# Social Franchising to Improve Quality and Access in Private Health Care in Developing Countries

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Article 25 of The Universal Declaration of Human Rights proclaims that everyone has a right to medical care necessary for health and well being [1]. As members of the United Nations, states have a normative responsibility to ensure access to necessary healthcare for their citizens. Nevertheless, private provision of healthcare is omnipresent and surpasses public provision in many developing countries [2]. The goal of this paper is to examine the ways in which public and private sectors can cooperate to improve the quality and accessibility of primary healthcare (PHC) to the poor in developing countries. The promise of alternative business models lies in their ability to accomplish several important functions in PHC. Business-style contracts can organize small providers into units that are large enough to yield returns to scale in investments in physical capital, supply chains, and in worker training and supervision. Furthermore, with donor assistance, business models can potentially arrange for cross subsidies to help improve access to care. In order to understand the problems that business models can help solve, this paper will set up

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a simple economic model of public-private interests in healthcare. The model identifies two key social interests in healthcare markets: quality of service provision and access to care by disenfranchised groups. These particular aspects of healthcare delivery are "merit goods," meaning that ensuring quality and access for the poor have positive benefits for society that are greater than what individual consumers perceive. A third component of the health system which will not be explicitly considered here is the risk spreading or "insurance" function that needs to be carried out in society so that the unpredictably heavy consequences of illness and injury are borne equitably. The alternative business models that will be considered here are models of primary healthcare provision at facilities, not models of health insurance.

## Definitions of key terms

Primary healthcare services are taken to include those delivered at 'primary level' facilities (such as health posts and health centers) or mobile clinics and consist of basic diagnostic procedures and prescribing services. At first glance, the profit goal of private enterprise may seem inimical to the interests of the poor. However, several alternative business models, such as voucher systems, contracting out, and social franchising, can be used to effectively transform the private sector into a "conduit" for public financing to support the public and donor interest in the health of the poor.

The term "alternative business models" is used to describe a variety of contractual arrangements between networks of private providers and coordinating agencies. The term "coordinating agencies" refers to administrative bodies that are able to offer in-service training, access to information and expertise, networking opportunities, monitoring of service provision, access to subsidized inputs, and, in some cases, promotion and marketing of a trademark or brand name. Coordinating agencies may be for profit, non-profit, or an agent acting on behalf of the state. The strategies they use and their contractual arrangements with individual providers are analogous to those used in the business world. Nevertheless, when commercial enterprises provide healthcare, regulatory oversight is necessary. Healthcare delivery lends itself to commercial methods of arranging cooperative behavior between several parties, each with individual goals and incentives. In business, each agent pursues financial gain. However, healthcare is different because financial gain should not be the sole goal of providers, patients, or the coordinating agencies. The inability of patients to evaluate the quality of the product they are buying invalidates the usual theorems about the optimality of the free market.

Section 2 of the paper sets up the model and reviews how quality and access may falter in a laissez-faire market for private healthcare. Section 3 of the paper applies the same model to show the potential weaknesses of a health system that is government-owned and operated. Section 4 uses the framework to yield predictions about the performance of several alternative business models of healthcare provision and Section 5

tests the theory using evidence from an alternative business model currently operating in Pakistan. The concluding section discusses future ways to improve the implementation of alternative business models in PHC.

## A simple system of private healthcare

Many policy makers in public health and healthcare systems see a link between their professional activities and the health of large groups of people. But health itself cannot simply be allocated to people. The household is the key ingredient in the health of each individual and collectively, it is household decisions that determine the health of any nation [3]. Household members themselves enjoy most of the benefits of better health; secondary benefits of health to employers, friends, colleagues, and beleaguered healthcare providers have lesser magnitude. Consequently, most of the incentives to improve and produce individual health fall on the household.

### Protection of the Poor as a Public Good

Public goods are goods which are readily available for any person to consume and whose availability is not diminished when one person consumes a share [4]. Standard examples include clean air and domestic tranquility. Under ordinary circumstances when one person feels sick and takes medicine to feel better, all or nearly all of the benefits the patient and their concerned friends and family enjoy are private, not public, goods. There are special considerations that make the health status of one poor person or poor people in general a factor that can be enjoyed by a whole society as a public good.

Because each household must devote some of its own income to health production, extremely poor households will not be able to afford substantial inputs to health and thus could acquire and spread contagious diseases. Contagion is a negative externality that motivates public interest in the ability of each household to acquire substantial inputs to health. Reducing contagion benefits all of society and is, in this sense, a public good. There are other potential justifications for social concern for the accessibility of healthcare for all citizens—simple altruism, a fear of terrorist acts by the downtrodden poor, or a belief in social solidarity. These justifications differ from contagion in that they would motivate a general interest in alleviating poverty, and in addressing poor health merely as one of the features that exacerbates poverty. The contagion externality would motivate a concern specifically for social efforts to break the link between extreme poverty and poor health.

### Quality Improvement as a Public Good

In order to illustrate why quality improvement is an input which must be regulated or monitored, let us imagine what would happen in an unregulated, wholly private market for PHC, where healthcare is produced by profit motivated firms. In response to households' demand for better health, firms will arise to profit by selling curative and preventive health services to households. In markets for goods where quality can be evaluated by customers, prices are generally proportional to the quality of the

items. Information asymmetry between households and healthcare providers would make our hypothetical laissez faire market for medical care operate differently. First assume that there is a way to separately measure both the volume of care and the quality of medical care produced, where increased volume implies greater access to care due to increased supply. For instance, one might count the numbers of visits, tablets, or the numbers of procedures to measure volume. One might determine the best practices and form rating scales for various types of medical care to measure quality. In order to generate increased quality or increased units of volume, providers will be required to expend effort and capital.

Quality increases with effort and capital, but generally decreases with the volume of service. The amount of medical care supplied also increases with effort and capital, but decreases with the level of quality. Because patients can easily measure the volume of care, but not the quality of care, the payment agreement between patients and providers will generally be based on fee for service volume, not fee for quality. According to the classical economic paradigm, the providers will choose to supply an amount of volume and level of quality that will maximize their profits. The volume supplied will be in proportion to the quantity demanded.

In an unregulated private market for healthcare, every unit that is purchased by the client has a cost that is equal to or less than the perceived value to that client. A provider may be able to generate a profitable amount of perceived value to a patient who is poorly informed without investing the costly inputs of effort and capital to make the services of sufficient quality that the health condition actually merits. Quality services may be underprovided because patients do not know enough to demand them.

Efforts to ensure that health services remain of high quality have a natural efficiency when they are applied across the board, to large numbers of medical practitioners. Social efforts to ensure high quality health services offer returns to scale. They are more efficient when they are applied across a system. Once quality assurance mechanisms are in place, one patient's receipt of quality health services does not diminish the availability of quality to others, and thus quality assurance in healthcare is a public good.

## The free market failure for providing access and quality

Because demand for medical care is well known to increase with income [5], individual free market providers will locate themselves more densely in areas with higher income. Increased supply and greater competition between providers in urban areas may paradoxically lead to cheaper primary healthcare for wealthy urban, compared to poor rural, consumers. While the private market can achieve an equilibrium between demand and supply of the volume of medical services, without regulation, this equilibrium is unlikely to achieve society's desired outcome regarding the accessibility of services for the poor. Furthermore, without regulatory mechanisms or the participation of coordinating agencies to address information asymmetry about the quality of medical care, the market equilibrium will suffer from a sub-optimal supply of quality. If the supply of health services is unresponsive to the aspects of qual-

ity that matter most for health, profit-seeking providers will have no incentive to address them. Technical quality of care may be low while perceived quality is maintained in the form of aspects of quality which are easily measured, such as cleanliness, presence of amenities and staff politeness.

The medical profession addresses the problem of medical quality by fostering professional standards among providers, by evaluating medical trainee applications for signals that the applicant is committed to putting patient welfare before private gain, and by socializing medical providers to disapprove of peers who seek to gain profit by undersupplying quality. Governments regulate the medical sector primarily by licensing individuals who have passed examinations and completed training in accredited institutions where they have presumably been socialized to the appropriate professional norms. Despite these mechanisms, there is abundant evidence that more could be done to improve the quality of care in the private sector of developing countries [6-8]. Saying that "more could be done" is also saying that the private market described above requires additional inputs to help providers to produce service quality. Consequently, primary healthcare markets, even in combination with professional and regulatory sanctions, still fail to guarantee socially desired levels of access or intangible outputs such as quality. Section 3 will describe in more detail the coordinating activity that could be added to improve the production of service quality.

## Quality and Access of PHC in Government Facilities

Led by the World Health Organization and other international institutions, many countries have become substantially involved in providing PHC in hierarchical systems of community health workers, dispensaries, clinics, and a tiered system of referral hospitals. In most countries, the public system operates parallel to a fairly autonomous private system. Despite the fact that primary health services have significant positive externalities, household data from several countries suggests that the majority of PHC service episodes involve private facilities [2, 9-11]

Higher perceived quality in the private facilities is an established reason that households in low income countries appear to prefer private sector PHC [12, 13]. This may seem paradoxical in light of the last section, in which the model of profit seeking private providers predicted an undersupply of quality. However, not all aspects of service quality are easily perceived. Additionally, public sector quality may be low for reasons that parallel the problems in the private sector. Public sector employees are paid a salary in most systems, although occasionally they may receive a "top off" drawn from locally generated user fees or dual practice[14]. In the case of a salaried employee, net profit is a function of salary and effort expended. Since effort is costly for the public healthcare providers, they will not supply effort unless they are closely supervised or unless they derive professional satisfaction from the supply of high quality medical care. Nevertheless, the high degree of concern exercised in admitting and socializing applicants to the healthcare professions makes it quite possible that

some providers will exert themselves for the sheer satisfaction of helping other people.

The volume and quality of healthcare supplied by the public sector is determined by a command and control process heavily influenced by political forces and loosely informed by outcomes data. Unfortunately, good planning is a necessary but not sufficient condition to achieve an efficient market in healthcare provision. The aspiration to equilibrate the supply of health services to demand is seldom realized during the process of allocating government budgets, particularly since adequate provision of health services requires many individual components, from materials and supplies to appropriate staffing. With prices not set by a market, government facilities lack the ability to tune the supply of services to price-borne signals of demand. Consequently, governments typically under-provide capital, supplies, and labor, resulting in under-production of primary healthcare services (volume) and medical quality.

It is difficult to specify a single objective for a government decision maker that is analogous to a private maximization of profit. The normative theory of the government decision maker posits that they ought to supply the volume and quality of PHC that enables each household to optimize health with available resources. In reality, this ideal is seldom realized. There is still no agreement on a universal descriptive theory of what government workers actually seek to do, although a variety of research has shown that health workers are motivated by some combination of job status, compensation, interpersonal relations and self-efficacy. [15, 16]. It is a fact that government bureaucracies often give greater job security to those who focus on internal politics rather than the organizational mission.

Although command and control decision-making can seldom efficiently achieve adequate levels of volume and quality of care, they can frequently surpass the private market in achieving access to services. With command and control allocation of healthcare resources, it is possible to deploy clinics and staff to remote or poverty stricken areas where there are social benefits of service provision that, due to poverty, do not result in private market demand that would attract the private sector. While less than ideal, by severely underpaying government workers and tacitly expecting them to moonlight (or resell government drug supplies) to make up the difference, government health ministries can leverage limited budgets to achieve even more access than would be possible by paying government workers their market wage [13] Similar to individual patients, elected legislators are better able to judge service volume than service quality. Elected legislative officials consequently find it more expedient to press for more government health clinics in their home precincts than to insist that adequate salaries and quality are maintained in the current health system.

A key advantage of the government system is the potential to exploit returns to scale in purchasing supplies, or in training staff. The providers in a government network can potentially benefit from centrally organized training, supervision, and coordination. Yet while health ministries possess management plans and the technical know-how that would enable them to improve quality through in-service training, the political

pressure to extend access first has been hard to resist. In-service training and supervision does occur in government networks, but has not achieved its potential.

## Improving Quality and Access in PHC using Alternative Business Models

In the business world there are several service industries that succeed by coordinating the activities of individual service units through an overarching administrative structure. Many NGOs have sought to emulate parts of business models in working with private healthcare providers. In so doing, they have realized that two separate actors must work together to supply health services: the primary health providers and the coordinating bodies that can check quality and protect the poor. There are multiple variants of the way these two actors can play their parts. While these systems are not mutually exclusive, alternative business models have included:

*Voucher systems.* In these systems, the coordinating body first certifies and follows the quality of a panel of private providers. It then issues vouchers to the poor that can be redeemed for services at the premises of certified providers.

*Contracted out systems.* In these systems, the coordinating bodies specify measurable outcomes in the areas of quantity, quality, and service for the poor and then tender bids by private agencies and networks of private providers who are contractually obligated to deliver the measurable outcomes.

*Incentive Payment Systems.* Here, providers are paid bonuses upon achieving measurable outcomes (number vaccinated, patient satisfaction, number of poor persons treated). This system works best when there is substantial vertical integration between the providers and the coordinating body, as if they inhabit the same firm.

*Franchised Systems.* This is one of the most complex systems of contracting out. In franchised healthcare systems, the coordinating body not only specifies the social outcomes that are desired but also forms a partnership with the providers to help them achieve the outcomes by training, overseeing quality, and assisting with media outreach such as trade-marking and branding to mobilize care-seeking by the poor.

The franchise model has been singled out as one that is of particular interest to healthcare [17]. The term "social franchise" can be applied to any activity directed towards a social goal that maintains an independent coordinating network to support the individual activities of network members. Thus many business relationships that would scarcely be recognizable as strict "franchises" can fall under the rubric "social franchise" as long as they use a coordinating network and work towards improving social welfare. This section will discuss the varieties of business franchising and describe the relevant issues for healthcare delivery.

### Franchising

The International Franchise Association defines a franchise as

> "…a system by which a company (the franchisor) grants to

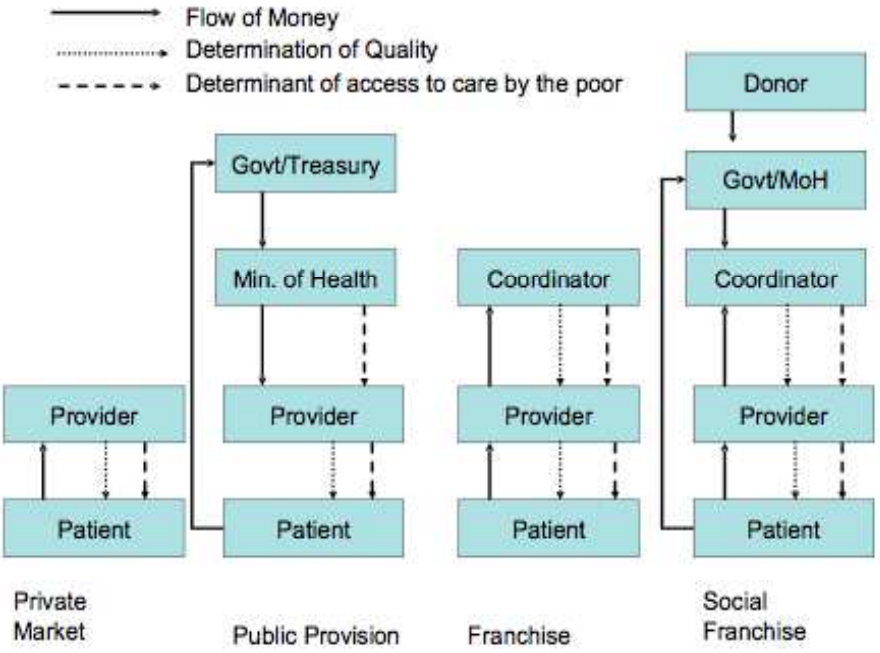
> others (the franchisees) the right and license (the franchise) to sell a product or a service within a specified area and to use the business system developed by the company" [18]

The core of any franchise arrangement is a contract between two specialized business partners. Franchise agreements can be used by wholesalers and retailers (ex. auto dealerships), by manufacturers and wholesalers (ex. soft drink bottling arrangements or the fast food industry), or by business format originators and independent retail shops. The primary alternative to franchising is integration of the two business partners into a single firm.

Figure 1 shows the essential elements of a franchised system and contrasts it to a private market and to the public provision of healthcare. The role of the coordinating body varies across the different types of provisions, however all systems can be assessed by the access to care for the poor provided, the quality of care provided, and the efficiency with which the services are rendered. Similar to contracted-out systems, the model of provision depends on the mechanisms by which providers are paid, and through which they receive oversight. [19]The key differences are that franchised systems retain financial support of the provider by monetary transfers from patients and obtain support for the coordinating/quality assurance function by financial flows from the provider. Social franchised systems add additional public support for the coordinator in recognition that the coordinating function is devoted exclusively to assuring that the public goods aspects of health services are delivered.

The McDonald's Corporation is

**Figure 1. Conceptual model of the flows of financing (solid arrows) and coordination to assure quality and access for the poor (dashed arrows) in the various types of health systems**



perhaps the most widely known franchise in the world. This business format franchise has shown the capacity to transform motivated and hard-working people who know next to nothing about a particular industry into financially successful independent entrepreneurs. Without the training and business support they receive, most McDonald's restaurant owners would not be able to succeed in running an independent restaurant.

The comparison between McDonald's franchisees and healthcare providers extends only to the notion of the provision of additional training, support and marketing. Potential franchisees in the healthcare industry are highly trained professionals who are usually quite capable of surviving on their own. Although franchises in healthcare may not make or break a private practice, they have the potential to add value to the healthcare operation by improving quality of PHC provision through training, maintaining quality through monitoring, and signaling to patients the presence of high quality providers through the use of trademarks and brand names. Evidence from existing franchised systems indicates increased quality and or access to care are being achieved [20, 21 , 22 , 23, 24]

## Characteristics of franchised and integrated systems in healthcare

The improvements realized in franchised healthcare could potentially be achieved with contractual structures other than franchising, such as incentive payment systems or voucher systems. To be successful, the system would integrate the function of the independent health provider with a highly pro-active organization coordinating and monitoring the quality and access to care. More than one business model could form the template for improving healthcare delivery.

Neither the franchised contract nor the options described above are fully optimal because effort is costly and difficult to monitor, so both parties will be tempted to withhold effort. The tendency to withhold effort is greatest for the one getting the lower share of revenue. In integrated, top-down models, the provider would be more likely to withhold effort. In franchised models, a coordinating body subsisting on franchise fees would be more likely to withhold effort. As industries choose between alternative organizational forms, one would expect integrated forms to be more common where the effort of the coordinating body is more crucial in determining revenue. Franchised forms would be more common where the effort of the individual providers is more crucial, but where coordinating bodies have economies of scale in marketing and training [25].

Whether they integrate or franchise to handle their essential functions, all businesses must engage in transactions with other businesses. Both integrated and franchised firms can take advantage of returns to scale in purchasing inputs and supplies. One possible hazard for franchised firms is that the coordinating body in a franchised system has an incentive to retain some of the advantages of bulk purchasing. Some franchise systems depend heavily for financial support on partially marking up the prices of some of the supplies instead of passing along all of the discounts to its members. Such a practice does not necessarily disadvantage the success of the individual units and may serve to secure

stable financing for the coordinating body. This is particularly important since low financing or weak administration at corporate headquarters can erode the value of the franchise [26].

### Motivating Good Discipline in Integrated Systems or Franchises

Preserving the reputation of the brand name is one of the most important functions of the coordinating body. The franchise agreement offers little contractual recourse for coordinating bodies to discipline franchisees for substandard quality. The coordinating body is beholden to the providers to pass along the royalties and franchise fees, but the providers are not financially dependent on the coordinating unit. If a provider was observed to have low quality, the coordinator can cajole and encourage, but the simple contracts offer very little recourse. Legal actions launched on the basis of "poor quality operation" are very difficult to litigate in developed countries, and would be even more difficult in regions with weak judicial systems.

The McDonald's Corporation's use of a real estate contract between the franchisee and the corporation provides a solution to this issue by essentially making the franchisee a tenant of McDonald's headquarters. Repeated misconduct by a franchisee of McDonalds can be used as grounds for eviction. Adherence to quality standards is more likely when franchisees are tied to loans and capital outlays that can be used to ensure compliance [27].

In PHC, coordinating agencies seek to maintain quality performance by providers in order to achieve the societal imperative of high quality provision for all. This complements the providers' needs for enforcement of quality standards, as lax enforcement will be detrimental to the value of the brand name. Client perceptions are paramount, and the brand reputation can be quickly destroyed if patients are treated badly.

## Case Study: Green Star

NGOs and charitable institutions have been operating integrated systems of private care for dozens of years throughout the developing world. In these systems the medical providers are typically salaried employees of the NGO. The NGO coordinates and monitors the quality of care and is incentivized to maintain high standards of quality and access to services primarily because of professional and ideological commitments to these principles. These systems offer tremendous services to humanity, but because they rely heavily on donor support for every unit of service provided, they have limited growth potential.

In contrast a social franchise can target the donor support at subsidizing just the public goods aspects (quality and access) of the private consumption of healthcare—leveraging local expenditure that finances the private goods aspects of medical services.

One such example is Green Star, a joint venture partnership between Population Services International (PSI) and Social Marketing Pakistan (SMP), a USAID spinoff. The network comprises over 2500 female health providers in a fractional social franchise. It is called a "fractional" franchise because a targeted package of family planning goods and services is added to the services of the provider who maintains additional "unfranchised" product lines.

To expand the network, variations of the package are offered to male doctors, midwives and pharmacists, resulting in over 11000 network members. The providers support themselves through user fees, but they receive training, supplies, coordination, and use of the heavily promoted brand name from SMP, the coordinating body [28]. SMP maintains standards by ensuring that providers are committed to serving low-income clients who have a high unmet need for family planning, and by monitoring the quality of service provision through supervisory visits and mystery client surveys.

Most of the evidence to date reveals the encouraging news that the individual providers are able to maintain support for their own operations through the user fees they charge. This is expected since private practices are sustainable in developing countries and network membership should not make them less sustainable. More surprising is the evidence that unlike McDonald's, franchise membership and the Green Star brand name do not add enough value to the practices to motivate royalties and franchise fees to support the coordinating body underlying the whole system. The coordinating bodies do not sustain themselves without outside support, although the providers can.

## Study description

A recent survey of 1718 family planning and reproductive health service facilities was conducted in Pakistan. Data were collected by the Carolina Population Center's Alternative Business Models initiative, in a multi-stage cluster sample of health facilities, providers and clients in urban areas of Pakistan. Two waves of data collection in 2001 and 2004 resulted in a total sample of 19801 clients and 2667 health providers in 1718 facilities. More information on the sampling strategy and data are available elsewhere [29].

Four types of facilities were surveyed: Green Star franchised providers, public providers, non-franchised private providers, and NGO providers. Cost of service provision included total salary and rent. Service quality was determined by identifying items in client, facility and provider surveys which fit within the Bruce framework for quality in reproductive health services, and creating a summative index for each facility [30]. Household poverty status was determined by rank of monthly income, with those households in the twentieth percentile or below classified as poor.

## Study Results

Our analysis shows that Green Star franchised facilities provided higher quality services (mean total quality = 24.9) than other private facilities surveyed (mean total quality private for profit = 15.2; private not for profit = 18.1). The quality score was calculated as the sum of Bruce's six domains of quality: Choice of methods; Information given to clients; Technical competence; Interpersonal relations; Mechanisms to encourage continuity; Appropriate constellation of services. Each domain was constructed from variables collected during facility surveys and exit interviews. Variable selection was decided strictly by using principal components with varimax rotation analysis to identify variables with factor loads greater than 0.4. Cronbach's alpha for the measurement of each domain ranged from 0.72 to 0.94, indicating strong correlation within the domain. Green Star

| Type of Facility | (N*) | Cost per Client (Rs.) | Poor Clients Served | Total Quality Score |
|---|---|---|---|---|
| | | Median | %, (95% CI) | Mean |
| Green Star Franchises | 654 | 32.5 | 35.1(33.4-36.8) | 24.9 |
| Government Facilities | 279 | 38.2 | 23.4(21.9-25.0) | 26 |
| Private (for profit) Facilities | 688 | 29 | 36.0(34.3-37.8) | 15.2 |
| NGO (not for profit) Facilities | 86 | 23.3 | 5.1(4.3-5.9) | 18.1 |

**Table 1. Data comparing costs, access by the poor and quality for the private sector social franchised Green Star facilities, government facilities, private, and NGO facilities. (Data source Carolina Population Center, Alternative Business Models Project)**

franchised facilities also served a higher proportion of poor clients than government facilities, and served clients more efficiently (lower cost per client) than government facilities. (Table 1)

As government facilities include tertiary care centers, greater access for the poor in franchised facilities may be a reflection of the broader range of clientele at a government hospital as compared to a single provider. The low cost per client found in not-for-profit facilities is likely an indication of lower real costs due to donations; however, this was unable to be verified from the survey data. Analysis also indicated that the four different types of facilities had nearly equal levels of client satisfaction, and differences were most clearly evident in choice of family planning methods available and appropriate constellation of services, with greater quality scores for government and franchised providers versus private for profit and NGO providers.

## Policy Proposals for Future Consideration

The quality and enhanced access provided by franchised networks of private providers can partially offset government efforts to provide access and quality. In other words, governments could potentially redirect funds away from their own efforts to achieve access and quality in government dispensaries and reroute these funds to support the coordinating bodies (but not the direct service provision) in socially franchised systems. The advantage of this is that the coordinating bodies of a social franchise could have as their primary outputs quality and accessibility of service. By comparison, government clinics devote much of their resources to producing the services themselves—services which are in large part private goods. For certain preventive and promotive services that are typically not produced or demanded at optimal levels without subsidy, another strategy is required. Here, governments may finance the provision of these services indirectly through transfer payments to coordinating bodies, which would operate as an intermediate agent to subsidize network providers. Qualified medical staff members are in short supply in most systems, so this proposal would not mean that government health workers would be terminated.

In practice, some government providers would be redeployed to networked, coordinated private facilities instead of to their government clinics, where they receive very little coordination, training,

and support. Instead of making their required appearance at the government clinic from 10:00 AM to 2:00 PM then disappearing to moonlighting in a private practice where quality is unmonitored, they would be put into service in networks where they support themselves legitimately through user fees and at the same time receive support and training from a coordinating network. Alternatively, governments could challenge private provision of primary healthcare by competing successfully on the basis of quality and reputation. Such a strategy would require strict attention to well-known organizational and incentive issues faced by public providers.

Supporting the coordinating organizations through government revenue is only one option. A more creative approach to supporting the coordinating bodies would be to allow them to exploit their comparative advantage in obtaining capital. An individual medical provider is too small to apply for a multilateral agency or foundation loan. By comparison, a network of 100 providers could potentially secure capital on the world market at rates as low as 4%. The coordinating body could then partially mark up its own lending rate and administer startup loans to private practices in the network. The network could even offer lower interest rates for providers working in underserved areas. Combining the coordinating body's role in quality assurance with its role as creditor would mutually enhance both roles. The coordinating body would be firmly committed to the success of each unit to avoid default and would work hard to support the needs of its debtor-providers in order to qualify for future funding from the international donor. Furthermore, the providers who owe money to the coordinating body would be very attentive to the advice and support they received. The coordinating body would be motivated to increase access to primary healthcare and deliver high quality healthcare in the spirit of international agreements such as the Declaration of Alma Ata, or the Universal Declaration of Human Rights.

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