

EFFECTS OF SOCIAL FRANCHISING ON ACCESS TO HEALTHCARE: A CASE OF TUNZA CLINICS

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ABSTRACT

The purpose of this study was to investigate the effects of social franchising on the access of health care with a case of Tunza Clinics. This was a descriptive survey which aimed at establishing the effects of health franchising with a case of Tunza Clinic operating in Nairobi County. The study concluded that the services should be made available to all the health care clinics so as all the clients to have an easy access to all services offered.

Key words: Social franchising, Health Care, Health Franchising

Introduction

Healthcare is essential to the citizens of any country and it is the responsibility of every government to provide accessible and affordable healthcare. According to Government of Kenya, (2007), the Kenyan government aims to provide an efficient and high quality healthcare system with the best standards to ensure improved livelihoods of its citizens as one of its major development goals. A major benefit in having healthy citizens is increased individual

productivity and improved standards of living while contributing greatly to the country's Gross Domestic Product (Boserup, 2006).

However with a population of approximately 37 million people, Kenya is still struggling to build a health system that can effectively deliver quality, affordable and equitable health services to its population. According to the Annual Health Sector Report, 2008 there were 6,190 health facilities in Kenya, the equivalent of 16 facilities per 100,000 people, or 11 facilities per 1,000 km squared. According to KNHA, 2005/2006 the key challenges to achieving better health status in Kenya is inequitable access to health services and shortages of qualified health workers with appropriate skills. In recent years policy makers, health sector leaders and donors have focused an increasing amount of attention on social franchising as a solution in primary care, reproductive and sexual health, TB and HIV/AIDS diagnosis and care (Montagu 2002; WHO and USAID 2007). Social franchising is defined as a system of contractual relationships usually run by non-governmental organizations which uses the structure of a commercial franchise to achieve social goals (Montagu 2002).

Problem Statement

Access to healthcare services remains a challenge in many countries including Kenya. A number of initiatives by players in the public sector, private sector, non governmental organisations and faith based organisation have been put in place to address this challenge. According to Turin, (2010) the health care utilization rate in Kenya is approximately 77% for those who are sick, meaning that a large percentage of the population does not seek care despite being ill. One of the initiatives aimed at improving health care access and utilization is social franchising in the health sector. The concept of social franchising in health sector in Kenya is relative new and little has been documented about this business model in the Kenyan health sector. Most of the available scholarly works on this subject are foreign (Montagu et al., 2009; WHO and USAID 2007; Sundari and Fonn, 2011) and this makes it a fertile area for research in the management and health perspectives.

General Objective

The main objective of the study was to investigate the effects of social franchising on the access of health care with a case of Tunza Clinics.

Specific Objective

The study sought to achieve the following specific objectives;

- i. To establish how availability/location of franchised facilities affect access of health care services
- ii. To determine how information about the franchised facilities affect access of health services
- iii. To establish the effect of quality of services offered by franchised facilities on access of health care services
- iv. To establish the effect of cost of services by franchised facilities on access of health care services
- v. To find out effect of nature of health care workers in franchised facilities on access of health care services
- vi. To suggest how the social franchising can be improved to enhance access to health care

Literature Review

Theoretical Framework for Social Franchising

Social franchising differs greatly from traditional franchising structures in several ways. The first difference pertains to the underlying mission (social vs. profit), which in turn may lead to different types of franchise concepts (social vs. business program) and different types of target groups (beneficiaries vs. customers). Second, the franchise units involved in social franchising vary from their commercial counterparts (social enterprises vs. individual business people) (Ahlert et al., 2008). Third, the actors engaged in social franchising usually adhere to different values: social entrepreneurs are more concerned with caring and helping than with merely "making money" (Justis and Judd, 2004)

Three main approaches have been used to explain business format franchising: resource scarcity, social capital theory and agency theory. While the agency and social capital theories have widely applied in the field of franchising, the potential of resource scarcity remains doubtful (Combs et al., 2004). Accordingly, we focus on the agency and social capital perspectives.

Agency theory

Agency theory is concerned with contractual relationships between a principal (the franchisor) and an agent (the franchisee) where the former delegates a set of tasks to the latter (Doherty, and Quinn, 2003). Two assumptions are inherent to the theory and drive complexity in agency relationships (Thompson and Stanton, 2010). First, external effects arise as the agent's behaviour affects not only its own but also the principal's success. This fact is particularly problematic when it comes to the second assumption of information asymmetries between the principal and his agent. Information asymmetries are caused by a loss of control over intentions and behaviours of the agent, because the principal cannot monitor all actions of the agent (Doherty and Quinn, 2006). Therefore, agency theory considers economic actors as self-interested and most likely to engage in opportunistic behaviour.

The inability to establish complete contracts leads to agency threats called adverse selection, moral hazard and hold up (Sashi, and Karuppur, 2002). In the context of franchising, agency theory suggests, "there is likely to be greater goal divergence between franchisors and hired managers than between franchisors and franchisees" (Garg and Rasheed, 2003). The basic premise of this argument focuses on the variability of the franchisee's compensation with unit performance. The moral hazard of suboptimal efforts is thus less likely by franchisees than it is by hired managers (Clarkin and Swavely, 2006). The franchisor has authority to monitor the franchisee for product quality and franchisee shirking if detected, could result in the termination of the contract (Thompson, and Stanton, 2010).

Social capital theory

Social capital theory is characterized by an interdisciplinary heterogeneity and it has only recently found its way into economics (Adler and Kwon, 2002). Despite its relatively young age, it has been widely adapted in various disciplines, such as sociology, political science, and economics. As suggested by Peredo and Mclean, (2006), social capital is the sum of the actual and potential resources embedded within, available through, and derived from the network of relationships possessed by an individual or social unit.

Social capital can be tackled either from a macro level or from a micro level perspective (Lin, 2001). On the macro level, social capital is recognized as a collective good or asset produced by a group of people. While these two perspectives help in classifying social capital, we would like to draw the attention on two dimensions clustering attributes of social capital: the structural and the relational dimension. Both of them are highly interrelated and provide a theoretical basis for the theoretical framework of social franchising.

Social Franchising in Health

According to Quinn and Alexander, (2002) the term “franchising” may describe a wide variety of business activities, but the contemporary franchise system commonly in use is known as business format franchising. With business format franchising a unique business relationship is in place. For a financial return, the franchising company, the franchisor, grants a license to its franchisees, entitling them to make use of a complete business package. This includes training, support and the corporate name, thus enabling them to operate their own businesses to exactly the same standards and formats as the other units in the franchised chain (Anwar, 2011).

Anwar, (2011) notes that the franchising concept is a highly flexible and adaptable one and ideally suited for developing service economies. He further notes that while franchising is well established in developed nations, it also works advantageously in transitional economies.

Social franchising applies the fundamental elements of franchising: a clearly defined product and delivery mode, strict quality criteria, quality assurance and a brand that can be accessed by

service providers if they abide by to the quality standards to which the brand is associated. In a social franchise, the end goal is a social gain, such as health improvement. Social franchising has been tested in reproductive health, sexually transmitted infection (STI) management, HIV testing and counselling, and essential drugs. There are no previously published examples of social franchising of TB services (Lönnroth et al., 2007). A social franchise in health services is a variant of the commercial franchise. According to the Global Health Group (2010), a social franchise "encompasses a network of private health practitioners linked through contracts to provide socially beneficial services under a common brand". The outlets are owner-operated and the services are standardised.

A social franchise is characterised by a number of core features. There is a model or prototype which is replicated in several locations; a manual that sets out the concept and all the processes; a brand name for the franchise; a contract governing the relationship between the franchiser and franchisee; standardised training for franchisees; and systematic and standardised methods of monitoring and quality control.

The franchisee pays a franchise fee and in return for membership gets access to commodities, supplies and equipment at reduced cost. S/he also receives training in clinical and business skills, and benefits from advertisement of the franchise "brand" which his/her facility is identified by. The franchisees' obligations include following standards of quality and clinical protocols and maintaining records and reporting regularly to the franchiser (Chandani and Sulzbach, 2006).

Research Methodology

Research Design

A research design is the general plan of how one goes about answering the research questions (Saunders et al., 2007). This was a descriptive survey which aimed at establishing the effects of health franchising with a case of Tunza Clinic operating in Nairobi County. Descriptive studies are undertaken to answer the 'why' and 'how' about a phenomenon. Therefore this research approach is deemed appropriate for the current study.

Population

The population of the study included all Tunza clinics operating in Nairobi County. There are 127 Tunza Clinics in Nairobi County. These formed the target population. At one level the employees at these clinics formed one segment of the target population. The other segment of the population was clients who frequent these clinics. The study also targeted senior management at PSI Kenya.

Sampling

The study used geographical and purposive random sampling. Geographical sampling enabled the study to select Tunza Clinics operating in Kasarani Constituency. Kasarani Constituency was selected as it is accessible and has a high number of Tunza clinics compared to other constituencies in Nairobi. There are 23 Tunza clinics operating in Kasarani Constituency and this formed the sample for the study. The study took 2 employees from each these clinics. The study also interviewed 2 clients in each clinic. The study then interviewed the PSI manager in charge of Kasarani Constituency Tunza clinics. The study therefore had 93 participants as the sample. This sample was deemed satisfactory as recommended by Mugenda and Mugenda (2003) who argued that a sample size of at least 10% or 30 units is appropriate for social sciences.

Data Collection

The research study utilised primary data. Primary data was obtained directly from the sample population. Researcher used questionnaires and interviews guides to collect the data. The questionnaire was pilot tested to ensure internal validity and enhance its reliability. The questionnaire was piloted in Tunza clinics operating in Starehe Constituency. The questionnaires were adjusted to ensure they are valid and have reliability and are bound to give credible results.

Data Analysis Techniques

The data gathered from the questionnaires was analysed using the descriptive statistics with the help of the Statistical Package for Social Sciences (SPSS). SPSS helped in summarizing the data by use of descriptive statistics such as tables and percentages and prediction for numerical outcomes. The study further used inferential statistics to bring out the nature of the relationship between the variables under study. Thematic analysis will be used to analyse and present interview findings.

Conclusions

The study concluded that the services should be made available to all the health care clinics so as all the clients to have an easy access to all services offered. The study also concluded that more investigation should be made on the various aspects of the social franchising. It also concluded that people should be more aware on the availability of these health care clinics and its availability to its clients and other people at large. The other conclusions drawn were the quality of health service to be more efficient to the clients.

Recommendations

It is clear from the findings that social franchising in form of Tunza clinics is creating a positive impact in the provision of healthcare services. It will be important if the ministry of health will also emulate this example and adopt the same strategy in providing some of the basic healthcare services in places where the government healthcare facilities are stained. The government can also support these health care clinics so as to improve its quality lower the cost to the consumers and improve its services.

The cost of services aids in development of quality health care service. Since cost has been growing and this affects the policy makers. Thus the researcher recommends low costs of services thus increasing the healthcare resources.

Suggestions for Further Studies

The researcher recommends the following areas for future studies. The researcher recommends that future study could be conducted the effects of access of healthcare on social franchising and base its study to the other clinics. The researcher suggested the case of the study to include other Tunza clinics in Kenya. A structured questionnaire was used to collect data from 2 respondents per each clinic. The researcher suggests that future studies to be conducted to involve all employees from all levels into discussions.

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