Manila Fish Dealers and Vendors Association. There is a huge informal sector in the Philippines, so an HMO that can successfully cater to this market segment could significantly expand private sector family planning services. The Enterprise-sponsored feasibility study found, however, that knowledge about the health status and health care-seeking behavior of informal workers is far too limited to estimate their usage of health facilities through an HMO. Moreover, it is anticipated that marketing costs will be high, because these workers have no experience with the pre-payment concept and are wary of it. Existing pre-paid packages offered by PhilamCare are too expensive for the average informal sector worker, and such workers are not covered by any form of national insurance (unlike the traditional PhilamCare client). As a result, the potential liability for hospitalization costs is very high; the potential revenue loss during the three-year test period is estimated to be about \$50,000. PhilamCare is unwilling to undertake the experiment without external donor funding to protect against this loss.

**d. People's Livelihood Foundation, Inc.**

Similarly innovative yet risky features are inherent in the HMO proposed for the People's Livelihood Foundation, Inc., a rural cooperative in Tarlac. The study indicates that a profitable, dues-based, managed care system can be developed for cooperative members, provided that low-cost, long-term financing can be obtained. If a standard commercial loan is obtained for the full investment required (\$80,000), the HMO will consistently incur losses during the five year start-up period, and suffer cash shortfalls. To counter this, two options are available, neither of which is acceptable to members: raising the payments per beneficiary or reducing the number of sites and service benefits. If, however, \$70,000 of the planned debt is converted to long-term loans at below market rates, it could be possible to achieve modest profitability by year five, and to meet all debt payments out of cooperative profits. Family planning acceptor figures were impossible to project given the focus and the low budget of the study, but the number could be significant: 32,000 members are projected to enroll in the plan in year one, increasing to 80,000 in year six.

Pre-paid schemes like these which would extend services to large new populations could be high-impact interventions. But, given the conservative nature of most for-profit market-based entities, donors will have to provide subsidies in the form of investment capital to test this hypothesis. Moreover, given the highly experimental nature of these approaches, traditional measures used to ascertain the cost-effectiveness of family planning donor investments are difficult to apply. For example, the proposed PhilamCare scheme will reach about 300 workers and 1,000 dependents, and will cost a donor about \$50,000. Despite a strong family planning component planned for the HMO, the bulk of pre-paid package options covers other services, and estimates of family planning acceptors are not made. However, even if every worker or spouse were an

acceptor, the per acceptor cost would be almost \$170. In comparison with other kinds of programs, this may seem like a poor use of donor funds. However, success in such an experiment could result in the expansion of HMO services to very large numbers of potential family planning acceptors throughout the Philippines' informal sector. If this occurs, then such an investment is more attractive. The issue is whether donors will take the risk, seeing a small payoff in the short-term but recognizing the potential for tremendous longer-term payoffs.

Throughout the discussion of initial donor or lender subsidies, it should be kept in mind that the countries that now have extensive networks of HMOs and managed care plans, especially in the Americas, deliberately employed initial federal grants and loans to enable the HMOs to get started. They did this in view of larger policy considerations in the development and governance of health care delivery systems -- especially with regard to equity and access, preventive care, cost control, and oversight of the quality of care. Thus, there is every reason to expect that in developing countries, too, similar grants and loans will be to implement managed care plans.

## **2. Setting: Insurance Companies**

Enterprise did not work with any commercial insurance companies, so the lessons drawn here are from work done in Zimbabwe and Haiti by another USAID-sponsored private sector family planning program, Technical Information on Population for the Private Sector (TIPPS), with which Enterprise collaborated frequently.

TIPPS' work with Zimbabwe's medical aid societies clearly demonstrates the potential of working with the insurance industry. Medical aid societies are private, non-profit organizations whose premium rates are regulated by the Zimbabwe Government. For-profit insurance companies are not allowed to operate in Zimbabwe. Although non-profit, these organizations are run strictly as businesses and do not depend on donations. There are, however, several characteristics that distinguish a Zimbabwean medical aid society from a for-profit insurance company. The societies were created to guarantee member/subscribers' access to affordable health care; all profits earned by the societies must be reinvested into the businesses to protect or expand service coverage; and, the societies are exempt from paying taxes on profits. Thus, a medical aid society does not make money for investors or shareholders -- it has a distinct service mission -- yet, it must cover its costs and be competitive or it will lose market share to its competitors.

Twenty-six medical aid societies operate in Zimbabwe, the two largest of which account for 85 percent of the approximately 500,000 beneficiaries. TIPPS focussed on the two largest, the Commercial and Industrial Medical Aid Society (CIMAS) and the Public Service Medical Aid Society (PSMAS), to convince them of the financial and public health benefits of providing coverage for family planning. To do this, TIPPS conducted an analysis of the costs and benefits of adding family planning using the largest society, CIMAS, as a test case. The analysis took 12 months to complete, after which TIPPS staff brokered a service agreement between CIMAS and the national family planning organization, ZNFPC (a parastatal). CIMAS agreed to reimburse ZNFPC for family planning services provided to its beneficiaries, if ZNFPC would

ensure service quality and keep good records. ZNFPC already offered high quality services, but TIPPS had to provide the parastatal with technical assistance to upgrade its record keeping system.

The entire process took about two years, and involved CIMAS's applying to the Zimbabwe Government for authority to increase premiums to cover the marginal cost of family planning coverage. CIMAS began reimbursing ZNFPC for services provided to beneficiaries in October 1989, and five months later extended coverage to include private practitioners. In early 1991, PSMAS was given government permission to increase its rates for family planning coverage. Unlike CIMAS, PSMAS beneficiaries will be allowed to obtain services only at ZNFPC facilities.

Family planning acceptor data on CIMAS beneficiaries during the first 12 months of coverage show that just over 5,000 acceptors obtained services from ZNFPC. In comparison, less than a quarter of this number obtained services from private practitioners during the first year that claims from the private sector were reimbursed. Considering that family planning benefits were extended to 164,000 of CIMAS' 190,000 beneficiaries, these are rather modest acceptor numbers.

In terms of sustainability, the extended coverage for family planning is now a permanent benefit offered to CIMAS beneficiaries. Cost-benefit analysis played an important role, by demonstrating to CIMAS that the society would not lose money by adding family planning, even after increased administration and overhead costs were taken into account. In addition to calculating required premium increases, the analysis determined that by adding family planning, CIMAS could avert over 200 unwanted or mistimed pregnancies and over 1,000 abortions in the first five years. This could result in savings to CIMAS of over \$120,000 through a reduction in OB/GYN and pediatric claims. Interestingly, approximately 30 percent of current users covered by CIMAS surveyed indicated that they would switch from public to private sources if family planning were offered as a benefit. As public services, including ZNFPC's, are free, CIMAS would incur additional costs -- but no savings -- for this group of transfer acceptors.

In addition to the forecasted savings, there were other, perhaps even more compelling factors which convinced CIMAS to sustain its family planning coverage. First, CIMAS wished to cultivate the good will of the Zimbabwe Government which exerts a great deal of control over the operations of medical aid societies. Second, CIMAS saw adding family planning -- much in demand in Zimbabwe -- as an effective marketing strategy to differentiate itself from its competitors. Third, CIMAS management focussed on the future and saw a changing Zimbabwe - - one where the largest segment of the population, lower income groups, plays an increasingly powerful role in the economy. CIMAS' future plans include developing lower cost insurance packages to attract this group, one characteristic of which is high fertility. In addition, adding family planning to help contain the skyrocketing costs of AIDS and other sexually transmitted diseases was a very strong consideration.

In Haiti, TIPPS worked with Compagnie d'Assurance d'Haiti, representing ALICO, a division of American International Group (AIG). TIPPS attempted to conduct a family planning cost-benefit analysis, on a much simpler scale than at CIMAS; however, there were many difficulties.

TIPPS was able to get data on maternity related claims and benefits paid out, yet it was not able to get information on numbers of women and children covered, since ALICO does not have a computerized record keeping system for its 15,000 beneficiaries. On the positive side, ALICO allowed TIPPS access to its records; several other local insurance companies would not.

Even more problematic to expanding insurance coverage for family planning has been the internal situation in Haiti itself. The health insurance industry is in turmoil. Traditionally, conventional group health insurance has not been a money maker for the larger, more stable for-profit companies like ALICO, and fewer policies are being issued. Small, undercapitalized firms are jumping in to fill the gap, and are slashing prices to attract customers. Many of these companies have gone out of business, thus further destabilizing the industry.

In this tough economic climate, ALICO is cautious and does not want to risk much in the way of new investment capital in its Haitian subsidiary. If other insurance companies begin to offer family planning, ALICO may follow to stay competitive. Also, if some of ALICO's more important group health clients ask for family planning coverage, the company may be willing to consider it. For now, however, not enough is known about how adding family planning will benefit the company, and much more thorough analysis is required.

**D. Strategy: Developing Privatization Policy Initiatives for Family Planning to Make More Cost-Effective Use of Host Government Resources**

**1. Settings: Individual and Institutional Service Providers, Health Financing Organizations, and Retailers**

Enterprise provided assistance to the Ministry of Public Health (MOPH) in Thailand to help identify ways to make more efficient use of the MOPH family planning budget. The problem addressed by Enterprise's work in Thailand is one that an increasing number of advanced developing countries face: sustaining a high standard of family planning service delivery with increasingly limited budgetary resources. With Enterprise assistance, creative solutions were developed to solve this problem, working directly with the market-based sector.

Enterprise contracted with a leading Thai research organization, the Thailand Development Research Institute (TDRI), to conduct a major study on behalf of the MOPH. The purpose of the study, which started in late 1988 and cost \$200,000, was to determine how to effect public sector cost savings by cooperating with private providers of family planning products and services and reducing subsidies where appropriate.

Family planning services in Thailand are essentially free to all acceptors, regardless of income. The Enterprise-sponsored study compared the public sector *costs* of family planning service delivery with *prices* charged by the private sector in 20 provinces and found that private prices were lower, in some cases, significantly lower, for all contraceptive services offered. To assist the MOPH to identify efficient market-based providers, an inventory of private practitioners in

the 20 provinces was also done. These activities demonstrated opportunities for reducing the public subsidy for family planning and suggested program strategies for transferring clients to market-based providers. Follow-on funding from another USAID program is planned to test the effectiveness of proposed privatization alternatives.

An innovative aspect of this policy initiative was calling upon key members of the market-based sector (officials from the Thai Medical, Hospital and Clinic Associations, leading private family planning service delivery organizations, etc.) to review study findings and to plan the follow-on pilot projects. By bringing together members from both the public and private health care sectors, Enterprise demonstrated that a mutually beneficial partnership can be established for the selective privatization of family planning services. Reducing public sector subsidies to transfer clients who can afford to pay and contracting with efficient private sector providers for service provision to the poor are initiatives that will provide business opportunities for the market-based sector. At the same time, such initiatives could save significant MOPH resources without compromising service quality or availability. From a donor standpoint, market-based programming may have the greatest national impact when it is integrated with public sector cost-containment initiatives.

## **V. CONCLUSIONS AND RECOMMENDATIONS**

### **A. Summary of Lessons Learned in the Market-Based Sector**

- *Initiatives must be based upon the best possible information on the local market.*

The strategies and models presented in this paper have inherent risks and opportunities that cross country and regional boundaries. Yet, as with any development initiative, the internal dynamics of a country -- its economy, government policies, composition of the private health service sector, etc. -- strongly influence the outcome and replicability of any market-based family planning program. Careful local assessments need to be done to determine the feasibility of applying a market-based model. As shown in this paper, however, such assessments can be excellent donor investments.

- *Donors must identify and provide the necessary critical inputs to motivate market-based partners.*

Market-based providers may require training both in family planning clinical aspects and in management, as well as material and financial assistance.

- *Private providers are motivated by the prospect of improving their position in the marketplace.*

- *Apex organizations are essential to manage multi-provider programs, and they may require significant management development.*
- *Non-profits are more likely to cost-share than for-profits.*
- *Market-based activities may be expensive by traditional measures, but the key concept is return on investment. Investment costs must be amortized beyond the project period to get a true picture of cost-effectiveness.*
- *Projects with large networks of providers or with programs serving large beneficiary pools have the best potential for wide impact, and for attaining economies of scale.*
- *Activities which integrate family planning with other health services that are profitable and in demand, like pediatric or other curative care, stand the best chance of financial success.*
- *The key factor is profitability. If an activity is profitable, it will be sustained. For program development purposes, it is important to note that profitability depends both on the mix of services the provider offers, and on how well she or he manages the business.*
- *Continuing subsidies, such as free or low-cost contraceptives, and continuing access to training and/or technical assistance, may be required to sustain quality family planning service delivery in the market-based sector.*

Some of these issues are discussed more thoroughly below, in the context of achieving specific objectives and identifying areas for further exploration.

## **B. Achieving Objectives**

The Enterprise experience has shown that few, if any, market-based models are likely to achieve all four impact objectives, and that trade-offs must be made. By prioritizing the four objectives, however, program models and strategies can be selected to maximize prospects for program success. For example, if the top priority is to establish a *self-sustaining* market-based intervention that attracts *large numbers of acceptors*, then working through an apex organization to reach medical personnel in private practice could be an effective option. If the top priority is to *leverage private sector resources*, then working through a non-profit organization to establish a full-service clinic may be a better choice. Donors working in the market-based sector need to be aware of these trade-offs, and select program strategies and models to maximize specific objectives. The range of trade-offs is explored in more detail below, along with guidance on how to optimize achievement of a specific objective.

## **1. Program Sustainability**

Achieving program sustainability is inextricably linked to ensuring the profitability of the market-based operation. Where the financial objectives of the market-based entity have been met, Enterprise-sponsored family planning initiatives have been sustained. Therefore, maximizing prospects for program sustainability means enhancing the profitability potential of the market-based operation. Doing this involves positioning providers in the marketplace, developing their capacity to compete in the marketplace, and providing them with resources to expand family planning service delivery.

Enterprise's most successful market-based operations have been either those that have integrated family planning with other highly demanded health services, or those that have filled a previously unoccupied market niche (e.g., the Ghana midwives' provision of IUD insertion). As has been demonstrated in developed countries as well, it is important to note that many market-based interventions will need concessionary financing for start-up and may require some continued subsidies (e.g., donated commodities). This will be particularly true for market-based interventions that serve lower income groups.

## **2. Attracting Acceptors**

Increasing the accessibility of family planning services by increasing the volume of services offered in the marketplace is one key to attracting large numbers of acceptors. Direct donor support to individual providers is costly and a considerable management burden; however, economies of scale can be achieved by working through apex organizations representing large numbers of market-based providers, or through managed care institutions with large numbers of beneficiaries.

Maximizing prospects for attracting acceptors also means ensuring that pre-project assessments target the right groups or individuals. Regardless of donor inputs, the family planning market for some providers will always be too small to make a program intervention worthwhile. To have real impact on shifting some of the family planning burden from the public to the private sector, acceptors that are not already obtaining services in the private sector need to be targeted.

## **3. Cost-Effective Use of Donor Resources**

The Enterprise experience has demonstrated that traditional measures of cost-effectiveness (donor cost per acceptor, typically), are not always appropriate when applied to market-based programs. The experimental nature and short time frame of some Enterprise-sponsored market-based programs did result in relatively high cost per acceptor figures, but this has had no effect on the programs' long-term financial sustainability. In fact, the converse is true; self-sustaining market-based operations have meant a falling donor cost per acceptor as Enterprise inputs are amortized over the ongoing life of the activities.

Moreover, programs which have high initial costs per acceptor may also have the greatest potential for long-term cost-effectiveness, because of their ability to attract large numbers of acceptors. A good example of this is the HMO in the Philippines interested in expanding services to the informal sector. Within the immediate scope of the project, costs per acceptor are high, yet, extending HMO services to new populations like the informal sector could result in very large numbers of acceptors. Given the risk-averse nature of most market-based health providers and payers, donors will have to provide funding to test the hypothesis that such investments are ultimately profitable.

#### **4. Leveraging Funds**

To leverage private funds from the market-based sector, Enterprise had to share some part of the risk of start-up. In some cases, this was as simple as a feasibility study to prove that the provider's financial and service interests would be satisfied. In others, capacity development and seed capital were necessary.

In general, Enterprise had more success at leveraging funds from non-profit market-based groups; they have been more willing than the for-profits to put up funds for program start-up. There are several reasons for this: first, for-profit providers are more risk-averse, since investment funds come either directly out of their own pockets or from commercial loans they will have to repay with interest. Non-profit providers on the other hand, often have access to low-, or perhaps no-cost sources of capital (donations, concessionary financing, etc.). Second, for-profits must pay taxes on earnings; typically, non-profits do not. Therefore, a for-profit's pre-tax profit margin from the proposed activity must be higher. Third, a non-profit may be willing to forego a higher profit margin if it means achieving an important service objective.

#### **C. Future Directions**

As demand for family planning continues to outpace the availability of public funds to provide services, it is increasingly important to identify new avenues for mobilizing private sector resources to fill the gap. The Enterprise Program's ground-breaking work in the market-based sector demonstrates its potential as an important new source of services and funds for family planning.

Three key issues in market-based programming still need further work. These issues are critical for donors, because they relate directly to donor concerns regarding target audiences, demographic impact, and cost-effectiveness. Additional field experience is required for the following questions to be answered conclusively.

- 1. How much donor investment is required to establish innovative service delivery schemes to reach new populations? What are the potential risks and payoffs?**

*Donor investments will continue to be needed to test high risk/high gain market-based initiatives -- and the initial cost per acceptor figure may be very high. The issue is, under what conditions should donors be willing to take this risk, recognizing a small payoff in the short-term, but seeing the potential for a tremendous payoff in the future? The returns from one-time, limited-scope donor investment in the marketplace need to be weighed against the returns from the much larger, longer-term investments characteristic of donor support to public sector or NGO programs.*

**2. How effective are market-based programs in transferring family planning users from the public to the private sector?**

*More data must be gathered to determine the prior service history of clients patronizing new market-based initiatives. Enterprise found that the majority of transfer acceptors come from the public sector, but some come from other private providers. What is the full potential reach of the market-based sector?*

**3. Does the support of market-based initiatives actually reduce the public burden for family planning services?**

*Unless it can be shown that private providers attract clients who formerly used public services or new clients who would have used public (not private) services, there will be little positive impact on public utilization and expenditures for family planning. The impact of pre-paid plans that use public facilities for their beneficiaries also needs to be assessed.*

Finally, in addition to work required at the field level, there is still much to be done at the policy level: using the market-based sector to expand family planning coverage will have little national impact without supportive public policies. The Enterprise experience has demonstrated that it is possible for mutually beneficial partnerships to be forged between the public and the market-based sectors. For these partnerships to be effective, however, public policies that reduce barriers to privatization must be in place (e.g., reducing public subsidies for health and family planning services for income groups who can afford to pay; loosening regulatory controls in key areas such as pricing, import duties and advertising; instituting favorable tax incentives).

Donors who wish to support market-based initiatives to expand family planning need to be aware of -- and be prepared to address -- these complex social, political, and economic linkages. By doing so, the risks involved can be minimized, and will be more than offset by the many benefits of successful, donor-inspired application of the private market in meeting public ends.