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Literature Review

Social franchising: Scale and spread of innovation in Canada

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ABSTRACT

Objectives: The Canadian healthcare system is caught in a perpetual cycle of pilot projects which precludes the spread of innovative projects. Social franchising is a governance and operating model used to support the scaling of certain types of social initiatives. This paper presents an overview of social franchising, discusses its applicability to HIT innovations, and proposes a framework based on this model for the Champlain BASE™ eConsultation program.

Methodology: A literature review on social franchising was performed to evaluate this model in non-healthcare and healthcare realms. A search was performed in electronic databases to identify peer-reviewed articles. Grey literature was also used to inform this review.

Results: Social franchising has been embraced internationally in healthcare and non-healthcare environments. Peer-reviewed articles related to social franchising and healthcare focused on patient outcomes in family planning and reproductive programs in low- and middle-income countries. Evidence related to developed and high-income countries was scarce, which may be attributed to the newness of this model. Evidence shows the model's ability to rapidly spread programs without sacrificing quality. A National BASE™ model using social franchising is proposed for the Champlain BASE™ program, which represents a recently developed eConsultation project with potential to address the challenges related to access to specialists.

Conclusion: Social franchising is the fastest growing healthcare approach in low- and middle-income countries. High-income countries (e.g. UK, Germany) are beginning to experiment with the model. The Canadian healthcare system should consider the model as a viable framework to scale and spread innovative HIT programs.

Introduction

The Canadian healthcare system is falling behind its peers in relation to improving healthcare performance through innovation [1]. This is especially true for e-Health innovations, which have received significant attention in healthcare systems around the world [2]. While there is an impressive amount of innovation activity across the nation, these programs too often remain in the pilot stage and fail to expand or sustain themselves beyond an initial period [1]. A 2015 report identified the major barriers to healthcare innovation across Canada [1], including: old fashioned human resources models; system fragmentation; inadequate health data and information management capacity; lack of effective deployment of digital technology; barriers for entrepreneurs; a risk-averse culture; and inadequate focus on understanding and optimizing innovation. System fragmentation has been considered the most important barrier to innovation, with governance and leadership structure being a major contributor to this problem [1]. In recent years, Canada has seen more efforts towards health information technology (HIT) innovation. The Champlain BASE™ project in Ontario, which presents a model for access to specialists through eConsultation, is an example. The project allows primary care providers (PCPs) and specialists to communicate directly through a secure web-based application in order to improve access to specialist care in an innovative and inexpensive manner [3]. Benefits include cutting response time from months to two days, enhancing patient experience of care, and reducing the per capita

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cost of healthcare [3–5]. Despite these achievements, the absence of effective governance and operating models and policies that support and enable the sustainability of these innovations persists, which represents a significant threat to their sustainability.

Social franchising is a governance and operating model that has been widely used to support the successful rapid scaling of certain types of social initiatives. The model adapts the business strategy of franchising, where the owner of a service or product grants exclusive rights to an individual (franchisee) for location distribution and/or sale in return for payment or royalty [6]. This allows an organization to grow without necessitating expansion in its operations, all while allowing the franchisor to retain control over the spirit, quality, and strategy of the original brand [7]. According to Hurley [8], social franchising is "a way to enable successful social enterprise models to be reproduced in a local context in a way that combines social impact and financial sustainability". Social franchising as a concept is still in its infancy, with the leading global social franchising organization formed in 2011 [9] and the world's first social franchising accelerator started in 2014 in Africa [10]. To date, limited information exists on the extent to which social franchising has been leveraged as a governance model in the context of healthcare innovations, especially in Canada. This paper addresses this area and provides an overview of social franchising and its relevance in healthcare. The first part of the paper provides an overview of social franchising and presents a literature review on social franchising in the context of healthcare. The second part discusses the applicability of this governance model in relation to HIT innovations in Canada by exploring its potential to supporting the scalability and sustainability of the Champlain BASE™ project as an example of these innovations [11].

Methods

We conducted a literature review using peer-reviewed and grey literature written in English. First, a general search was performed in electronic databases (e.g. Ovid Medline, ProQuest, Scopus) to identify peer-reviewed articles on social franchising and gauge the scope of research. The initial search of the term "social franchising" yielded 438 hits, after which the yields were narrowed using more specific search terms (e.g. "social franchising" and "health"). Three systematic reviews on social franchising were identified in the process [12–14]. Grey literature from organization websites and news articles were used to supplement peer-reviewed articles. The concept of social franchising was synthesized and a governance and operational model for Champlain BASE™ was then conceptualized and proposed to support the expansion of the program.

Social franchising

Overview

On a global scale, social franchising has been embraced with social franchising accelerators emerging in Canada [15], Africa [10], and internationally [16]. In Canada, it has helped scale diverse social programs, from teaching children to code [17] to empowering communities to work towards a healthy and fair food system [8]. Internationally, it has been used to develop a rural entrepreneurial ecosystem [18], fight poverty [19], reduce homelessness [20], improve the operation and maintenance of school sanitation facilities [21], and build peace [22].

Theory behind the model

The importance of franchising in social missions can be explained by applying the Austrian social philosopher Hayek's distinction between small-group logic of the microcosm (e.g. family) and big-group logic of the macrocosm (e.g. capital market) [7]. Microcosm focuses on social and informal interactions such as face-to-face personal relationships; the group is thus "end connected" as coordination relies on all group members striving towards one shared goal. Macrocosm consists of the manifold and complex interactions that take place in a larger society where individuals follow their own objectives within a framework of formal and informal rules; this large group is "rule connected" as their coordination relies on impersonal or even anonymous interactions instead of personal relationships. This distinction between micro- and macrocosm explains why social entrepreneurs are often successful when their social ventures are small and drawing on small-group logic, but then face difficulties when scaling the operations toward big-group logic – the logics conflict. Social franchising, thus, is suitable for scaling up certain pilot projects which rely on the separation of small-group versus big-group logic. The benefits being the local franchise continues to be based on microcosm interactions allowing a certain amount of autonomy and flexibility to adapt to the local needs and resources, while the franchisor establishes rules in the overarching franchise system that preserve key components of the original pilot, retains loose control over the network of franchisees, and reaps the efficiency advantages of a growing, impersonal organization that follows macrocosm logic and interactions. These benefits will be demonstrated in the framework proposed for the Champlain BASE™ program as described in the following sections.

Social franchising and healthcare – a literature review

Peer-reviewed articles related to social franchising and healthcare generally presented low quality evidence and concentrated around patient outcomes in family planning and reproductive programs implemented in low- and middle-income countries, with a paucity of discussion around the assessment of social franchising as a model [12–14]. Articles related to social franchising in high-income countries were largely absent, except for a few papers that discussed pharmaceutical franchises [14] and a mental health program in Australia currently also considered by Denmark [23]. Many of the peer-reviewed articles were repetitive, with the same services described multiple times by different authors or from different angles. Nearly all peer-reviewed articles focused on primary care-based social franchises (family planning and pediatrics) set in Southeast Asia and Africa [24–26], particularly India [27,28,29], Vietnam [30–32], African countries [33–35], and Myanmar (Burma) [36–38]. One article addressed HIT and social franchising, but discussed the results of the HIT and not the application of the model itself [39].

The lack of high quality and comprehensive studies on the application of social franchising in the healthcare industry is also paralleled by limited evidence in the grey literature considered. Most of the information obtained was extracted from organizational websites that employ social franchising in their operations in the primary care sector, with emphasis on family planning in low- and middle-income countries [40–42], organizations which promote and support social franchising [9,10,15], or news articles that discuss high visibility initiatives also described in peer-reviewed articles. One interesting exception is a new program funded by the National Health Service (NHS) in the United Kingdom (UK), which uses social franchising as a model to scale up innovation [43]. This program is operated by The Health Foundation, which is an independent charity committed to better health and health care for people living in the UK. This foundation is exploring social franchising as a new technique to scale proven health interventions. Four projects from a pool of applicants will receive funded consultancy support from the International Centre for Social Franchising [16] and £143,000 of funding for

one year from The Health Foundation. The application process has two-stages. In the first stage, teams are invited to express their interest and to explore whether the technique of social franchising could support the scaling of the intervention. The teams have to demonstrate a clear understanding of the elements core to their intervention to make them successful (key to the social franchise methodology), have had the intervention independently evaluated, published, and peer reviewed, present mature evidence based on testing across many sites or across multiple years, and be from a UK health or social care organization that is not-for-profit or is free at the point of service. The second stage involves inviting teams involved in stage one to apply for funding, with the maximum of four projects selected [54]. Currently, both stages are closed and four successful teams were announced in December 2017, one of which is directly related to technology. This technology project will be scaling up PINCER, a successful pharmacist-led information technology intervention for reducing medication errors in prescribing [43]. Based on our review, the NHS program is the first publicly announced program in a high-income country to use social franchising as a large-scale health innovation expansion model. Australia's mental health program [23] also uses social franchising, but is restricted to mental health.

Overall, the lack of high quality peer-reviewed articles on social franchising in healthcare may be partly attributed to the recent advent of this model. While many of the model's impacts remain uncertain (e.g. clinical outcomes, long-term sustainability, efficiency, and utilization rates), several strengths are reported consistently across articles [12–14]. When used correctly, social franchising has shown to increase patient satisfaction and program accessibility, which led to increase in patient volume [12–14]. Social franchising also helped healthcare programs expand without sacrificing quality. For example, Marie Stopes International expanded their family planning program from 7 to 17 countries and reached 3.75 million patients in just 7 years while maintaining high-quality services and results [44]. As a result of these benefits, Harvard Business Review selected social franchising as the model of choice to make progress in times of instability [45]. Social franchising is now the fastest growing approach to improving the quality of and organizing healthcare in low- and middle-income countries, with 83 franchises in Sub-Saharan Africa and Asia by 2013 [27]. Healthcare systems in high-income countries, such as the UK, Germany, Australia, and Denmark, are starting to experiment with the model as well [23,43]. Therefore, while there are still uncertainties, social franchising has demonstrated its potential to be leveraged in the health care context. Canada should consider the model as a governance and operating framework option to scale up and spread innovative healthcare programs including HIT programs, especially since the nature of the Canadian healthcare system lends itself well to the social franchising model which is further discussed below.

The Canadian healthcare system

Function follows form

The Canadian healthcare system consists of 14 provincial, territorial, and federal administrations, with 13 provincial and territorial healthcare insurance plans. Funding, responsibilities, and authority are shared between administrations [46]. Most provincial and territorial systems are further fragmented internally; Ontario, for example, has 14 Local Health Integration Networks each responsible for planning, funding, and integrating health services within their region [47]. Poor integration is also reflected at the individual organization level as hospitals and other facilities are funded through separate budgets than physicians, and there is limited integration and information sharing between them. As a result, at the system level, each administration can act fairly independently, and, at the organization level, silos of budget and practices flourish [1]. Although other countries also have regional health authorities, what makes the Canadian system behave particularly fragmented is the number of independent players and the level of independence of each administration. Meaningful scaling up and spreading of innovation requires significant resource investment and cooperation between organizations, regions and administrations, which is not easily accomplished in a heavily decentralized system. Since starting anew is unrealistic, teams must find a framework that will respect the varied operational and funding structures of the different administrations while maintaining a cohesive innovation strategy.

Technology holds potential in helping Canada breakthrough the silos and improve communication and cooperation, and Canada has made deliberate strides over the past decade and achieved some notable successes provincially and nationally with regards to healthcare IT through Canada Health Infoway (CHI) [53]. CHI is a not-for-profit, independent organization funded by the federal government, with the purpose of improving the health of Canadians through innovative digital health solutions. It co-invests in and supports projects in every province and territory. The CHI 2014 strategic plan [55] outlined six health care priorities that digital health technologies support including digitizing and connecting more patients, clinicians, and administrators; sharing and knowing more information and evidence to allow for collaboration and communication that supports informed decision making; and innovating and transforming the health system by helping consumers become more accountable for their own health, enable clinicians to provide better care, and enhance health administrator's abilities. Based on national focus groups, one-on-one, and small-group meetings with Canadians, clinicians, jurisdictions, Deputy Ministers of Health, regional stakeholders, and other key representatives, five important opportunities of action based on the six priorities were developed. A summary of CHI's accomplishments by opportunity of action and province is shown in Table 1 [55]. Despite the progress made in Canada, significant challenges are still present in the health care environment which make it difficult to achieve health system reforms, including funding shortages, slow adoption of eHealth by clinicians, and a lack of skilled human resources [1,56]. To fully implement innovation and sustain long term clinical outcomes improvements, like in the UK, Canada could benefit from exploring methods to quicken the pace of innovation scaling. Therefore, social franchising could be a strong complementary method and framework to the progress already made by CHI.

Social franchising: a bridge between silos

The distinction between micro- and macrocosm in social franchising is useful in Canadian healthcare to balance the need for flexibility and control across a fragmented healthcare system. This model is flexible since it can be used at the national or provincial level. For example, at the national level, each provinces/territory may be established as a franchisee, and at a provincial/territorial level, each individual region may act as a franchisee with the provincial government as the franchisor. The franchisor can pool funds collected from each franchisee's budget silo to invest in the overarching program. By separating the logics, the social franchising model would present added value by allowing the integration of different silos while respecting the administrative boundaries and local needs. Therefore, this model is suitable for the Canadian healthcare system environment because of its malleability. In order to illustrate its applicability, we present in the following sections a proposed framework for the Champlain BASE™ project based on

Table 1
CHI Successes(55).

Opportunities for Action	Description
Bring Care Closer to Home	ONTARIO: The Ontario Telemedicine Network reduced the average number of visits by 66% in hospital admission, 74% in emergency room visits, and 97% walk-in clinic visits. NEWFOUNDLAND: Telehealth for chronic disease management significantly reduced travel time and cost, improved access to information, extended provider and management continuity, and increased the frequency of patient follow-ups. NEW BRUNSWICK: Extra-Mural Program, or hospital without walls, uses digital heath solutions and an inter-disciplinary team to provide comprehensive health care services to patients of all ages in private, nursing or special care homes, and in schools to promote, maintain and/or restore health in patient's natural environment. This program helps 40,000 patients annually, and patients are able to avoid hospital stays or to assure early discharge.
Provide Easier Access	NATIONAL: Canadian Blood Services developed an online appointment management solution for blood donors. Use of the solution continues to increase. BRITISH COLUMBIA: Excelleris's *my ehealth* provides British Columbians access to lab tests through secure, easy-to-use web portal or smartphone that can be shared with family or members of their health team. eHealth facilitates more than 300,000 subscribers and empowers patients to be more active members of health team and decreases level of anxiety when waiting for results. BRITISH COLUMBIA: University British Columbia Student Health Service implemented *myHealth* which ensures patients and providers are equal partners by allowing shared ownership of health information. Specifically, lab and diagnostic reports, prescription lists, and health care plans, book appointments or connect with care team via smartphone or computer. Saves time and unnecessary appointments allowing clinicians to serve more patients and administrators can spend more time interacting with patients.
Support New Models of Care	MANITOBA: *eChart Manitoba* connects health providers with patients' key health info in right place at right now, with the goal to improve efficiency, access, safety and the quality of care for timely informed decisions. ALBERTA - Cancer Surgery Alberta (CSA) introduced structured reporting to consistently capture and share key information about cancer surgeries to improve patient care. CSA is currently developing a solution that will enable breast and gynecological patients to have greater participation in their own health care. Data collected through the portal can be used by surgeons and nurses to improve the quality of life for patients, e.g. alerts with significant changes from baseline. NORTHWEST TERRITORIES: A single territorial EMR that includes not only physician offices but also specialist clinics, emergency department, public health, rehabilitation, mental health, home care, social services and long-term care. The aim is to create better transitions through the health care system and foster better communication between patients and providers.
Improve Patient Safety	ONTARIO: eCare ensures patients get the right medication by virtually eliminating repetitive manual process and enhances communications in hospital by combining computerized provider order entry with barcode scanning. QUEBEC: provincial drug infomation system connecting 465 community pharmacies to feed medication profiles and retrieve e-prescriptions.
Enable a High Performing Health System	PROGRESS MADE OVERALL: Use health system analytics to support better care e.g. checking for patients with diabetes who have not had a recent eye exam. PROGRESS MADE OVERALL: Improving processes to reduce waste in health care through use of Lean – a patient-focused approach that systematically eliminates waste in organizational processes to improve quality, productivity, and efficiency. More than 200 Lean projects are underway in health regions that resulted in significant improvements in care and millions of dollars in savings.

the social franchising model, which would support the scaling up and spreading of eConsultation at the national level.

Champlain BASE™ – a candidate for social franchising

Overview

Champlain BASE™ is a multi-specialty asynchronous eConsultation model which improves access to specialty care by facilitating secure online communication between PCPs and specialists [5]. The platform began in 2009 as a small proof-of-concept and has now grown to a fully implemented regional service in Eastern Ontario, Canada [48] offering PCPs access to 105 different specialty groups. The implementation has been highly successful on a number of measures including improved access and increased satisfaction from healthcare providers and patients while achieving cost effectiveness [5]. With the success in Eastern Ontario, potential expansion across multiple provinces is currently being explored [5]. Given the complexity of scaling up from a regional service to a multi-provincial service and the limited working models internationally, the Champlain BASE™ team explored operating and governance models that could be used to inform the development of a structure and governance model for the expanded service (e.g. Kaiser Permanente (KP), Veterans Health Administration (VHA), Constellation model). Expected requirements and challenges of the Champlain BASE™ expansion include: flexibility to accommodate variations in political climate and resource availability across different administrations, light governance to respect the professional bodies with their own licensing requirements and governance, and cohesiveness to maintain quality consistency and preserve the original concept of the research project [4].

Proposed social franchising model

Incorporating the Champlain BASE™ requirements, the social franchising model, and relevant components of other governance and operating models, a National BASE™ Governance model is proposed in Fig. 1. A detailed description of each component is described in the following sections, with the roles and responsibilities summarized in Table 2.

Networks (franchisees)

A Network consists of those responsible for managing the delivery of the eConsultation services within the province; each Network will have one seat in the Committee. The Network administration consists of a local representative of each partner involved in delivering services (e.g. medical specialty groups) and an IT Lead who will manage the IT infrastructure. When a province joins the National BASE™ service model, it will approach the Corporate Liaison who will initiate the social franchising process and provide the province with a skeletal Network Agreement (i.e. social franchise agreement) outlining the foundational processes and infrastructure, policies, Network Fee, criteria, expectations, and other administrative details. The parties involved, scope of the services provided, and resource contribution (e.g. IT) will be discussed and added to the Network Agreement. The day-to-day operation of the Network will be supported by the Corporate subcommittee. Examples of subjects discussed at the network level: request for addition of a new specialty group, specific qualifications of an eConsultation specialist due to population needs, and implementation of service feedback pipeline and resolution process. The Networks are inspired by the VHA Veterans Integrated Service Networks [50] and is governed by a franchise agreement described by the social franchising model.

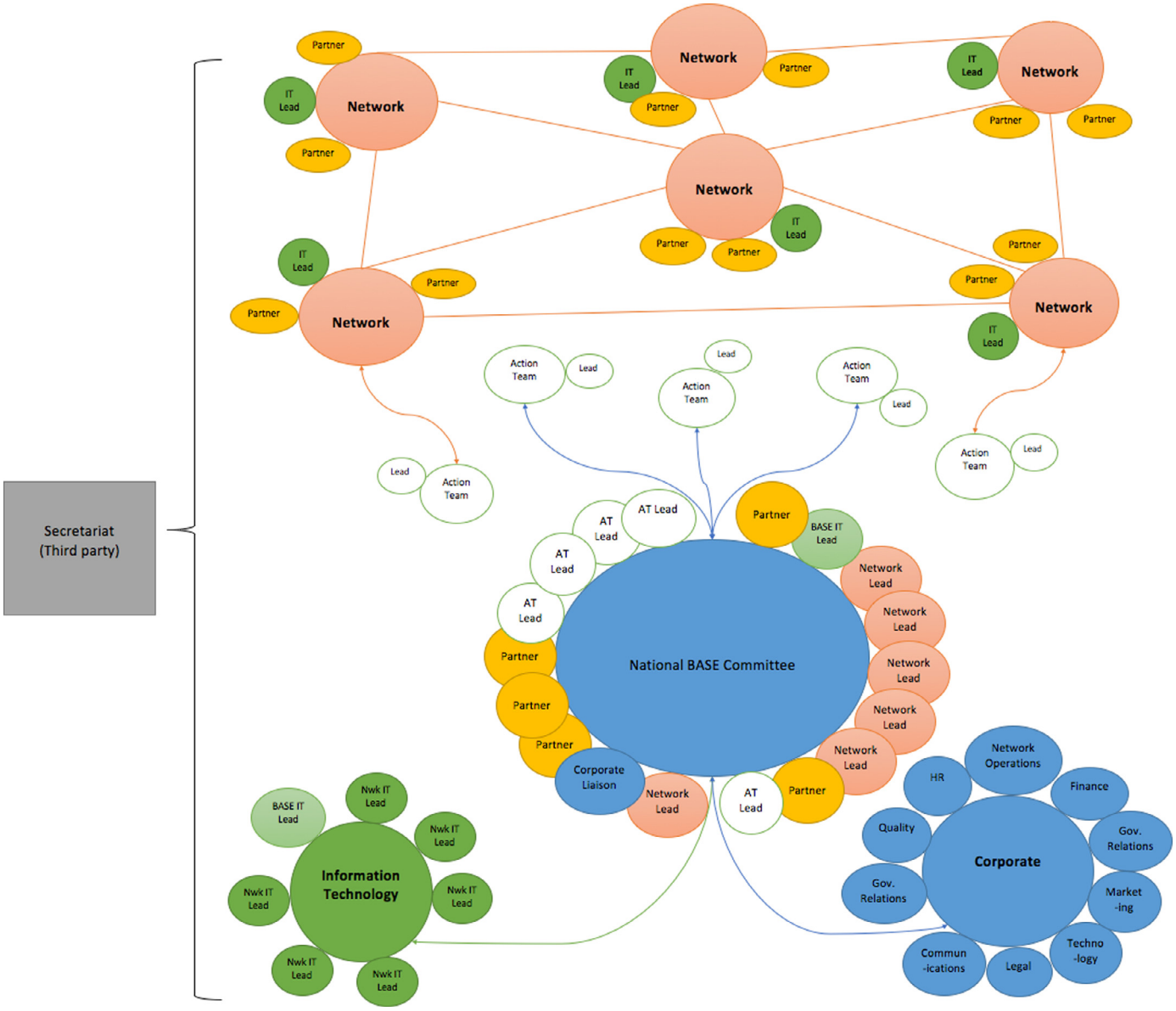

Fig. 1. Proposed national BASE governance model.

Table 2
Roles & responsibilities of proposed national BASE model.

Roles	Description
(i) National BASE Committee (franchisor)	Steering committee formed by the collaboration of multiple partners to fulfill a common objective. Governed by a Foundational Agreement.
(ii) Partners	Stakeholders directly involved in the delivery or governance of the BASE service. At the Committee level, these partners should belong to a more national body e.g. Canadian Medical Association.
(iii) Networks (franchisees)	Collection of local partners providing the e-consultation services e.g. Ontario Medical Association. Governed by a Network Agreement and pays a Network Fee; each network selects a representative or "lead".
(iv) Action Teams	Temporary teams organically formed for a specific purpose or initiative and are to be eventually creatively destructed. Function is to promote nimbleness, creativity, and experimentation; any party can initiate and/or lead. Each Action Team selects a lead to report to the Committee.
(v) Subcommittee - Corporate	Provides the crucial business and administrative services to support day-to-day network and governance operations; includes the national leadership team. The Networks, Action Teams, and the National Committee share these services.
(vi) Subcommittee - IT Group	Consists of an IT Lead from each network (chosen by the network) and a BASE IT Lead selected by the National Committee.
(vii) Secretariat	External and experienced third party, facilitator, catalyst, and internal auditor.

National BASE™ committee (franchisor)

This committee is modeled after the Steering Committee of the Constellation Governance model [49], and reflects the central role of the VHA National Leadership Board [50], the neutral platform of the Norwegian National Council [51], and the KP contractual collaboration between their three organizations [52]. The National BASE Committee is a leadership committee that includes Network Leads, Action Team Leads, the BASE™ IT Lead, a Corporate Liaison, and one representative from every partner (e.g. professional bodies) that directly contributes services such as the Canadian Medical Association. The purpose of the committee is to achieve a "coordinated mutual self-interest" [49] that respects each partner's autonomy while allowing for successful collaboration towards a mutual goal (i.e. improved patient access). The Committee develops a Foundational Agreement that establishes overarching mission and vision, sets the tone for a collaborative culture, decides on the scope, role, and resource contribution of each partner, discusses priorities and resource allocation, manages foundational and network agreements, settles on a conflict resolution process, deliberates on an entrance/exit strategy, and determines how to manage the Network franchise and Committee membership. Incorporation is not required which minimizes administrative and infrastructure costs since a new organization is not created. When more specialist services are requested, those professional groups are invited to join as a member. The Network Fee paid annually by each Network will fund the Corporate and IT subcommittees, the Secretariat, and contribute to the National BASE™ fund which will be used for future Action Team activities. Examples of topics that would be discussed by the Committee include: baseline qualifications of eConsultation specialists, service feedback pipeline and resolution process, communication and evaluation standards and policies, and overall expansion strategy.

Corporate subcommittee

This subcommittee consists of the national leadership team and all staff and programs who provide the business and administrative services required to develop and maintain the eConsultation service, manage and allocate resources, and support the governance partners. Example of services provided include day-to-day network operations, financial services, human resources, legal services (e.g. management of all agreements), communication, marketing, government relations, quality assurance, and technology (e.g. IT helpdesk). This subcommittee mimics the Corporate subgroup of KP's National Functions organization [52].

Information technology subcommittee

As eConsultation services are IT dependent, resources should be dedicated to implement a robust information technology strategy. Provinces can contribute IT resources directly or provide funds to the subcommittee for this purpose; therefore, this subcommittee consists of each Network's IT Lead and the National BASE™ IT Lead. This subcommittee is responsible for developing and executing an IT strategy that unifies the various IT resources and delivers a consistent and high-quality IT infrastructure. This may require an overlaying platform over the different individual Network IT platforms. The National BASE™ Lead is responsible for ensuring that the strategy aligns with the Committee priorities. This subcommittee mimics the Information Technology subgroup of KP's National Functions organization [52], which demonstrates the need to have dedicated IT resources if the National BASE™ service is to expand successfully and smoothly.

Action teams

These are temporary teams that are organically initiated and eventually dissolved after their objectives have been met, resources have been drained, or interest has waned. The purpose of the Teams is to promote nimbleness and professional autonomy, encourage creativity and innovation, and provide a safe space for experimentation. The results of the initiatives could alter the operations of the Networks or the Committee, but it is not a requirement. Projects can be initiated and lead by any of the Partners, Networks, the Committee, or the Secretariat. The initiator is responsible for garnering interest and resources for the specific initiative and does not need to obtain approval from the Committee, so long as the initiative falls within the scope of the foundational agreements and does not require funding support from the Committee. The initiator does not need to be the lead of the Action Team, but an Action Team Lead needs to be selected to liaise with the Committee. To form an Action Team, the initiator will contact the Corporate Liaison who will mobilize the process and services necessary to draft the Action Team agreements. Like the Foundational and Network Agreements, the Action Team agreement will entail the objectives of the team, parties involved, scope, resource contribution and allocation, evaluation criteria, conflict resolution, and other basic terms. Examples of potential Action Team initiatives include: developing a protocol for eConsultation services of specific specialties, creating a quick response team during an epidemic, and conducting research to see which user interface is preferred. The Action Teams are modelled after the constellations in the Constellation model [49] and embody the spirit of KP's operating model [52] by making National BASE™ partners (many of whom will be clinicians) full and equal contributors.

Secretariat

The Secretariat is an external third party who acts as a facilitator, catalyst, and internal auditor in order to maintain the power dynamic and resources between the parties, and facilitates communication and transparency. This is not a coordinator role, instead it requires a high level of skill and experience. In the literature review, this role in VHA was fulfilled by the Office of Medical Inspector [50] and the Norwegian National Council had a Secretariat as well [51].

In summary, the social franchising model unique properties provides the National BASE™ Governance model with flexibility to accommodate the variations in political climate and resource availability across different provinces and light governance to respect the professional bodies with their own licensing requirements and governance. Yet the model maintains cohesiveness for quality consistency and preserves the original spirit of the research project. The use of social franchising as the foundation for the National BASE™ Governance model is expected to overcome the fragmentation of the Canadian healthcare system while meeting the specific needs of the project.

Conclusion

Canada has the energy and appetite for innovation and formidable assets to support it, but this innovation cannot be unleashed until the barrier of fragmentation is overcome. Social franchising has not been thoroughly tested in diverse settings within the healthcare industry, but with preliminary success in the healthcare systems of low- and middle-income countries and in non-health industries, this model presents opportunities that may benefit Canadian healthcare by enabling a faster scale and spread of innovation. We hope that this paper will initiate discussion amongst policy-makers, health professionals, health technology providers, and related stakeholders with regards to the application of social franchising as a viable option for the governance and operation of innovation in the Canadian healthcare system with emphasis on HIT.

Disclosure

Champlain BASE™ is publicly funded and there is no financial interest nor profit generation from the service. It is available free of charge to providers in order to support the timely care for their patients. Belinda Maciejewski, Mirou Jaana, Louis Crowe, and Dr Clare Liddy have no financial interest. Dr. Erin Keely participates in the Champlain BASE™ as a specialist provider, so is compensated for providing eConsults in the same fashion as all other participating specialists in the program.

Author Statements

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Competing interests

None declared.

Ethical approval

Not required.

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