

Sustainable rural healthcare and social franchisee selection – an India study

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Abstract

Geographical isolation, unavailable healthcare professionals, and insufficient government investments in healthcare severely constrain health services access in rural Bottom of the Pyramid markets. Social franchising offers a solution to this issue. It combines commercial franchising principles with social marketing to offer a sustainable business model for expanding healthcare access. Clinical franchising within social franchising is crucial in providing medical services. In this article, we put forth an argument for considering franchisee selection as a key ingredient in clinical franchising success. An exploratory study in India on social franchising among social enterprises and its results are also presented.

Keywords

Franchise selection, rural BoP market, social franchising, sustainable healthcare

Introduction

Sustainable development rests on three major pillars, namely economic, environmental, and social sustainability.¹ Sustainability research has concentrated on food, clothing, and shelter – necessities of life and less on other aspects like healthcare. In addition, emphasis has been on products rather than services. Sustainable durable and non-durable products have been subject of large number of research projects. Sustainable services have been less researched.² Economically sustainable healthcare for rural areas is crucial in developing countries like India. India has one of the largest rural Bottom of the Pyramid (BoP) populations globally.³ Four billion people who earn less than 3000 US dollars per annum in local purchasing power comprise the BoP market.⁴ After food, clothing, and shelter, healthcare is a crucial constraint in BoP markets. Specifically, healthcare affordability and access are barriers facing most BoP consumers. Without significant government investment, social enterprises (commonly called non-governmental organizations or NGOs) operate in BoP markets to fill deficient government service provision.⁵ While these organizations have an option of expanding on their own, social franchising as a concept is fast developing as an alternative.

Social Franchising⁶ is a new phenomenon among NGOs. It represents a combination of commercial business-format franchising principles and social enterprise functioning. Social healthcare franchising

aims to initiate and increase healthcare awareness, accessibility, affordability, and acceptability.⁷ These aims directly relate to sustainable healthcare. For effective social franchising, a key influencer is the healthcare franchisee. In this article, we argue, specifically as to how franchisee selection influences sustainable healthcare. We present an exploratory study to support our argument.

The rest of this article is structured as follows. Initially, we discuss issues regarding healthcare access and the challenges in rural BoP market. Next, this article describes how social organizations develop and grow to fill in deficient healthcare services. Later, we discuss about franchising and the role of social franchising. Further, this article delves into social franchisee selection, details pertaining to our study in India, and then ends with implications for public policy and further research.

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Rural Indian BoP market and healthcare access challenges

BoP market consumers are poor and struggle to have their basic needs fulfilled.⁸ Poverty in turn may lead to diminished healthcare access, increased environmental risk exposure, and malnutrition.⁹ Healthcare access is crucial here. Accessibility has a number of dimensions, including physical, information, and economic accessibility.¹⁰ While physical accessibility deals with reach of healthcare services, economic accessibility means that health facilities, goods, and services must be universally affordable. Like many emerging economies, India faces several healthcare issues.¹¹ Eighty-three percent of Asian population and almost the entire rural India's population falls under BoP.⁴ The total BoP healthcare market is estimated at 158 billion dollars. In Asia's BoP market, healthcare spending out of total household spending is as high as 85%. This BoP market resides in two locations, namely urban and rural areas.⁴ A majority of the BoP market in Asia and Africa lives in rural areas. However, due to high population density and high-income households, best healthcare facilities¹² are available mainly in urban areas. This situation may help urban BoP consumers as high-income households can cross-subsidize their healthcare costs. In rural areas, however, without sufficient public healthcare infrastructure investment¹² and scarcity of doctors/other medical staff, healthcare access is minimal. Geographical distance, doctor scarcity, unwilling urban-based doctors, bulky medical equipment, spurious drugs, and fake doctors are severe constraints to rural BoP market access.¹³ Rural India's healthcare spending is high too, without adequate health insurance and healthcare facilities.

Most rural consumers learn to live with preexisting illnesses. They manage their life without taking adequate medical attention. They resort to self-medication or local and home remedies to treat minor illnesses. Unqualified medical practitioners provide medical advice that patients follow blindly. Several indigenous medical systems have been in use for long in rural areas due to non-penetration of modern medicine. Therefore, medical practitioner's reputation, proximity, and affordability¹⁴ explain rural BoP consumer's traditional medicine usage. However, most practitioners are unqualified. When monsoon/lack of funds, prevents distant and costly healthcare access,¹⁵ these act as practitioners of last resort.

Filling up government's rural healthcare gaps without commercially viable private healthcare requires efforts of rural social organizations. These organizations do not have a wide presence in terms of reach. Franchising can help in the rapid multiplication of an economically viable business model for serving rural

healthcare needs. Here, we need to distinguish between commercial and social franchising.

Commercial and social franchising

Commercial organizations adopt franchising as a method of rapid distribution of products and services. There are broadly two commercial franchising models,¹⁶ namely product/trademark and business-format franchising. Internationally, business-format franchising has gained popularity due to a product and service combination involved in the contract. The franchisee obtains a complete business format that includes business operational procedures, trademark, marketing assistance, and products/services from franchisor. While sole franchisees have been popular, multiunit franchising¹⁷ is gaining importance. In multiunit franchising, franchisees own multiple units thus helping to rapidly expand franchisor's reach. These commercial models can form the basis for social franchising too.

Social franchising is a form of social organizational expansion. It helps in rapid spread of social marketing efforts like health services marketing. Social franchising¹⁸ combines commercial operation and social goals attainment. This combination, however, poses a major organizational challenge. The term social organization is subject to a wide variety of interpretations. An employee-owned home-care service, car pooling company, retail outlet employing disabled people, hotel chain employing disadvantaged workers, renewable energy company working for a community – all are termed social organizations. The various social franchising formats¹⁸ are as follows:

1. Employment format – commercial businesses in general use this format for supporting social causes. Franchisees employ disadvantaged individuals and accept franchising with this employment requirement.
2. Price recovery format – this format serves social causes with lower product/service costs. Lower costs are managed either through scale of operation or sustainable income generation from various sources. Income generation could include part price recovery from beneficiaries.
3. Donor funded format – in this format, franchisors are large network of non-profit organizations that are entirely donor-funded. They provide free/low-priced products/services to the needy.

The second format is gaining ground as a dominant and sustainable mode of social franchising. In this article, we specifically consider social organization as a non-profit organization helps rural healthcare services

expansion through franchising. This organization's activity is in social franchising.

Social franchising in healthcare is differentiated⁷ as commodity and clinical based. Commodity-based healthcare franchising involves franchising pharmacy outlets selling over-the-counter/prescribed pharmaceuticals and medical devices. Clinical social franchising entails medical care services provision using doctors/other paramedical personnel. Commodity/clinical healthcare franchisees in rural BOP markets typically face a problem of economic sustainability. Therefore, a modified franchising form called fractional franchising¹⁹ operates. In fractional franchising, new products/services are added to an existing franchisee's operations to make the franchisee financially sustainable using an existing asset (store space for example).

A recent study²⁰ on international social franchising has highlighted many challenges. A key franchisor apprehension, new to this organizational form, is clubbing social mission with commercial business model. Franchisors fear that social franchising could lead to loss of their non-profit status. They expressed difficulty in understanding operations of this new organizational model. Other challenges related to reputation loss, legal and financial issues, and service standardization. Many of these issues relate to franchisee's role in social franchising.

Franchisee's role and franchisee selection

To understand franchisee's role, a study of two major franchising theories, namely resource scarcity and agency theory, are important. Resource scarcity theory¹⁶ states that organizations franchise to access scarce resources (particularly capital/managerial resources) to expand rapidly. In BoP markets, capital scarcity is a significant reason for organizations to adopt franchising. In addition, local market information and social franchising motives insure better franchising system performance. Agency theory²¹ explains organizing relationships where one party (the principal) determines work that another party (the agent) undertakes. Franchising has a principal-agent relationship. This relationship insures benefits for both parties. There is lesser need for monitoring and evaluation. Applying such a relationship to clinical social franchising, franchisees would ideally insure that their organization performs well. Significantly, franchising system performance therefore rests greatly on the franchisee. Therefore, for a franchisor, franchise initiation, propensity to franchise, and franchise performance depends on franchisee availability, selection, and performance.

Franchisee performance while dependent on many factors, highly correlates with franchisee selection. A franchisor can use several criteria to insure good franchisee selection. Franchisee selection²²⁻²⁶ in clinical social franchising depends on the following major factors:

1. Objective factors like the financial capability, professional qualification, presence of viable market, space availability, and qualified human resources availability.
2. Subjective factors like business acumen, local-market knowledge, practical intelligence, computer literacy, family/social support, etc.

In clinical franchising, franchisor's dilemma is to find balance between franchisee's business acumen and personal characteristics. Social franchising is a mix of commitment to social cause and sustainable business proposition. A dilemma is whether to select a person with business acumen and induce interest in a social cause or select a socially committed individual and provide training in sustainable franchise operation. Literature is scant in this regard. In commercial franchising, greater emphasis is on personality-related factors for franchisee selection.

Social franchisee selection, however, needs to consider franchisee dependence and opportunism to insure a sustainable franchise.²⁷ In commercial franchising, a franchisee's economic success depends on her ability. Franchisee's financial failure may not significantly affect a commercial franchisor. In clinical franchising, franchisee's financial failure greatly reduces franchisor's attainment of social goals. Thus, it is in franchisor's interest to help franchisees to succeed at all cost. Moreover, if clinical franchisee closes down his services due to financial failure, it deprives consumers of its services. Another significant risk for purely services-based clinical franchising is franchisee opportunism. If a clinical franchisee does not value his franchisor's relationship, then he could pursue his personal goals. In addition, the franchisee could also misuse franchise system's intangible assets like brand name. Franchisee selection needs to anticipate this challenge. This study explored the franchisee selection process among Indian NGOs.

Study methodology

A recent global compendium²⁸ on clinical franchising lists eight umbrella organizations that serve as franchisors/funding agencies. It also features 33 different organizations involved in these initiatives across different countries. In many cases, however, pilot studies have dominated social franchising initiatives globally.

The following are the social franchising initiatives operating in India

1. Surya Clinics supported by Janani and DKT international.
2. Key Clinics supported by Population Services International.
3. Sky Health Centers and Sky Care Centers supported by World Health Partners.
4. PSP One supported by DIMPA Network India.
5. Hindustan Latex Family Planning trust supported by Merrygold Health Network India

All these initiatives are in family planning and sexual/reproductive health. In addition, franchisees offering voluntary HIV counseling/testing services also exist. Population Services International India supports one such initiative called Operation Lighthouse. Medicine Shoppe India (under brand name Sehat) and Vision Spring operate commodity-franchising initiatives. Medicine Shoppe provides low-cost medicines with free consultation through its franchisees. Vision Spring sells low-cost eyeglasses for poor with vision problems.

We embarked on an exploratory field study in India. Karnataka State in India has been a pioneer in healthcare with unique schemes like Yashaswini that provides low-cost health insurance and cashless hospitalization for the rural BoP. Manipal and Bangalore in Karnataka were chosen for the study. While Manipal and its surrounding areas represent the rural area, Bangalore the capital city of Karnataka houses local headquarters of many state level NGOs.

An internet search yielded NGOs operating from in/ around Manipal, Udupi, Mangalore, and Bangalore – key cities in Karnataka. Initially, a large number of organizations were contacted by email. While none of the organizations responded or could be contacted through email in Udupi, Manipal, Mangalore area, three organizations from Bangalore responded through email. Based on the response, we decided to conduct the study following a multiple case studies format using in-depth personal interviews.

The purpose of in-depth interviews with heads of healthcare NGOs on social franchising was to assess the following:

1. Awareness about social franchising.
2. Acceptability of this mode for scaling up their organization's activities.
3. Positive/negative views on this organizational expansion mode.
4. Franchisee criteria adopted in organizations that already follow (some form of) social franchising.

Findings

We present a brief about the NGO first and then detail the information collected from in-depth interviews

CARDTS – Citizens Alliance for Rural Development and Training Society – is an NGO involved in the HIV/AIDS prevention and rehabilitation program. They work with different sets of people like male and female sex workers and other disease carriers. They also provide technical support to other organizations working in this field. Project sustainability is based on local community activity. They strive to develop stakeholder involvement and encourage volunteers from other NGOs.

While this NGO would consider social franchising, they were not clear about operationalization of this new concept.

Preeti Neethi Trust is a registered NGO independently for the past almost two decades. It mainly works with leprosy patients and HIV affected people. One of its major aims is to provide self-confidence and economic independence for their target segment through government and private sector employment. The trust provides housing, food, and medical care through government and private hospitals along with income generating activities. It depends on individual donors for pursuing its activities.

The head of the trust was critical of many NGOs working on the same or similar causes and therefore the wastage of funds. She felt that social franchising would reduce her organizations' independence and flexibility. She would not mind her organization's low-key operations and low awareness compared to large, heavily advertised, standardized services.

ENABLE India works for the economic independence of the disabled in addition to looking at their healthcare needs. Given the founders' information technology background, its emphasis is on computer training for the disabled. Disability assessment and structuring learning requirements based on it is a key component of their activities.

This NGO was keen on social franchising but only for the operational part of their activities. They were apprehensive of quality maintenance and control after franchising.

APD – Association of People with Disabilities – is a 50-year-old organization dealing with education, therapy, intervention, and advocacy for the disabled.

This NGO had apprehensions about service replicability in social franchising. Moreover, it felt that application of commercial business models would dilute social causes. It was also not keen on donor dependency. A major issue in expansion of NGOs according to them was the lack of adequate manpower.

FAME – Foundation for Action, Motivation and Empowerment, India, works toward rehabilitation and empowerment of children and young adults with neuro-muscular and intellectual development disabilities, such as cerebral palsy, Down's syndrome, mental retardation, and muscular dystrophy. This NGO helps through the entire lifecycle of the person starting from childhood to adulthood.

Lack of time for monitoring and trust in addition to unavailable specialist manpower were the key constraints to social franchising according to this NGO.

Belaku is an organization working on rural healthcare.

According to its founder, availability and willingness of potential candidates to work in NGOs and rural areas and salary were the key constraints in expansion of activities. While she supported social franchising as an idea, service quality standardization and network collaboration were not feasible in this model.

Vaatsalya is a branded chain of hospitals whose main aim is to extend low-cost healthcare to rural areas. They are involved in standardizing operating procedures in managing a small hospital and centralizing purchases of medicines and medical equipment to lower cost.

They follow a form of social franchising. The brand *Vaatsalya* is offered to existing clinic or hospital owners in return for their services and adherence to their hospital management format. Transparency of healthcare services pricing for rural BoP consumers is a key target. According to *Vaatsalya*, training cost and maintenance of healthcare service quality are crucial in social franchising success.

PSI – Population Services International – was initially associated with Indian government for condom distribution as part of the population control measure. Later, it also expanded its activities in the HIV/AIDS prevention, counseling, and treatment.

PSI has a clear method of choosing doctor's (private practitioner) clinics for branding as *KEY Clinics*.

Their criteria includes:

1. clinic location, patient profile, and patient load;
2. doctor's profile – *PSI* was interested in doctors treating sexually transmitted infection, providing HIV/AIDS counseling, and population control services;
3. doctor's willingness for *PSI*'s services protocol training; and
4. contractual acceptance of service quality and price maintenance.

In return, *PSI* provided marketing support, which directed patients to the nearest *KEY* clinic. This

benefits the doctor too as it increases the fee he earns. *PSI* adopted typical retailing techniques like mystery clients for monitoring/controlling doctors' service quality. *PSI* does a surprise check on doctor's service quality (using reputed *PSI* doctor panel) to insure franchisee quality. Similar to business-format franchising, *PSI* takes decisions on franchisee recruitment, selection, monitoring, appraisal, and termination using objective measures.

In summary, the smaller NGOs were not aware of social franchising. Two organizations followed social franchising in some form. Of the two organizations, *PSI* is involved in social franchising in full measure and was clear about its application and impact. Social franchisee selection was almost on the lines of commercial franchisee selection. On the other hand, *Vaatsalya* followed a limited form of social franchising. Social franchisees were selected based on acceptance of a pricing policy mainly to expand affordable healthcare and their willingness to rebrand the existing facility as a *Vaatsalya* hospital.

All organizations in the study accepted social franchising as an effective mode of scaling up their activities. However, apprehensions were about (1) loss of reputation, (2) franchisee monitoring and control, (3) gaging and maintaining franchisee's passion for the social cause, and (4) social sector manpower availability, especially as social franchising jobs are not remunerative compared to mainstream jobs.

Implications

Sustainable healthcare in BoP markets could use social franchising for expansion. In developing countries (which suffer from investment deficiency), this could be a mode of public private partnership for affordable healthcare services for the rural poor. The key for social franchising success is franchisee selection and specifically qualitative factors in selection.

Social franchising for healthcare is replicable across other services like education too. Many corporate entities have now taken up corporate social responsibility (CSR) seriously.²⁹ One method of organizing this activity is to have a separate CSR department. Another method is to allocate financial resources and solicit social franchising organizations to execute CSR activities on their behalf. The latter method can help in making a greater social impact. It also represents new corporate and civil society collaboration for mutual benefit and greater efficiency. Many developed and developing countries apportion a part of their country's yearly budget for funding civil society activities. In such instances, governments can choose NGOs that undertake social franchising. Government can choose these organizations based on their credible

franchisee selection procedure for efficient/effective service provision.

Conclusions and directions for further research

NGOs and civil society organizations in different countries are exploring and experimenting with social franchising in its infancy. While economically sustainable and socially relevant services form broad objectives of social franchising, its implementation is a difficult proposition. Several studies describe successful clinical social franchising; however, franchisee selection has been a neglected area of research. This article is an attempt to highlight franchisee selection in social franchising.

Two types of studies will be useful in furthering research in social franchising. Longitudinal studies that track franchisors and franchisees over time can help relate to ingredients of successful franchising. Cross-sectional study of different social franchising types would help in delineating common factors that facilitate social franchisee success. Causal relationship between franchisee selection and social franchise impact through empirical research can help future social franchising research/practice. Conceptually, researchers could analyze mediating factors like franchisee dependence or opportunism for their influence on franchisee selection.

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