Profile: Merrygold Health Network

Private health service providers provide low-cost, high-quality reproductive health services through social franchising in Uttar Pradesh, India

Challenge

Uttar Pradesh, India's most populous state, has a high unmet need for family planning: 25 percent of women who want to postpone pregnancy or avoid getting pregnant do not have access to family planning (World Health Partners). Despite significant progress, the number of maternal deaths per 100,000 live births (292) is among the highest in India.

Thousands of community health workers support Merrygold's networks of midwifes and doctors, like this gynecologist in Uttar Pradesh.

Innovation

Launched in 2007, Merrygold Health Network (www.merrygold.org.in) is a social franchise (similar to a commercial franchise, a social franchise is the replication of a social enterprise model linked through agreements to provide goods or services under a common franchise brand), implemented by the Hindustan Latex Family Planning Trust (HLFPPT), an NGO promoted by HLL Lifecare Limited, a public enterprise of the government of India. The network employs a three-tiered model of fully franchised hospitals, fractionally franchised clinics (relying on the state's extensive network of licensed private healthcare providers), and community outreach workers to provide affordable services to lower-income populations. Its services include antenatal, perinatal, and postnatal care as well as related maternal and child health services and family planning. Its Uttar Pradesh network consists of 280 health facilities, 280 doctors, 1,540 nurses and midwives, and about 9,500 community outreach workers.

Franchised hospitals and clinics generate revenue through a low-cost, high-volume strategy that allows them to price services at 50–60 percent below market prices. All facilities accept health insurance and make services affordable through tiered pricing and the cross-subsidization of preventive and curative services. Merrygold ensures that general ward patients account for at least 70 percent of its patients; the other 30 percent pay higher fees in the semi-private and private wards. Franchisor revenue is generated through a franchising fee of about USD 6,000 for hospitals and USD 20 for clinics, plus a royalty fee for hospitals of 3 percent of revenues. Community workers provide outreach, particularly in rural areas, and generate demand for the network. They receive a monthly performance-based reward from Merrygold.

Impact

In its first seven years of operation, the network conducted more than 890,000 antenatal check-ups, delivered 170,000 babies, performed 11,000 sterilizations, and inserted 42,000 intrauterine devices. It provided more than one million "couple years of protection" (a measure used by family planning services that indicates the estimated protection from pregnancy provided by contraceptive methods during a one-year period) and saved 14,157 disability-adjusted life years (Viswanathan, Schatzkin, and Sprocket 2014). Price pressure from Merrygold forced some private service providers to revise their price structures to stay in business.

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This series on Inclusive Innovations explores business models that improve the lives of those living in poverty. Editors are Elaine Tinsley and Natalia Agapitova. Written and researched by Endeva and Ashley Insight.

Scaling Up

The network has been enormously successful in ensuring equitable access to good-quality health services. Impressed with its results, the government of India asked it to expand to all 75 districts of Uttar Pradesh, up from 25 districts.

Merrygold was set up with the goal of financial sustainability. During its first four years of operations, it relied on donor funding to establish the network, its branding, protocols, and software and to build caseloads. Since 2011 revenues have provided about 85 percent of its funding. It plans to become fully sustainable by about 2017 or 2018.

Merrygold's experience indicates that an exclusive focus on family planning limits the prospects for profitability: Offering additional services, such as maternal and child health services, was necessary to render the model sustainable. Ensuring equitable access to quality services in rural and remote areas remains a challenge.

References

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