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Elise Catherine Davis, Ashley Evans, Caroline Uptmore, Sarah Lang, Jessica K. McElroy, David Ellenburg, Tony Nguyen, Bita A. Kash,

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Elise Catherine Davis
Department of Epidemiology and Biostatistics, Texas A&M Health Science Center School of Rural Public Health, College Station, Texas, USA

Ashley Evans, Caroline Uptmore and Sarah Lang
Department of Health Administration, Texas A&M Health Science Center School of Rural Public Health, College Station, Texas, USA

Jessica K. McElroy
Department of Health Administration, Texas A&M University System, College Station, Texas, USA

David Ellenburg and Tony Nguyen
Department of Health Administration, Texas A&M Health Science Center School of Rural Public Health, College Station, Texas, USA, and

Bita A. Kash
Department of Health Policy and Management, Texas A&M Health Science Center School of Rural Public Health, College Station, Texas, USA

Abstract

Purpose – The purpose of this paper is to present proposed solutions and interventions to some of the major barriers to providing adequate access to healthcare in Kenya. Specific business models are proposed to improve access to quality healthcare in low- and middle-income countries. Finally, strategies are developed for the retail clinic concept (RCC).

Design/methodology/approach – Google Scholar, PubMed and EBSCOhost were among the databases used to collect articles relevant to the purpose in Kenya. Various governmental and news articles were collected from Google searches. Relevant business models from other sectors were considered for potential application to healthcare and the retail clinic concept.

Findings – After a review of current methodologies and approaches to business and franchising models in various settings, the most relevant models are proposed as solutions to improving quality healthcare in Kenya through the RCC. For example, authors reviewed physician recruitment strategies, insurance plans and community engagement. The paper is informed by existing literature and reports as well as key informants.

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This paper forms part of a special section "Global health and human development in Africa", guest edited by Fredrick Muyia Nafukho.

Research limitations/implications – This paper lacks primary data collection within Kenya and is limited to a brief scoping review of literature. The findings provide effective strategies for various business and franchising models in healthcare.

Originality/value – The assembling of relevant information specific to Kenya and potential business models provides effective means of improving health delivery through business and franchising, focusing on innovative approaches and models that have proven effective in other settings.

Keywords Kenya, Franchising, Patient engagement, Physician recruiting, Retail clinic, Social franchising

Paper type General review

Introduction

Upon becoming a republic and developing constitutional amendments in 1964, the Kenya government made a goal to promote and improve the health status of Kenyans by making healthcare effective, accessible and affordable. The main healthcare concerns in Kenya are: how to best deliver healthcare services and how to finance healthcare services in a way that makes them effective, accessible and affordable (Kimani *et al.*, 2004). The public sector of healthcare in developing countries frequently lacks timeliness and hospitality towards patients, while the private sector can be inefficient and medically ineffective (Basu *et al.*, 2012). In Kenya specifically, there is a lack of engagement between the private and public sectors. Because both sectors have successes and challenges of their own, engagement between the two may solve greater problems in a timelier manner and more effectively (Sood *et al.*, 2011). The model presented in this paper is applicable to private and public healthcare institutions and can be implemented in a variety of settings.

The models presented in this paper are relevant to the retail clinic concept (RCC). RCCs are designed as medically capable buildings with a retail center for local markets and distributors. The RCC will ideally be distributed by franchising and tied together through an information network. Each RCC will carry space for basic ambulatory capacity, a clinical examination room, a dispensing pharmacy, a clinical diagnostic laboratory and space for clinical trial research work. While the model presented in this paper focuses on Kenya, it is applicable in all low- and middle-income settings with a need for improved health. Kenya is a good example of a country with both private and public needs for improved health delivery and so is used for the purpose of this paper.

Methodology

Information to support our theoretical model were collected using PubMed and Google Scholar, as well as some governmental websites. Articles were selected based on their relevance to the healthcare market of Kenya, as well as their relevance to the RCC model. The focus of the search was twofold. Primarily, search parameters included business models that have provided evidence of financial success and sustainability in low-resource countries. Further, these models must be applicable (either in complete original format or in a piecemeal format) and transferable to meet the geographic, cultural and financial demands of this particular market. Second, literature that is informative from the perspective of current epidemiological trends, geographic and physical landscape considerations and cultural barriers was used to assess the feasibility of proposed business models for the production of health and access to primary care.

Models for practice

Kaiser permanente – per member per month model

Kaiser Permanente (2007) is an integrated healthcare system based out of California which provides both insurance and care to its members (Strandberg-Larsen *et al.*, 2010). Kaiser's

model provides an example of how to use a capitated payment method within a vertically integrated system. Using this model, healthcare systems are incentivized to reduce length of stay and increase preventive services. The model allows infrastructure to be constructed and provides a team model for the providers to prevent disincentives (Crane, 2009). Because the organization has a multitude of providers such as primary care providers, specialists and therapists all under one organization, they are able to refer the patient to the best team member rather than referring for care outside the organization. This model has proven to be effective and is transferable to the RCC. The model demonstrates that when the medical group and the health plan are in alignment and health service contracts remain within one entity, a greater number of patients remain healthy while optimizing utilization (Crane, 2009). Clinicians who are a part of the Kaiser Permanente model report timeliness of information transfer, agreement on roles and responsibilities in the workplace and coordination of mechanisms to ensure effective handoffs (Strandberg-Larsen *et al.*, 2010). The RCC model is specific to primary care, but a model such as the Kaiser Permanente one would allow for RCC physicians and pharmacists to communicate effectively and also provides opportunity for RCC primary care providers to hand off patients to hospitals when necessary.

Texas A&M university system – self-insurance model

Texas A&M University (TAMU) System has its own insurance plan. Blue Cross and Blue Shield plans are paid by the university to act as the administrator, but TAMU assumes the role of the insurer. Lower insurance premiums, better coverage and increased cost savings are benefits of this model because third-party administrative costs are eliminated (Self-Insurance Institute of America, 2010). In addition to the self-insured model, the TAMU System provides a financial incentive to its employees. A condition of this incentive is to receive discounts on premiums if the employee shows proof of receiving a yearly wellness exam. Therefore, the university is encouraging its employees to take advantage of preventive services which keep costs low for both the patient and the university by maintaining an environment of healthy, productive employees.

The TAMU System is taking steps to encourage employees to live healthier lives by actively engaging with a healthcare provider and utilizing preventive services available under the Care Health Plan. By completing an annual wellness exam, employees and their spouses remain eligible for the lowest premiums. For instance, $30 is added to premiums for employees that do not complete annual wellness exams, while $50 is credited to deductibles if employees complete an additional health assessment. This $50 deductible is also available to the employee's spouse and children (Texas A&M University, 2015).

One of the goals of the RCC is to provide healthcare services, as well as the means for Kenyans to participate in their own healthcare through physical and economic vesting. Therefore, the Wellness Works program at TAMU is an excellent model to accomplish these objectives. Wellness Works is a program designed to encourage employees to live healthier lifestyles, to support a healthy workplace and to create a culture of wellness focusing on three critical aspects of over-all health: physical, financial and interpersonal (Texas A&M University, 2015). The RCC insurance could offer a similar program and incentive to encourage Kenyans to rethink the preventive services they engage in and utilize.

Cleveland clinic – partnerships with employers

Cleveland Clinic is an academic medical center based out of Cleveland, OH that was founded in 1921. Cleveland Clinic has partnered with Wal-Mart and Lowe's to provide bundled payment contracts when employees of these partner companies need medical

care (Advisory Board Company, 2013). This competition for employer contracts will keep quality high and prices low. Employers are incentivized to retain healthy employees.

Furthermore, the Cleveland Clinic operates under the employed physician model. This employed physician model reduces any unnecessary surgeries and fees because the physicians do not receive income according to volume. Therefore, patients receive only necessary care. Patients and employers are incentivized to partner with organizations like the Cleveland Clinic because the contracts are among many efforts by public and private payers to use financial incentives to get providers to join together and take responsibility for reducing costs and improving quality. Employers have announced contracts that direct patients to no more than a few health systems which companies identify as high quality. Patients do not pay travel costs or medical bills. Hospitals and doctors agree to one price for all related services (Herman, 2015). RCCs can emulate this model and will, therefore, be able to incentivize employers to partner with them.

Proposed business model: franchising

In a business sense, franchising is a method of expansion with the benefit of risk-sharing. There is not a wealth of literature on healthcare franchising, but experts indicate it is becoming more and more common stateside and internationally (Daley, 2014). Countries such as India, Pakistan, South Africa and Kenya are currently leading the industry in healthcare franchising.

In the USA, healthcare franchising typically takes the form of elderly and home care, eye and ear care, dental care, paramedic care and pharmaceutical care (Nijmeijer *et al.*, 2015). In low- and middle-income countries, however, family planning has proven to be particularly lucrative for franchising. Profit margins can likely be strengthened by expanding services beyond family planning to include curative care, such as treatment for infectious diseases that are common to low- and middle-income countries, for which the willingness to pay is typically higher (Ruster *et al.*, 2003).

Health franchising offers benefits such as training, access to business loans, access to pharmaceuticals, brand recognition and advertising (Prata *et al.*, 2005). Franchising also has the capacity to transform motivated and hard-working individuals into financially successful independent entrepreneurs (Bishai *et al.*, 2008).

Social franchising and healthcare

The formal definition of social franchising is the application of commercial franchising concepts to achieve socially beneficial ends, rather than profit (Montagu, 2002). This concept is most successful when social and cultural analysis is done in conjunction with front end market research. Franchisees who are typically citizens in their target market offer unique insight on cultural barriers that may be difficult to identify as an outsider. In today's healthcare marketplace, providing services to specific populations and building a niche practice can assure a provider's competitiveness (Rivers and Glover, 2008). Gaining experience in providing services to members of certain communities can help a provider become recognized as an expert in working with particular populations (Vasquez, 2007). The marketing approach and services offered must be aligned with the needs and preferences of the intended audience, in this case the patient and their family.

Hybrid value chain

Hybrid Value Chain (HVC) is a business model that leverages the capabilities of the business and citizen sectors to enable the delivery of needed goods and services to low-income populations in a cost effective way. Companies tap into new markets and expand their client

base. Citizen Sector Organizations (CSO) increase their impact by generating new revenue sources for their programs and expanding their service range to beneficiaries. Additionally, low-income populations improve their livelihoods as their basic human needs are met and new economic opportunities arise.

The HVC model is relevant for essential goods and services that represent a significant investment for low-income populations and that typically require complementary services to develop markets and maximize customer value. Its implementation implies new roles and practices for businesses and CSOs. The HVC model goes beyond philanthropy and corporate social responsibility. By leveraging the core assets of CSOs and businesses, HVC partnerships are breaking the inefficient paradigms that separate the two sectors. HVCs enable a world in which CSOs and businesses collaborate, compete and learn to serve low-income markets with new business models so that all individuals benefit from products and services delivered by the formal economy (Drayton and Budinich, 2009).

Costs associated with a wage-earning relative's death can be financially devastating for members of low- to middle-income families. Zurich Financial Services sells affordable insurance policies to underserved communities in rural Mexico, for which it assumes financial risk. The Mexican Association of Social Sector Credit Unions (AMUCSS) provides on-the-ground know-how and distribution networks for market usage. Zurich and AMUCSS partnered into an HVC and were instrumental in creating the demand for insurance in these markets, which helps to ease the financial burden of funeral costs and reduced household incomes of many already impoverished families. This sustainable, low-cost, high volume model created by the collaboration of AMUCSS and Zurich has created a new standard in the rural micro-insurance sector. The model has been so successful (50,000 policies sold in 2009) that Zurich plans to use it to introduce other mass-market products in the coming years that will benefit the rural, underserved communities. Therefore, this could be replicated in Kenya to better finance the citizens of Kenya and make sure they are insured (Budinich, 2012).

Forming a CSO would provide citizens of Kenya the information on the ground about local communities and networks. Cooperating with a large health insurance entity such as Cigna or Aetna International would be helpful to sell affordable insurance to communities that may not have access to insurance. Kenyans can help create the demand necessary for health insurance so that the financial burden of medical care for local communities can be lessened.

Clinics called E-Health Points use telemedicine, which allow patients to consult with a doctor without having to travel to a clinic or hospital (Drayton and Budinich, 2009). Therefore, this affordable yet sustainable HVC model could allow for high volume, driven health insurance plans created by the citizens of Kenya and a partnership with a large health insurance company. This model can become very successful and tap an unreached mass market that can benefit Kenya.

Proposed solutions and strategies for implementation of retail clinic concept

Physician shortage in rural Kenya and recruitment strategy

To successfully implement the RCC, developing effective physician recruiting and retaining strategies will need to be taken into consideration. According to a study published by Canadian Family Physicians, rural family physicians tended to rate the following as the most important educational and practice solutions for recruiting and retaining: funding for learner-driven continuing medical education (CME) and limiting-on call duty to 1 night in 5

(Rourke *et al.*, 2003). This information will be important for further developing physician education to produce top research at the RCC site.

The American Academy of Family Physicians states that the two strongest predictors that a physician will choose to practice in a rural area are specialty and background. For example, family physicians are more likely than those with less general training to go into rural practice (American Academy of Family Physicians, 2014). This is important information to note in our marketing strategy. It will be necessary to ensure that a majority of the marketing will be targeted at family physicians as opposed to specialists to try and increase the number of physicians on staff in retail clinics in rural Kenya.

Recruiters will need to have a solid local knowledge of current events and cultural considerations and be able to express safety concerns to prospective physicians. Recruiters should be able to develop safety plans and work schedules around the local environment. When marketing the RCC to prospective employees, it will be necessary to break down any misunderstandings that are commonly associated with life in rural Kenya. For example, many healthcare workers stated that they feared for their safety in rural Kenya because of the areas being dominated by other tribes. These individuals attributed their fear to post-election violence that swept across Kenya in 2007 and 2008 (Mullei *et al.*, 2010). Many individuals surveyed stated that they had family members who were victims of the violent events. This type of information will be necessary when recruiting new physicians into these areas. Recruiters will need to have a solid local knowledge of events such as those mentioned and be able to express safety concerns to prospective physicians, as well as listen to and understand the concerns of prospective physicians. Overall, it will be necessary to take three main strategies into account when marketing physician jobs in Kenya. Three strategies include casting a wide net of recruiters, understanding what makes retail clinics different from other rural health facilities in Kenya, as well as properly supporting new hires (Doyle, 2013).

The RCC physician job should not be over-sold in low-income settings. Recruited physicians should be an appropriate fit for retail clinics and should be willing to relocate to areas with the highest needs (Healthcare Source Blog, 2013). If these steps are not properly taken, then physician turnover could turn into a major issue for the RCC, as has been observed for many low-income settings (Zurn *et al.*, 2010). Managers of retail clinics should maintain relationships with all health workers to ensure employee satisfaction. Additionally, conducting exit interviews if a physician chooses to leave the RCC will be necessary in improving the RCC for physicians and other healthcare workers (Echevarria, 2014).

It is in our recommendation to implement not only proven physician recruiting methods, but to implement incentives for physicians to stay in Kenya and work for the RCC. Efforts to keep physicians in Kenya include setup of on-campus physician housing and to keep physicians on a contract basis. In addition to paid physician housing, it would be helpful to have physicians on 1-2 year contracts to ensure that physicians remain on site. Finally, it would be best to offer a student loan forgiveness program to entice the new physicians to stay at the RCC site.

Creation of a self-insured and vertically integrated medical city

The aforementioned partnerships with employers will also include employee membership in the designed RRC insurance plan. This arrangement will benefit the employee, the employer and the community. The benefit to providers is that contracted partnerships will ensure a certain number of members per month while keeping costs

low. Self-insured healthcare providers would profit from policy purchases as well as a decreased cost to provide services. Furthermore, providers would be vertically integrated. That is, they will provide a spectrum of services so that transitions of care will occur within the one organization. This is another method of ensuring revenue as well as cost containment.

Conclusions

The RCC model, when implemented while considering the needs and wants of patients and physicians, can be successful in low- to middle-income settings. The model increases community engagement through franchising and market opportunities for local sellers and by increasing health awareness and healthy behaviors. By including communities in the development of the RCC, acceptance of the RCC will increase, and community members will be more willing to seek out healthcare from the medical center. This can lower burden of disease and spread of disease in high-risk areas. The model is applicable for urban and rural areas but specifics of each community must be considered when developing a new RCC. Including an insurance model with the RCC will improve the overall success and reach of the clinic.

This manuscript is limited to a theoretical model and a brief scoping review of literature. While unique, further research on implementation of the RCC model is required for true success of the model.

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Corresponding author
Ashley Evans can be contacted at: evansa0913@gmail.com