

Review article

Franchising of health services in low-income countries

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Grouping existing providers under a franchised brand, supported by training, advertising and supplies, is a potentially important way of improving access to and assuring quality of some types of clinical medical services. While franchising has great potential to increase service delivery points and method acceptability, a number of challenges are inherent to the delivery model: controlling the quality of services provided by independent practitioners is difficult, positioning branded services to compete on either price or quality requires trade-offs between social goals and provider satisfaction, and understanding the motivations of clients may lead to organizational choices which do not maximize quality or minimize costs. This paper describes the structure and operation of existing franchises and presents a model of social franchise activities that will afford a context for analyzing choices in the design and implementation of health-related social franchises in developing countries.

Key words: franchise, social franchise, family planning, business model, private sector, reproductive health

Introduction

During the 1990s in the United States franchising became the most popular method of expanding commercial retail stores quickly with limited capital risk (Bradach 1998). Characterized by locally owned outlets which deliver services according to a standardized model, franchises such as McDonalds, Starbucks or The Body Shop have become ubiquitous in all developed and many developing countries.

A number of factors have made franchising a successful business model: new store expansion can be accelerated because much of the investment capital and many of the management decisions come from local franchise owners, distribution of fixed costs across many outlets provides economies of scale in purchasing and advertising which only large networks can provide, and the financial risks and rewards associated with local ownership assure that franchise operators will work hard with a lower level of supervision than would be needed in a company-owned chain of stores.

Social franchising¹ is an attempt to use franchising methods to achieve social rather than financial goals, influencing the service delivery systems of the private sector similarly to the way in which social marketing has adapted traditional outlets for commodity sales.

While the concept of social franchising is being proposed in connection with an increasing range of services, from drinking water distributors to voluntary testing and counselling for HIV/AIDS (Haffar 2001; PSI 2001), the majority of experience to date comes from family planning service franchises, and this context forms the basis for this paper. When possible

I attempt to extrapolate beyond family planning franchises to issues that are relevant to all potential health-related social franchises in developing countries.

Beginning in the early 1990s USAID funded ‘first-generation’² social franchising programmes in the Philippines and Mexico in order to expand markets for clinical family planning services (Smith 1996). Franchises for family planning or reproductive health now exist in Mexico, India, Pakistan and the Philippines and are being developed in Kenya, Ecuador, Honduras, Burma, Ethiopia and many other countries. A number of these have now expanded their brands to include such services as vitamin supplements, essential drugs and oral rehydration therapy.

Family planning social franchise programmes adapt the commercial franchising model to create networks of private medical practitioners offering a standard set of services under a shared brand. Franchise members are offered training programmes, brand and commodity advertising, and a range of other benefits which might include inter-franchise referrals and referral fees, follow-up and on-site technical support, opportunities for professional networking and exchange, and subsidized equipment, medicine and contraceptives. In return, providers may be required to meet sales quotas, maintain specific levels of service quality and pay franchise fees.

This paper provides an introduction to the franchising of family planning services in developing countries and explores which aspects of a franchise’s context, business design and market positioning are critical to the success of the franchise organization’s ability to achieve social goals. The goal of this paper is to present a model of social franchise activities that

will provide a context for analyzing choices in the design and implementation of health-related social franchises in developing countries. In the first section the types of commercial and social franchise are defined. In the second section the theoretical model of franchising is introduced, and in the third and fourth sections the implications of the model are explored, first at the theoretical level, and then with respect to specific areas of franchise operation.

Definitions of franchising

The most widely accepted definition of a franchise comprises 'a contractual relationship between a franchisee (usually taking the form of a small business) and a franchisor (usually a larger business) in which the former agrees to produce or market a product or service in accordance with an overall 'blueprint' devised by the franchisor' (Stanworth et al. 1995).

The concept of creating a valued brand for goods or services and extending the reach of that brand by leasing the right to use it to private individuals became widespread in the food and hospitality services in the United States during the first half of the 20th century and grew quickly from the early 1950s (Justis and Judd 1989; Milgrom and Roberts 1992). Today, franchises are divided into two types: traditional and business-format. In traditional franchises the rights to sell a product or service in a geographic area are sold to a franchisor, for example, a car dealership or a gas station. In business-format franchises a full set of advertising, service methods and delivery models are leased to a franchisee in a contract that allows for an ongoing relationship between the two parties – assuring quality and price controls to varying degrees (US Department of Commerce 1988). This paper will focus exclusively on business-format franchises because the process focus makes this structure the most relevant to health care.

Franchising is a hybrid business structure somewhere between a market and a firm in the study of organizational economics. Franchisors and franchisees typically engage in a contractual exchange, with a regular transfer of goods or services between the two, similar to what would occur in a

market with long-term contracts. As part of the contract, however, franchisors strictly regulate many of the activities of the franchisee – standardizing retail outlet design and colour, the range of goods and services offered, and acting to assure quality and prices (Lafontaine 1992).

Most franchises are stand-alone franchises. A stand-alone franchise, as the name suggests, exclusively promotes and sells the goods and services of the franchisor (e.g. McDonalds). A less common commercial variant, but the norm for social franchises, is the fractional franchise (Federal Trade Commission 1986). A fractional franchise adds a franchised service or product to an existing business, creating additional income for the franchisee and using existing business assets: building and shared utilities (e.g. Best Western Hotels³). In many commercial franchises it is possible to have tiered structures with sub-franchises or multiple outlets per franchisee. This has not occurred in social franchises, and so for this paper we will focus on single unit fractional franchises, which represent the most common design for social franchises (Kaufmann and Kim 1995; Smith 1996).

The agency theory explanation for franchising is that monitoring costs for the central corporation to assure quality will be high compared with the localized benefits. Sales occur through local outlets, and therefore depend to a great extent on local effort in addition to price and advertising. Because local effort is difficult to monitor in the context of service delivery, it is often more efficient to localize incentives and align managers' goals with organizational goals. Franchising is one method of accomplishing this.

Financial constraints on corporate expansion are often put forward as the basis for the creation of traditional commercial franchises (Oxenfelt and Kelly 1969; Hunt 1973). While this is disputed (Lafontaine and Slade 1996), there is little doubt that there are significant cost savings to social franchising programmes in expanding service delivery points through fractional franchises, although the same savings might not appear in a stand-alone franchise. In fractional franchise programmes, local franchisees contribute a large amount of pre-invested capital in terms of facilities, staff and

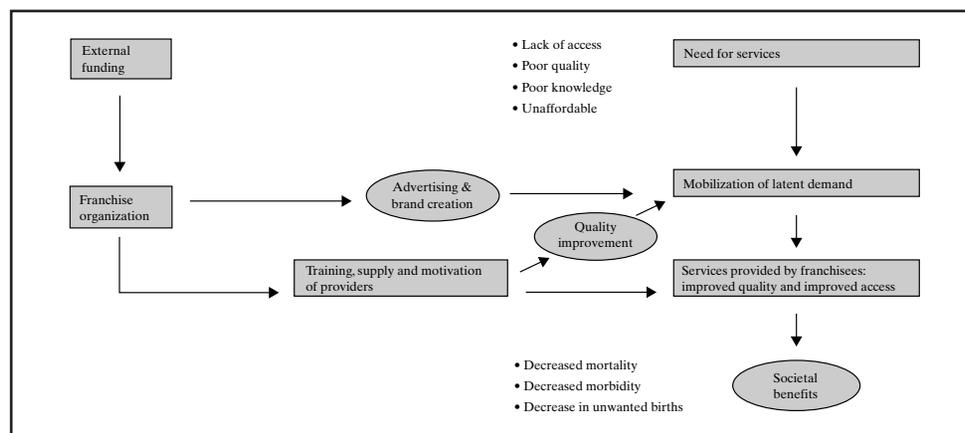


Figure 1. Social franchise benefits

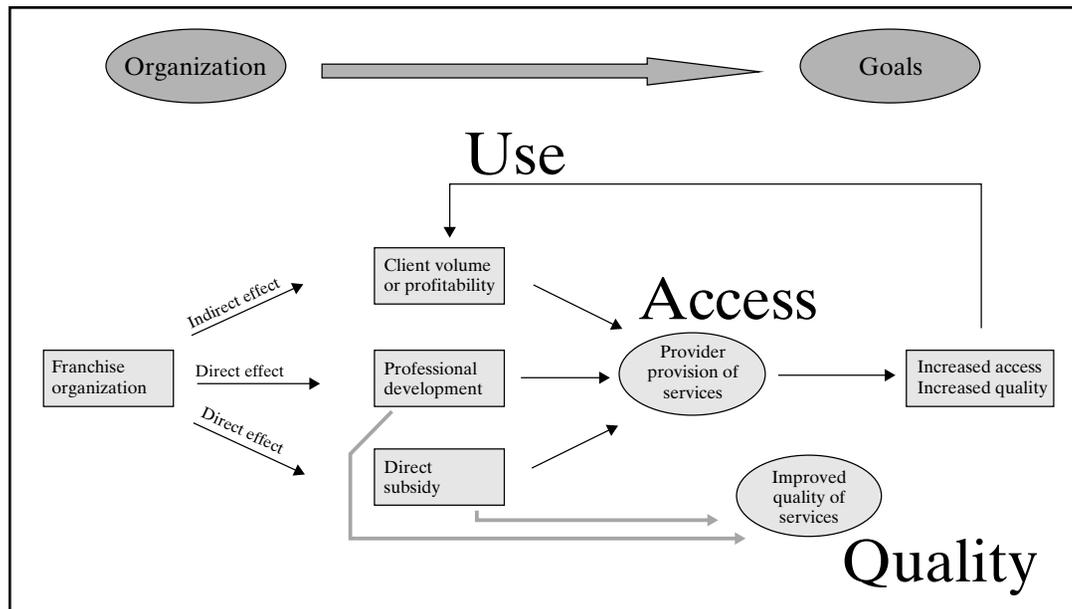


Figure 2. Activities and goals of social franchises

pre-enrolled clients. This allows for large savings during expansion and a corresponding fast track up to scale for beginning franchises. There are non-financial costs associated with fractional franchising, particularly brand confusion arising from parallel distribution of both franchised and non-franchised goods and services. For a social franchise, these costs must be weighed against the benefits indicated by both agency theory and investment savings.

Conceptual framework of franchising health service

The goal of social franchising programmes is to use the commercial relationship of a franchise network to benefit provider members, and then to leverage those benefits into socially beneficial services; socially beneficial either because they are of higher quality than services previously available, or because they are less expensive, or because greater availability and awareness of availability leads to greater use of a merit good service.⁴ The theoretical mechanisms for this are outlined in Figure 1.

The specific activities of social franchises can be divided into three programmatic areas: assuring the availability of services, the quality of services, and the awareness and use of services. In each area, the franchise has a vested interest in assuring that its programmes are effective, because success in one area has a spillover effect on the others, strengthening each area in turn as illustrated in Figure 2. In this way the activities in each programme area can create a virtuous spiral supporting not only the subsequent activity in the chain, but the franchise as a whole. What this means in practice is described below.

Assuring the availability of services – In the context of a social franchise this means that the providers who are recruited as

franchisees must gain enough benefit from their association with the franchisor that they can and will provide the commodity sales and/or clinical services of the franchise.

Assuring the quality of services – Given some net benefit, any provider will be willing to provide services. There is little social benefit in providing poor quality services however, and so a second area of focus for health franchises is maintaining the ‘quality’ of services provided by franchisees: that they be safe, effective and leave clients satisfied with their treatment and prepared for any questions or complications which may arise. The last two aspects are important because research in a number of countries provides evidence that decisions about where to seek treatment are often dependent upon word of mouth referrals and the treatment experiences of friends and associates (Yip and Orbeta 1999). Improving clinical quality without perceived service quality could improve outcomes but decrease use.

Assuring use – Once safe and effective services are available, they must be used. This is a necessary component of franchising for three reasons: first, as will be discussed later, services will not continue to be available if they are not used; secondly, because however beneficial services are in theory, their availability is only a condition for social benefit not a measure of it; and thirdly, because provider skill is dependent upon practice. A central goal of social franchises is to assure that latent demand for health services does not go unmet because of lack of awareness of service availability or because poor service quality discourages use.

Franchise implementation

Franchises of all sorts succeed or fail partly on the merit of the local operation management and partly upon the appropriateness of their brand to the market they serve. As

franchises grow, it becomes increasingly difficult to permit deviation from the standardized characteristics of outlets – both because monitoring variable criteria is expensive and because a diffuse brand will be less valuable as its associations in the minds of consumers will be muddled. This trend towards strict standardization is particularly true in sectors where service is critical to the brand such as hospitality and food services (Kauffman and Eroglu 1998).

The fractional franchise model seems suited to health care services because it has been shown, in commercial settings, to be capable of remaining financially viable while surviving much greater variations in quality and conformity than have been allowed in the large food and hotel stand-alone franchise chains. There has been little research on why this happens, but one possible explanation is that, while the brand value and potential profits for franchisees may be lower in a fractional franchise than in a stand-alone franchise, non-financial considerations such as increased independence and greater local responsibility make the trade-off attractive to the franchisees.

The range of services provided in medical practices makes them difficult to standardize, and expensive to monitor. While it may be feasible to standardize health services at the level of a hospital or health system in a developed country, there are as yet no measurement methods that could affordably and credibly monitor private medical clinics in developing countries. There are few developed country examples: the limited number of medical franchises that exist tend to be pharmacies (Medicap, GNC) or provide non-clinical services (e.g. Comfort Keepers, a franchise for home care of the elderly).

Economies of scale, management of scope

Medical social franchises are unlikely to be a more efficient use of financial subsidies than government or NGO owned clinics unless their networks are large enough to benefit from economies of scale in advertising and monitoring. As with most commercial franchises there are savings to be had from centralized purchasing, but important cost savings can be achieved only by addressing the fixed costs of brand advertising, regular training programmes and monitoring of quality. These can only be reduced through distribution over a large number of outlets.

Monitoring large numbers of providers raises additional problems. Evaluating the technical capability and quality of the full range of services provided by medical practitioners is an imprecise, expensive and time-consuming affair (PBGH 2001). In hospital facilities in developed countries compliance with standardized procedures can be tracked through credible records, but even in this setting provider quality results are imperfect predictors of patients' health outcomes (Peabody et al. 2000). In the context of a large franchise attempting to be cost-efficient, an evaluation of member providers' overall diagnostic and treatment quality is unfeasible. Regular monitoring of the same would be impossible. Because of this, quality measures for medical fractional franchises are likely to be limited solely to the services that

are under the brand umbrella. For this same reason, services that can be easily delineated and standardized will lend themselves to franchising, while most medical services will not.⁵ This is the most important reason why most experience to date with social franchising has been with family planning programmes.

Quality control in this context will be reduced primarily to the observable service aspects of provider care, the verifiable processes involved in repetitive functions (single use of disposable needles, effective sterilization equipment and other infection prevention techniques) and book-keeping. Quality control is unlikely to extend beyond the franchised services for which simple procedures are standardized.

Standardization and monitoring are important because of an inherent cost in franchising, which stems from the incentive for franchisees to become free riders on the brand. While brand equity from advertising or reputation helps the franchise as a whole, the individual franchisor has an incentive to provide low cost, low quality service – what economists know as 'the tragedy of the commons', post-contractual opportunism, or moral hazard⁶ (Williamson 1985). When moral hazard of this form is great, monitoring by the franchisor becomes more important, and correspondingly more expensive. Because health services are usually a locally consumed service, this may not at first glance appear to be a critical issue among health care franchising programmes – local perceptions of a provider are likely to be the result of personal or secondary experience, rather than advertising. However, because of the great information differential between clients and medical providers, personal or second-hand experience provides a poor basis for judging provider quality, and external certifications (e.g. membership of a reputed franchise) can carry great weight (Scrivens 1996; Leonard 2000). This is the basis for a franchise's success, but it also means that the potential for abuses by franchised medical providers are higher than might be the case in franchises of hospitality services or utilities, and the importance of monitoring is correspondingly greater.

Effective expansion of scope for franchising health services, at the level of the provider, is therefore likely to be limited. By which we mean that there is limited potential to incorporate multiple profitable service areas under a single brand and a single provider network. It is unlikely that unrelated services, such as infectious disease treatment or cancer screening, could be easily integrated with a family planning franchise. The opposite is more likely: those services that are most focused and clearly demarcated will be the most effectively branded, monitored and supported.

This does not necessarily imply that advertising or brand positioning must be limited to the focus services. However, the implications of the brand beyond the core services will likely be closely delineated to include not services, but *attributes* that are widely applicable. For example, a pharmacy brand might have as its core mission assuring quality and accuracy of treatment for all diagnosed sexually transmitted diseases (STD) or malaria cases. The advertising and brand positioning could emphasize the efficiency, politeness and

cleanliness of the outlets – all attributes of value to clients, easily monitored and standardized, and unrelated to the larger issues of prescribing practices for non-malarial or STD illnesses. This would not be a problem of unbounded services: the core services are clear. However, within the core services the brand promotion focuses on aspects of service delivery that are also applicable to other, non-branded, services offered by the providers. Monitoring would therefore assure the clinical issues related to core services, and process or service-delivery issues related to client treatment across all services, both potentially achievable goals.

Application of the framework

By elaborating on the framework for social franchising illustrated in Figures 1 and 2 above, we can examine the ways in which aspects of franchisor–franchisee relationships affect the goals of the franchisor. A better understanding of these will lead to a clearer evaluation of the potential for franchise application. In particular, a better understanding of the framework components has the potential to improve the efficiency of franchise programmes through an appropriate evaluation of the various levers of control available to the franchisor in order to achieve social goals.

Incentives for providers

The reason why a franchisor might want to allow brand positioning and advertising images to spill over beyond the core franchised services is that doing so will increase the benefits for member franchisees. The greater the benefits accrued to franchisees by the programme, the faster the franchise will be able to increase the number of outlets and the more leverage the programme will have to assure compliance with quality standards. Greater benefits will also allow a franchise organization to select the best providers as members.

The criteria for incentives to providers are that they be sufficient to assure compliance with the practice standards and to attract new franchisees, and that they be non-distortionary. By this we mean that the incentives offered to providers ought not to alter the value of the services being offered in the marketplace – a product or service can be subsidized indirectly, but if consumers are unwilling to pay for a service, expanding access through franchising is the wrong methodology. Full subsidy of goods or services has a number of drawbacks, including high costs, difficulty in verifying usage, potential for corruption at many levels and undercutting competing private providers of the focal good or service. Experience in social marketing programmes has shown convincingly that charging a price for services, however small it may be, is a critical component of a successful programme for tracking purposes, to assure use and to convince consumers of the product's value (Harvey 1999).

The incentives offered to providers need not be solely, or even primarily, financial benefits from the franchised service. While data are limited, the experience of existing health franchises and other programmes working with private providers makes it clear that many providers place high value on

opportunities for post-medical education, access to new medical techniques, and interaction with other medical professionals (Bennett et al. 1994; Janani 2001; Montagu 2001). Sole practitioners without a position in a medical institution are often isolated from their colleagues and welcome the opportunities to make contacts and exchange ideas that franchise membership may offer (Thaver and Harpham 1997).

An example of this can be seen in the Green Star Network in Pakistan. Green Star franchises a range of family planning services through its network of 2000 private doctors. The doctors receive subsidized supplies, signage and benefit from advertising for both the clinic network and the socially marketed contraceptives, which have an affiliated brand. However, one of the most important benefits to providers, in their view, is the start-up training and monthly visits from Green Star doctors, during which they can discuss difficult cases, learn about advances in clinical practices in reproductive health and have one-on-one training in areas they feel uncertain. In a recent survey of Green Star providers, 23% said that the increased number of clients as a result of their membership in the network was the most important benefit they received from membership; however, a further 21% said that training was the most important benefit (Montagu 2001, ongoing research). Most Green Star members make little profit from family planning services but find the side-benefits very attractive (Agha et al. 1997).

The spin-off financial benefits of a successful franchise brand may also be substantial. In an undifferentiated market for healthcare, an affiliation with a known and respected brand may make an important difference to a provider's reputation, even if the brand is for only a portion of the medical care offered (Leonard 2000). This may be a reflection of the local market, of the skilful marketing of the franchise, of true quality reflecting either provider membership screening by the franchise or the positive by-product of quality training and monitoring in one area on other services, or a combination of all of these. Regardless of its origin, the benefits of brand affiliation have the potential to go far beyond the direct income from franchised services.

The indirect benefits of franchise affiliation are often difficult to value and may not be appreciated by members. Because of this, tracking of new clients, client volumes and income among franchised and non-franchised providers is highly desirable, particularly during the start up years of a franchise. This information can be used to provide feedback to member providers, demonstrating the benefits that result from their association with the franchise organization. Similar techniques are common in the commercial franchise sector (Bradach 1998).

Standardization of services

Standardization of services is critical to franchises for a number of reasons. The clarity of a brand is a reflection of its immediate associations for consumers. Inconsistency, in advertising or in services, weakens the brand by clouding associations. McDonalds is a place to buy good, cheap

sandwiches and fries. A variation on this, either to sell lower quality meat at bargain prices or to add lobster as an option for richer clients, would confuse potential customers seeking the core product. Similarly, when Mexfam, the Mexican Planned Parenthood affiliate, decided to create a rural network of clinicians using new medical school graduates they avoided using the Mexfam brand in part to avoid possible risks to their existing brand.

Within a branded set of services the goal of a franchise is to remove as much variability as possible. The poor performance of an individual outlet can effect the reputation of the larger group, sometimes significantly. Undercooked meat at one restaurant in the Jack-in-the-Box fast-food chain in the US led to an outbreak of *Escherichia coli* infection and the death of four children in 1993 and nearly bankrupted the entire franchise group (Kent 1993). The potential for similarly disastrous incidents is high when franchises provide clinical medical services. Because of this, monitoring is crucial to medical social franchises, and the central tool of affordable, replicable monitoring is standardization.

A franchise, or a chain of any sort, must have a regular set of criteria upon which to judge the performance of members. In the for-profit sector, business-format franchises place particular emphasis upon monitoring process indicators as well as outputs. Assuring that service standards are upheld is as, or more, important than products, as is suggested by the qualities that restaurant franchises in particular promote with their advertising: Burger King sells the chance to 'have it your way', while the Saturn subsidiary of General Motors sells the hassle-free sales force. One of the best examples of process monitoring of medical franchises can be seen at the Planned Parenthood Federation of American. PPFA conducts extensive evaluations and re-certifications of its local affiliates every 4 years. This is done to assure that at each affiliate service quality, pricing and financial management are all being properly managed so as not to hurt the Planned Parenthood brand. The evaluation focuses on quality assurance methods: are there certification requirements for all medical staff, are there codes of conduct and regulations to assure board accountability, is there a mix of funding sources to assure financial stability?

PPFA has an advantage in that their affiliate programme is akin to a stand-alone franchise system, not a fractional franchise system. This means that PPFA does not need to distinguish between branded and unbranded services when evaluating members. This matters because one of the most difficult aspects of fractional franchising is the separation of franchised services from other provider-offered services that share the same facility. Often, this is impossible, both in practice because the branded and unbranded services share the same examination areas, equipment and providers, and in perception, because clients perceive the quality of the provider or the clinic, and do not differentiate between categories of services offered. This makes the selection of the providers critical to the parent organization and the monitoring of *general* service criteria – cleanliness, politeness of staff, sterilization techniques and appropriate time per client – particularly important.

Brand positioning

Thirty years of experience with social marketing has dispelled any myths that family planning commodities, anti-malarial bed nets or vitamin supplements behave differently in the marketplace than traditional commercial goods: condoms and colas both succeed or fail based on branding which reflects market niches, positioning themselves as low cost or high quality, or targeting a particular age or ethnic group. Although the cumulative experience on the subject is still limited so far as franchising is concerned, there is no indication that this method of service delivery behaves in any way other than one would expect from the study of health commodity social marketing.

In the early years of any social franchise product the trade-offs of brand positioning – high volume/low cost vs. low volume/high cost – are likely to be weighted towards high-paying, urban clients (Dmytraczenko 1997). The experience of Janani in India (see below) has shown that, without an established brand and developed market, providers are unlikely to sign up for a franchise whose business plan is based on volume. The alternatives are either heavy subsidies or initial targeting toward more affluent urban dwellers. In most of the documented examples, a combination of both high subsidies and urban targeting has been used (Arango 1989; Agha et al. 1997; Janani 2001; Mortimore, personal communication, 2001).

The trade-off between profitability and a focus on the poor can be avoided in instances where there is sufficient awareness of, and demand for, the services being franchised that an identifiable brand can have an impact on the number of patients visiting a provider. In this case, a well advertised brand and a rural or poor-urban focus has the potential to create enough demand quickly enough that member providers will find the association beneficial and new providers will be enthusiastic to join the franchise. This situation is rare, however, particularly for the kinds of services most apt to be supported by social franchising programmes.

Brand positioning is essentially a decision about where to compete for clients. Competition is of particular importance to organizations attempting to franchise brands in developing countries (Stanworth et al. 1995; Amies 2000). Poor legal protections for brands, slow or non-existent enforcement of legislation that does exist, particularly in rural areas, and the lack of enforceability of contractual agreements with suppliers and franchisees are all significant problems (Smith 1996; Baru 1998). There are no straightforward answers to these issues, but some documented experiences offer helpful illustrations of the challenges involved: in some instances environmental conditions have been able to take the place of enforceable contracts with franchisees. Thus as part of the support offered to franchisees, Janani, a franchise NGO in the Indian state of Bihar, repaints signs and wall-painting advertisements annually. Franchisees who do not want to re-enroll in the network or who are expelled because of quality failings are simply left to have their signage erased by the summer monsoons. The provision of branded supplies, discussed further below, can, if marketed in parallel to the services of

the franchise, play an important role in distinguishing franchise and non-franchise outlets to potential clients.

There are three primary ways in which providers can be made accountable for the quality of their services, through shifting demand to other providers, influencing provider activity through community level feedback or accountability within a bureaucratic system (Paul 1992). In most cases only shifting demand, 'exit', plays a significant role for private providers. Yet, as noted above, the misbalance in information between providers and patients makes it difficult for patients to judge whether or not they are receiving appropriate care. The result is that, even where competition exists, shifting demand is a very poor mechanism to assure quality (Hongoro and Kumaranayake 2000; Mills et al. 2001).

What competition can do is influence a provider's adherence to rules set by a franchising organization. If a franchise provides sufficient benefits to its member providers that there is competition on the part of medical practitioners to join, then many of the problems that arise from differential information between providers and clients can potentially be addressed by the franchising organization. The franchisor, with more information on which to judge providers than would be available to most clients, is in a position to demand quality of many sorts from members and to screen providers for membership. In this context Paul's bureaucratic system provides an accountable hierarchy, in the form of the franchising organization. In a situation such as this the franchise operates much like an accreditation agency, managing its brand through access to membership (Scrivens 1996). In the Indian state of Bihar the Janani programme works this way at the level of Rural Medical Providers (RMPs). These untrained and unofficial medical practitioners provide almost all health care to the 80% of Biharis living in rural areas. Janani has created a brand for Titli Centres ('Butterfly' in Hindi). RMPs who are accepted into the franchise get 3 days of training in basic family planning and reproductive healthcare, and a regular supply of Janani's branded commodities. More importantly, they become associated with a heavily advertised and well-regarded brand, distinguishing them from the numerous other RMPs competing for the local medicine sales and healthcare market (Janani 2001). From surveys conducted in 2001 with clients and potential clients in the villages, it is evident that the association with Janani is an important indicator of RMP service quality in the eyes of the community (Montagu forthcoming).

Where demand for the franchised services is low, and benefits from franchise membership are few, the franchisor will inevitably be in a weak position to enforce standards. Where competition for franchise membership cannot exist, due to low numbers of potential providers for example, franchising is likely to be impossible.

The ability of a franchise to become financially sustainable will, more than anything else, depend upon the target population it is hoping to serve and the corresponding positioning of its brand in the market. In most instances it is unlikely that services targeted at the poor and/or rural populations will ever be financially sustainable through franchising or any

other market-based programme (Harvey 1999). In many cases urban programmes do have the potential to become financially sustainable over time, depending upon the market size, potential demand for the service and structure of the private medical sector.

Brand communication

Building a brand has two principal components after decisions on positioning have been made: advertising and avoiding mistakes. For normal consumer goods building a brand consists of identifying and communicating, through advertising, the desirable attributes of your good. With less control over production, business-model franchises advertise both the goods available at outlets and the services provided.

When the brand represents a service, the advertising must highlight that and the monitoring of the programme must assure the quality of the service. As Aaker (1991) writes: 'the key to obtaining high perceived quality is to deliver high quality, to identify those quality dimensions that are important, to understand what signals quality to the buyer, and to communicate the quality message in a credible manner'. But, beyond assuring the level of service at each outlet, the mass media communication must work to associate both the services and the brand name with the desired attributes.

Beyond the individual outlet qualities, mass advertising will always be critical to the success of the franchise, and central to the value of the brand (Sen 1995). While this may be obvious in a western society dominated by advertising, outlet stores and fast food franchises, for a private health care provider in a developing country the attributable benefit of a brand is likely to be very uncertain. Much rests on the franchisees' appreciation of the benefits that they gain from their association with the franchise brand. Measuring and communicating franchise benefits is important; equally important will be having a long enough project duration that providers are given adequate time to realize on their own the value of the franchise brand.

Starting a new franchise involves significant investment in providers. For a brand to be valued it must be advertised. Advertising services that are not available risks creating frustrated consumers, but until the demand exists it will be difficult to sign up franchisees. In practice, it is normal to reward the early members of a franchise with greater benefits, including low interest loans, renovation services, long-term fee remissions, etc. (Smith 1997). This is not different from commodity social marketing start-ups, but is at a different scale of importance because of the involvement of providers, whose level of motivation must be maintained at a higher level than those of merchants.

With any franchise that operates on a large scale, there will always be a risk that the franchise will come into conflict with non-member providers. These could be government providers, commercial commodity retailers or other private practitioners, depending on the services being franchised. These sorts of conflicts cannot be avoided, only mitigated through foresight. In some cases the potential conflicts can be

prevented through involvement of the agencies affected (government ministries, public sector clinics, national medical associations) in the design or implementation of the network. However, public-private partnerships are inherently political, and problems should be expected (Farrell 1984; Bradach 1998). Advertising is generally straightforward, while avoiding mistakes in brand communication is much harder.

Quality assurance

Professionals are difficult to franchise. There is a strongly held belief among all highly trained entrepreneurs that their clients are attracted by their skills, not by the brand of the franchise (Bradach 1998). This is particularly true of medical professionals, who have gone through many years of training and invariably occupy a place of respect in their community. Convincing medical professionals to change their practices, through training or through the imposition of mandatory procedural requirements, is always difficult, particularly so when the providers are operating without direct supervision in their own privately owned clinic. Recent research on the importance of perceived quality in clients' choice of use of family planning services suggest that while client perceptions of provider skills matter, the broader community-wide quality reputation of the provider is also important (Speizer and Bollen 2000). This would not surprise a brand manager for a service franchise.

The solutions to quality assurance problems are three-fold. The technical quality of services can be improved through: (1) training, to assure that providers are aware of best practices in the hope that practice will follow knowledge; (2) encouragement, by advertising quality standards (e.g. single-use

needles for injections) at franchise clinics, regular feedback through cooperative monitoring or offering fee remissions and other subsidies to providers who adopt best practice procedures; and (3) penalties for providers who do not comply with franchise standards of care, including ultimately, expulsion from the franchise.

None of these solutions are likely to yield perfect compliance with desired practices. However, when benefits from membership are sufficiently valued by the member providers, a mixture of training, encouragement and penalties can together be used to assure that providers have an interest in improving quality. At that point monitoring of proximate determinants of quality, such as cleanliness and adequacy of equipment and stocks, can be used to determine those providers who are unable or unwilling to meet the standards of the franchise, and their contracts can be ended (Vera 1993).

A fair amount has been written on ways to evaluate quality of care (Bruce 1990; Bertrand et al. 1995; Kols et al. 1998). While the Bruce framework (1990) provides a model of attributes that compose quality services, it does not purport to be a blueprint for monitoring. For the reasons described above, regular monitoring of technical quality of private clinicians is effectively impossible. In its place, franchises must use a variety of proxy measures which have an established link with client perceptions of quality, and a theoretical link with clinical measures of quality (Bruce 1990; Jain et al. 1992; Bertrand et al. 1995). Examples of these include establishing the provision, use and proper disposal of single-use needles, availability of sterilization methods, stocks of medicines and associated materials, cleanliness of consulting and operating rooms, the number of clinical procedures done each month and knowledge of potential side effects associated with the

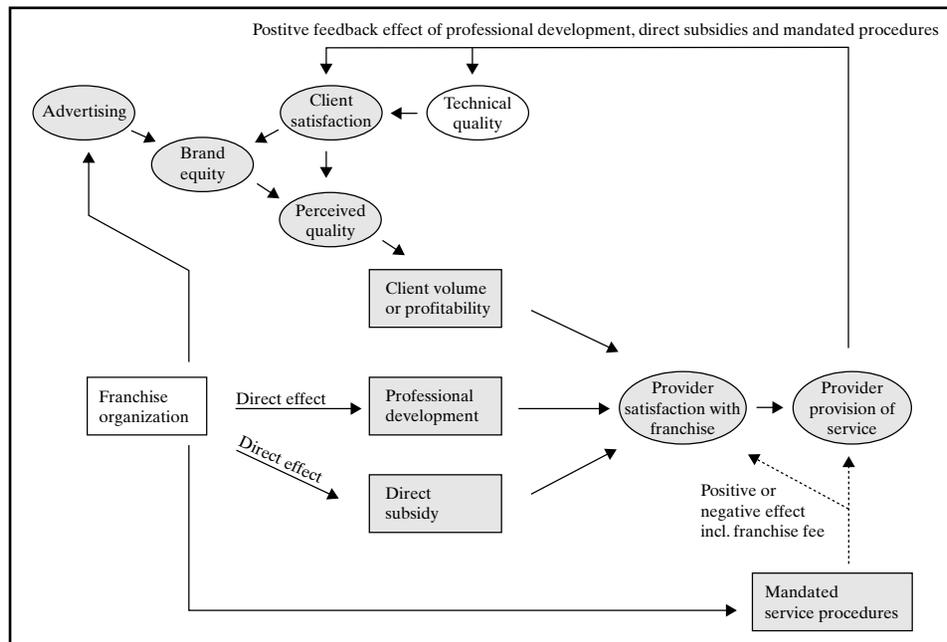


Figure 3. Model of social franchising

franchised services. While all of these are unsatisfactory, they are, to paraphrase Churchill, the least satisfactory monitoring criteria except for all of the others.

Taken together, these attributes of a franchise can be used to produce a more detailed model of franchise working, as shown in Figure 3. This model shows the importance of the feedback effect of service quality on provider motivation. An important consideration for franchise operators or funders will be what subsidiary benefits might be needed in order to assure critical aspects of the cycle (e.g. the additional service volume generated by a second tier of referral agents).

Conclusions

The primary advantage of business model franchising is the potential for fast, low risk expansion through local ownership, backed by a recognized brand with well-established attributes desired by consumers. With these advantages, the application of franchising to health services is more a matter of time than a matter of dispute. Already, franchising has been used in half a dozen countries to deliver reproductive health services to populations beyond the reach of government health programmes.

While there is much potential for service franchising to expand access to a range of services with social benefits, there are a number of basic requirements before any franchise can be considered successful – meaning that it meets the goals set forth in the beginning of this paper for increasing access, quality and use. There must be an existing and under-employed private medical sector; this must be sufficiently large and widespread that it justifies the cost of building an umbrella franchise organization. The services being franchised have to have some potential to motivate private clients to pay for them. Most curative services will meet this criterion, but only rarely will people pay for preventative services or cures requiring long-term treatment regimes; these latter, therefore, may not be suitable for delivery through franchise networks. There must exist sufficient local capacity to build and manage a large organization, working in an effectively for-profit manner. Finally, the services being franchised must be sufficiently limited and definable that they can be both monitored and promoted with an assurance that quality can be maintained. Family planning services meet this goal, as might tuberculosis treatment or HIV/AIDS counselling. More general services such as paediatrics or internal medicine will be difficult to evaluate and thus do not lend themselves to dissemination through a business model based upon standardization. Franchising, ultimately, is about clarity of service marketing and then assuring that the service qualities that are advertised are present throughout the franchise network.

Endnotes

¹ Terms used in the paper: *traditional franchise* – also known as *geographic franchise*, this system gives a franchisor the sole right to sell goods in a demarcated area. Common examples include car dealerships and gas stations.

Business-format franchise – the franchisee gains the rights to the product and the process of the franchise, and is usually required

to follow certain service standards. This structure entails a close ongoing relationship between the franchisor and the franchisee. Examples include fast food outlets such as Burger King or Starbucks.

Stand-alone franchise – a franchise outlet that only sells the products of the brand. Most business-format franchises are of this nature.

Fractional franchise – a franchise outlet where only some of the goods or services provided from an outlet are part of the branded group. Traditionally rare in commercial retail because of the lower degree of control of the brand, some aspects of this exist in Post Office branches within local stores in the United Kingdom, or in the Ace Hardware network in the United States.

Social franchise – a franchise system, usually run by a non-governmental organization, which uses the structure of a commercial franchise to achieve social goals.

² So-called ‘first generation’ franchises have, as a goal, the overall growth of their market. ‘Second generation’ franchises are run more like commercial enterprises, and have goals for financial and organizational sustainability as well as market growth (Smith 1996).

³ All individual Best Western franchisees own their hotels, often in Europe a pre-existing hotel. The members operate their hotels as they see fit beyond the areas of control of the franchise; so restaurants, swimming pools and conference facilities are not the purview of the Best Western Group, which focuses on the hotel franchise and the related amenities of in-room showers, IDD telephones and cable television.

⁴ A merit good is a good (or service) which some ‘outside analyst’ considers to be intrinsically desirable, uplifting or socially valuable for other people to consume, independently of the actual desires or preferences of the consumer himself. Vaccination services and education are common examples.

⁵ Standardization is at the root of the quality assurance systems that have been developed by McDonalds and other large food franchisors, but their successes do not easily transfer to medical services. A typical McDonalds restaurant in the United States offers approximately 50 items – each with individual standards and procedures for preparation, making it difficult to standardize, but feasible. By contrast the 1999 International Classification of Disease lists over 1700 different medical conditions, each with a diverse range of possible causes, complications, co-infections and competing treatment regimes (Medicode 1999).

⁶ Moral hazard is most often used by health economists to describe why consumers of insurance use more healthcare than they would if they were paying directly. We use the term here in the labour economic or agency theory sense, where the term has a more general application in relation to post-contractual opportunism. In this usage the term describes occasions when ‘because it is costly for the principal to know exactly what the agent did or will do, the agent has an opportunity to bias his actions more in his own interest, to some degree inconsistent with the interests of the principal’ (Alchian and Woodward 1988).

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Biography

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