Making Franchising in Healthcare Work

Karlijn Nijmeijer

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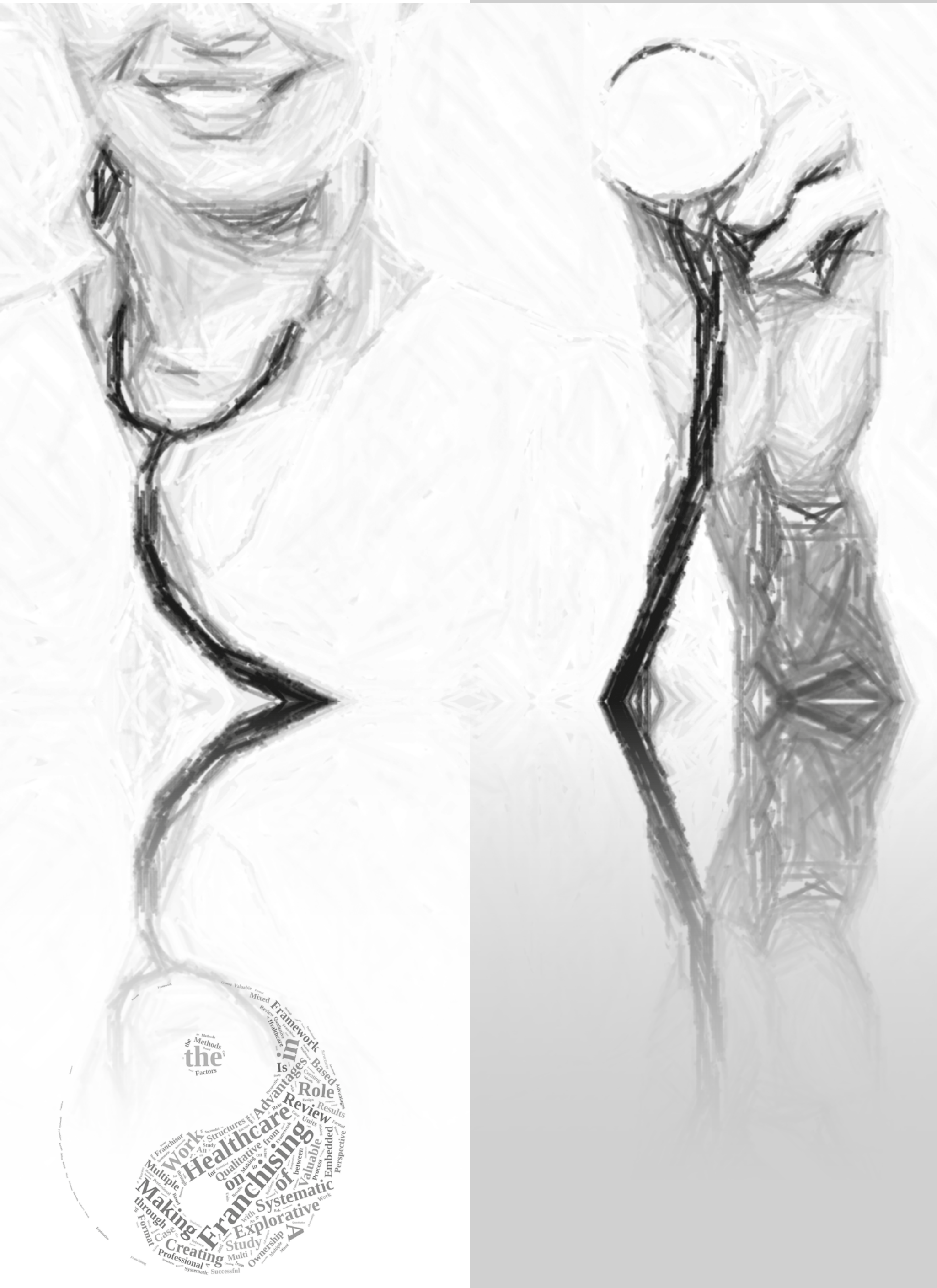
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Chapter 1

General Introduction

Introduction

Business format franchising is a form of interorganizational cooperation that originates from the business sector. It is increasingly used in a variety of healthcare services to reach positive results. In a franchise system contractual arrangements are made between two firms: the franchisor and the franchisee. In exchange for a payment, the franchisor offers a business format that consists of a brand name, support systems, and a specification of the healthcare services that must be delivered in local units. Franchisees provide healthcare services in local units using the business format, the own local market knowledge, and the own resources (Blair & Lafontaine, 2005; Falbe & Welsh, 1998; Komoto, 2005). Thus, franchising combines central management of a business format and local entrepreneurship (Cox & Mason, 2007; Sorenson & Sørensen, 2001). Some franchise systems also include units owned by the franchisor. These units are operated by managers that are employed by the franchisor and that use the same business format as the franchisees. So, a franchise system consists of a franchisor, the franchisees, the business format, the franchise contract and, in some systems, unit managers with the company-owned units they operate (Croonen, 2005). In this thesis the concept 'unit actors' is used to commonly refer to franchisees and unit managers (including their units), while the terms 'franchisees', 'unit managers' and 'professionals' are used to refer to actor groups separately.

Franchising is stated to be a promising model for the healthcare sector. Websites and trade magazines promise that franchising will help individuals in realizing their dream of being able to deliver the highest quality of care in a satisfying, supportive work environment (FranchiseBusinessReview, 2010; Fusco, 2012; Jongen, 2010, 2011; Meijer, 2013). Moreover, potential franchisees are promised to benefit from a strong competitive position with a shared strong brand name and to earn good incomes (FranchiseBusinessReview, 2010; Fusco, 2012; Jongen, 2010, 2011; Kennedy, 2012). Franchise experts and websites for entrepreneurs even argue that franchising in healthcare services is among the top 10 of franchise trends and entrepreneurial opportunities, with senior care and home healthcare providing the largest potential for growth (FranchiseBusinessReview, 2010; Stapp, 2010; Kennedy, 2012; Paraprofessional Healthcare Institute, 2010; International Society of Franchising Conference Panelsession Global Franchising, 2012). The large Dutch ING Bank recently described franchising as a promising model to rigorously improve the client-centeredness, efficiency, effectiveness and transparency of healthcare (ING, 2013). However, this interest in franchising in practice has not been paralleled with a large-scale scientific interest in healthcare franchising.

Insights from other industries suggest that the choice for franchising does not automatically lead to success. Scholars have estimated that between 50 and 85 percent of

the franchise initiatives fail on the long term (Bates, 1998; Shane & Foo, 1999; Lafontaine & Shaw, 1998). Moreover, at times, media report about conflicts between franchisors and franchisees of apparently successful franchise systems (e.g., Engeman, 2014; Franchiseplus, 2012, 2013; Kan, 2013; Keuning, 2014). Also in the healthcare sector, a subset of theoretically promising franchise initiatives ultimately went out of business or did not acquire the expected number of units (e.g., Pozniak, 2006; Shift Consultants, n.d.).

Thus, the key question seems not whether franchising in healthcare can be valuable. Key is how one can make the theoretically promising franchise model really work in practice. Practitioners that use or consider using franchising in healthcare need information about the structural designs and the processes that can help them to be successful, and which structural designs and process dynamics may hinder success. Therefore, the overall aim of this thesis was to explore how franchises in healthcare can be structurally designed and operated so as to achieve positive strategic, organizational, professional and client-related results.

Expected and expressed advantages of franchising in healthcare

The advantages of franchising that are theoretically assumed by scholars and described in the 'popular' literature differ for clients/customers, franchisors, and unit actors. Clients could profit from the business-orientation that franchising brings to healthcare. The clients' needs and wants regularly are pivotal in the thinking and processes in franchise formulas, as it is in business (Jongen, 2010, 2011; Hogan et al., 2006). The transparency and uniformity in product and service delivery may also reduce the clients' search costs for care (Pozniak, 2006). Quality monitoring and standardization of best practices can help ensuring that clients receive the best available care (Knott et al., 2009; ING, 2013; Montagu, 2002). Clients can receive this care in their own localities through the combination of central support and decentralized franchised units.

Franchisors frequently set up a healthcare franchise for ideological reasons. They developed a good concept – often based on dissatisfaction with the impossibilities of large-scale traditional healthcare organizations – and want to spread it to ensure that as many individuals as possible can receive care within this particular concept (Jongen, 2010, 2011; Hogan, 2006; ING, 2013). Healthcare organizations also set up a franchise because they want to spread their concept to gain a stronger competitive position toward clients, insurers, the government and other organizations, and as such enlarge their chance of survival and solid financial performance (Jongen, 2010, 2011; ING, 2013). Spreading the concept via franchising can have several advantages for franchisors in comparison to setting up only company-owned units. First, the use of franchisees can facilitate growth in the number of units because they bring financial and managerial resources (Knott et al., 2008). Second, they can use the innovative entrepreneurial

capabilities and motivation of franchisees as they are assumed to have larger incentives to perform well than have employed managers (Jalan & Kumar, 2009; Knott et al., 2008). Third, they can benefit from the franchisees' in-depth knowledge of the local market (Jalan & Kumar, 2009).

Many franchisees choose to work in a franchise system to be better able to fulfill the needs and wants of clients (Hogan et al., 2006; Jongen, 2010, 2011; Weijers, 2013). Others choose for franchising to gain a stronger position in the market, enlarge their chance of survival, achieve cost advantages and/or create a satisfying work environment for healthcare professionals. They expect to achieve these advantages through a combination of decentralized entrepreneurship and centralized support in purchasing, marketing, ICT, administration, on-suite guidance, training etcetera. Through this combination, they can benefit from economies of scale – and thus cost advantages – and are able to strongly focus on delivering care rather than being busy with non-care business activities (Jongen, 2010, 2011; Hogan et al., 2006; Knott et al., 2008; ING, 2013; Meijer, 2013; Gebhart, 2006; Pozniak, 2006; Weijers, 2013). The franchisor support also speeds starting-up or adapting units (Pozniak, 2006). Franchisees are said to have bigger chances of survival and good incomes through operating in a tried-and-tested concept with a recognizable brand name that can pull clients to franchise practices (Gebhart, 2006; Fusco, 2012; Pozniak, 2006; Bishai et al., 2008). Franchisees can also benefit from the knowledge and experience from the franchise network (Jongen, 2010, 2011) and can use best practices and innovations from the franchisor headquarters that can maintain their competitive advantage and help them to deliver the best quality care efficiently (Gebhart, 2006; Hogan et al., 2006; Knott et al., 2008). Finally, the support and the opportunities for knowledge exchange among care professionals in the same field may provide healthcare professionals with a more pleasant, satisfying and supportive work environment (Agha et al., 2007; Jongen, 2010, 2011). It is assumed that most of these advantages also apply to unit managers, except for those related to independent entrepreneurship, survival and risk-taking.

Potential problems with franchising

Franchising is also associated with potential problems. For franchisors a franchise system can be difficult, expensive and time consuming to manage. Some uniformity is essential to achieve economies of scale and to build a recognizable brand name linked to a particular quality and cost level, but the autonomous nature of healthcare professionals can make standardization difficult (Pozniak, 2006; Montagu, 2002). Franchisors continuously have to ensure that franchisees keep going in the right direction and must monitor the quality of the healthcare services. This is especially hard in case of professionals providing complex medical services, while the quality of the

brand name depends on the quality of the services provided by franchisees (Jalan & Kumar, 2009; Knott et al., 2008; Montagu, 2002). As independent franchisees cannot be steered as directly as employed managers, there also is an increased reputation risk when franchisees fail to deliver good care (ING, 2013; Montagu, 2002). There may also be a risk of contradiction of interests between some franchisors seeking standardization and minimization of costs to maximize profits and franchisee-professionals aiming to provide high quality care that may not be the same for each patient (Pozniak, 2006).

Unit actors run the risk of being harmed by other franchisees failing to deliver good care (ING, 2013; Montagu, 2002) and by profit-seeking franchisors (Pozniak, 2006). Such a too strong focus on commercial interests can also harm the clients. The uniformity requirement in franchising may clash with the professionals' desire for autonomy, which can lower the professionals' work satisfaction and the quality of care for services that need customization rather than standardization (Montagu, 2002). These risks are primarily present when the actual care provision is heavily controlled. The guidelines and monitoring of franchisors can also bound unit actors from implementing own ideas, developing an own identity, and implementing products and services that fit best with the needs and wants of professionals and clients (Christensen & Curtiss, 1977; Knott et al., 2008; Hogan et al., 2006). Finally, the fees and royalties paid to the franchisor lower the franchisees' financial performance and may not always be worth the money; once in the system, the support can be disappointing (Gebhart, 2006; Christensen & Curtiss, 1977).

Research questions

The key question in this thesis is how one can make the theoretically promising franchise model really work in the healthcare sector. Therefore, the overall question of this thesis is:

> *How are the structural design and process dynamics of healthcare franchises related to achieving positive strategic, organizational, professional and client-related results?*

The structural design comprises all the structural and procedural aspects of the franchise arrangement. Process dynamics of franchises refer to the actors' individual behavior and the interaction with each other in the system, as well as to the dynamical processes that evolve in daily practice. Results are defined as the consequences of an activity, plan or process within franchise systems. As franchising in healthcare has hardly been a subject of scientific investigation, the conceptualization of these key concepts 'structural design', 'process dynamics' and 'results' receives attention in this thesis. The empirical studies in this thesis apply a managerial and organizational perspective to study the key question. They thus focus on how one can make franchising work from the perspective of franchisors and unit actors. Studying the question from the perspectives of these two groups was important for obtaining a comprehensive understanding of how healthcare

franchises can be operated successfully because the franchisor and unit actors have different roles and interests and must make the franchise system successful together (Bordonaba-Juste & Polo-Redondo, 2004; Elango & Fried, 1997).

The studies covered in this thesis have been set up around four sub-questions to answer the overall question. The first question concerns the conceptualization of franchising in healthcare. Scientific insight is lacking regarding how franchise organizations in healthcare are structurally designed and operated. In other words, it was unknown what the key characteristics and elements of healthcare franchises are that practitioners can use to determine the structural design and process dynamics in their system, and that scholars can use to investigate success factors in franchising.

1) *How are franchises in healthcare being designed and operated? Which configurations / types of franchises can be distinguished?*

The second question concerns the results achieved in healthcare franchises:

2) *Which results can be achieved in healthcare franchises from the perspective of franchisors and unit actors?*

Next, the studies were focused on identifying the main structural design elements and process dynamics in franchise systems that promote or hamper achieving positive results with franchising in healthcare.

3) *Which structural design elements and process dynamics are related to achieving these results?*

Finally, the studies aimed to understand the underlying reasons for the importance of these structural design elements and process dynamics to really grasp how healthcare franchises work. Such an understanding can support individual practitioners in making the most effective choices regarding the design and operation of their franchise.

4) *Why are these structural design elements and process dynamics related to results?*

The next section describes how each of the chapters in the thesis contributes to answering the preceding questions.

Research design and outline of the thesis

An exploratory sequential mixed methods design (Creswell et al., 2011) was used to answer the research questions. By sequentially combining systematic literature research, qualitative research and quantitative research, the thesis could result in a comprehensive in-depth and broad picture of an unexplored phenomenon in healthcare, and findings could be triangulated (Doyle et al., 2009).

The thesis starts with two systematic literature reviews that were used as a foundation for the empirical research. *Chapter 2* identifies the available empirical evidence regarding the results of franchising in healthcare for clients, professionals and organizations (franchisors and unit actors), and thus contributes to answering

research question 2. This chapter confirmed that franchising in healthcare could be valuable, but that results vary within and across franchise systems. It also revealed that insights into what factors produce those results are lacking in the healthcare sector. Therefore, *chapter 3* comprises a systematic literature review of the empirical evidence concerning the structural design elements and process dynamics that make franchising work in all industries. This literature review resulted in a framework of success factors of franchising from the perspective of franchisors and franchisees – the perspective of unit managers rarely received attention in other industries. The results from chapter 2 and the framework from chapter 3 were used as a theoretical framework for the subsequent empirical research in Dutch healthcare franchises to answer all the research questions.

The qualitative research comprised an exploratory comparative embedded case study design. Three Dutch healthcare franchise systems providing mental healthcare, hospital eye-care and care for the intellectually disabled were investigated. Data were sampled from both the franchisor and the unit actors. This qualitative research aimed to provide insight in how healthcare franchises are structurally designed and operated in practice (research question 1), which structural design elements and process dynamics are perceived to promote positive results in healthcare (question 3), and in the reasons underlying these perceived relationships (question 4). Chapter 4, 5 and 6 present the results of this qualitative research. *Chapter 4* explores the role of the business format and contractual payments, *chapter 5* explores the role of the ownership structure, and *chapter 6* seeks to understand the role of the relationship between the franchisor and the unit actors. The latter chapter integrates the qualitative results in a mixed methods design. The qualitative findings were translated into a quantitative nation-wide cross-sectional survey instrument that was disseminated among nineteen Dutch healthcare franchise systems in five different healthcare sectors (mental healthcare, hospital care, care for the intellectually disabled and youth care, paramedical care, home and elderly care). Through integrating the qualitative and quantitative findings on the item-level, the study offers a deeper, richer and more objective understanding regarding the role of the relationship than the subjective 'common sense' relationships about this subject that were retrieved from only the qualitative study. All together, these three chapters indicate which structural, strategic and behavioral decisions are perceived to be important in franchise systems in healthcare to ensure that the desired results are achieved. The integration and aggregation of these findings resulted in an adapted, aggregated framework depicting the success factors of healthcare franchising.

The operationalizations underlying the qualitatively adapted framework were translated into a quantitative survey instrument to explore the breadth of the findings and quantify the qualitatively perceived relations. The relationship characteristics items from chapter 6 were a subset of this cross-sectional survey instrument. In *chapter 7*

the entire healthcare framework is quantitatively explored, thereby contributing to answering research questions 2 and 3.

The outline of the thesis, including the connection between the chapters, is depicted in figure 1. A detailed description of the methods used is included in each of the chapters. The thesis ends with an overview and discussion of the main findings, methodological issues, and practical and research implications in *chapter 8*.

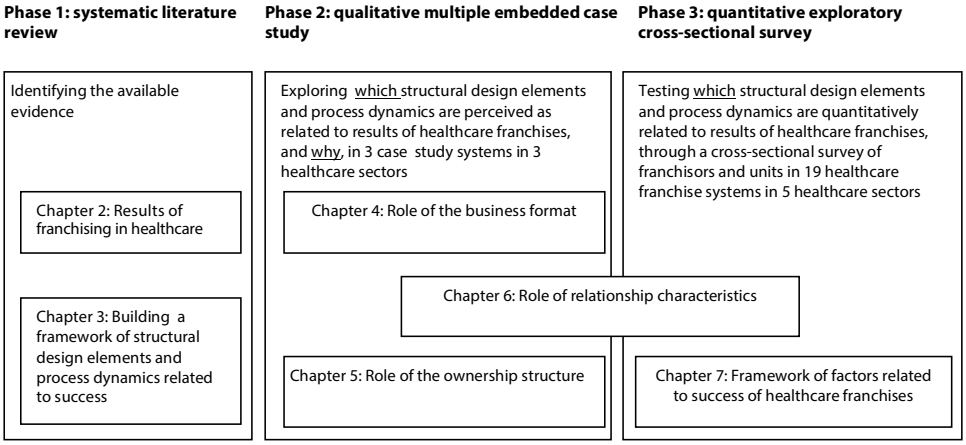

Figure 1: Overview of the dissertation content and connection between chapters

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Franchising
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Making
Systematic
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Chapter 2

Is Franchising in Healthcare Valuable? A Systematic Review

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Abstract

Background. Franchising is an organizational form that originates from the business sector. It is increasingly used in the healthcare sector with the aim of enhancing quality and accessibility for patients, improving the efficiency and competitiveness of organizations and/or providing professionals with a supportive working environment. However, a structured overview of the scientific evidence for these claims is absent, whereas such an overview can be supportive to scholars, policy makers and franchise practitioners.

Methods. This study provides a systematic review of literature on the outcomes of franchising in healthcare. Seven major databases were systematically searched. Peer-reviewed empirical journal articles focusing on the relationship between franchising and outcomes were included. Eventually, 15 articles were included and their findings were narratively synthesized. The level of evidence was rated by using the Grading of Recommendations Assessment, Development, and Evaluation scale.

Results. The review shows that outcomes of franchising in healthcare have primarily been evaluated in low- and middle-income countries in the reproductive health/family planning sector. Articles about high-income countries are largely absent, apart from three articles evaluating pharmacy franchises. Most studies focus on outcomes for customers/clients and less on organizations and professionals. The evidence is primarily of low quality. Based on this evidence, franchising is predominantly positively associated with client volumes, physical accessibility and some types of quality. Findings regarding utilization, customer loyalty, efficiency and results for providers are mixed.

Conclusions. We conclude that franchising has the potential to improve outcomes in healthcare practices, but the evidence base is yet too weak for firm conclusions. Extensive research is needed to further determine the value of healthcare franchising in various contexts. We advocate more research in other healthcare sectors in both low- and middle-income countries and high-income countries, on more types of outcomes with attention to trade-offs, and on what factors produce those outcomes.

Introduction

Franchising is increasingly applied in the healthcare sector in both low- and middle-income countries[1] and high-income countries. Franchising comprises a contractual arrangement between one firm (the franchisor) and a second firm (the franchisee), whereby the franchisee has the right to market goods or services under the franchisor's brand name (Blair & Lafontaine, 2005; Combs et al., 2004). In business format franchising, the most common form of franchise, franchisees also obtain the right to use a business format. This consists of the brand name, support systems, and a specification of products and services that need to be delivered (Falbe & Welsh, 1998; Komoto, 2005). Currently, 42 franchises in various Asian and African countries were documented at the end of 2009 (Montagu et al., 2009). Websites and trade magazines document the existence of approximately 50 franchise systems in the USA in various types of care (elderly and home care, eye and hearing care, dental care, paramedical care, and pharmaceutical care)[2]. In the Netherlands, approximately 30 care franchises exist in, among others, home care, hospital care, mental healthcare, and care for the disabled. Websites report the existence of at least 15 franchises in the UK[3] and 19 in Canada[4].

Franchising is increasingly explored in low- and middle-income countries as well as high-income countries as an organizational model to overcome several challenges in the healthcare sector. Many countries are confronted with inequalities in access and health outcomes (Dzau et al., 2010; Montagu, 2002; Institute of Medicine, 2001), unreliable quality (Dzau et al., 2010; Hussey et al., 2008; IOM, 2001; Knott et al., 2008), an increasing scarcity of healthcare professionals and continuously rising healthcare costs (Dzau et al., 2010; IOM, 2001; Shortell et al., 2000). Increasing market competition and privatization of healthcare in various developed countries (Cutler, 2002; Schut & Van de Ven, 2005) also force care providers to search for organizational models that can help create competitive advantages and increase their survival chances.

However, does franchising help to overcome these challenges? Various authors argue that in low- and middle-income countries, the clearly defined products and services, delivery standards, training, quality monitoring, and the donor-funded or subsidized system in many of the franchises in these countries should, in theory, lead to a rapid expansion of accessible, high-quality care for all citizens, subsequently resulting in health improvements at local and societal levels (Montagu, 2002; Lönnroth et al., 2007). Those same elements—except for the donor-funded or subsidized system—can

1 In low and middle-income countries some healthcare franchises are termed 'social franchise', as these franchises are designed to fulfill social instead of primarily financial goals.

2 http://www.entrepreneur.com/franchises/healthcare/indexhlth.html, http://www.bison.com/Healthcare_Franchises, retrieved 14 October 2011

3 http://www.franchisesales.co.uk/search/care-services-franchise-health-care-franchises, retrieved 14 October 2011

4 http://canada.franchisesales.com/search/home-health-care-senior-care-franchise, retrieved 14 October 2011

also allow for the geographical dispersion of high-quality and efficient care in high-income countries (Hogan et al., 2006; Knott et al., 2008). Franchising could provide a better working environment by offering training to improve the quality of care (Agha et al., 2007b; Bishai et al., 2008), stimulating interaction and knowledge-exchange among care professionals in the same field (Agha et al., 2007b), increasing efficiency through economies of scale (Christensen & Curtiss, 1977; Montagu, 2002), providing access to innovations originating from franchisor headquarters and other franchisees (Knott et al., 2008), and offering other types of management and operational franchisor support (Christensen & Curtiss, 1977). Furthermore, some authors hypothesize that the use of a brand name and other marketing strategies can pull more patients to the franchise practices by signaling the presence of high quality providers, which will subsequently result in higher revenues (Bishai et al., 2008; Agha et al., 2007b).

Authors also theorize about the possible disadvantages of franchising. Knott et al. (2008) and Montagu (2002) predict difficulties in controlling the quality of services provided by franchisees—especially in the case of highly educated professionals who provide complex medical services—while the quality of the brand name depends on the quality of services provided by those franchisees. Furthermore, Montagu (2002) expects trade-offs between quality and social goals on the one hand and competitive prices and patients' demands on the other hand. There is also a risk of a contradiction in interests between the franchisor and the franchisee, especially in developed countries where some franchisors are more profit-oriented than quality-oriented (Pozniak, 2006). Finally, mandatory fees (Christensen & Curtiss, 1977) and a reduction in professional autonomy (Dobson & Perepelkin, 2011; Montagu, 2002) are potential drawbacks for care providers who become franchisees.

These potential advantages and disadvantages raise the question of what the actual value of franchising in health care is. Because of the increasing use of healthcare franchising, the public function of healthcare and the multiple challenges with which the healthcare sector is confronted, answering this question is crucial. However, a systematic overview of the actual outcomes of franchising in healthcare does not exist. Only Koehlmoos et al. (2009) conducted a review of the influence of franchising on access to and quality of health services in middle- and low-income countries. They restricted themselves to a search for high-level evidence and concluded that there was none; however, lower-level evidence can also provide indications of what franchising can effect, particularly when multiple lower-level studies find the same results. Furthermore, that review did not comprise evidence gathered in high-income countries and did not focus on all types of outcomes. Therefore, we have conducted a systematic literature review, considering two related questions: *1) What is the state of empirical scientific knowledge about outcomes of franchising in healthcare for patients, healthcare*

professionals and organizations? 2) Which outcomes of healthcare franchising have been identified in these studies?

Methods

Before starting a review of the evidence about outcomes of healthcare franchising, we determined our inclusion criteria, definitions, search strategy, selection procedure, and a standardized data extraction form to retrieve data from the eventually included studies. We referred to various guidelines for reviews (Cochrane; Campbell Collaboration; Popay et al., 2006; Petticrew & Roberts, 2006), other systematic reviews (e.g., Buljac-Samardzic et al., 2010; Johns & Torres, 2005; Lemmens et al., 2009), and more experienced colleagues in reviews to do this adequately.

Inclusion criteria and definitions

We included empirical studies on the outcomes of healthcare franchising for customers (patients), franchisees (care professionals and organizations) and franchisors. The term 'healthcare' includes all preventive, diagnostic and treatment activities (related to both curing and caring) for those who are injured, ill, mentally or physically impaired, or at risk to be so in the future. 'Outcomes' are defined as the results of an activity, plan, or process; we included all types of outcomes. Consistent with the basic definition of business format franchising, franchises considered in studies needed to include a brand name accompanied by a contract between a franchisor and a franchisee that regulates the provision of goods or services by the franchisee under that brand name, with standard supplies, delivery standards, training and/or management (Blair & Lafontaine, 2005; Combs et al., 2004).

To be included in our review, studies had to compare franchise and non-franchise, pre-post franchise or different franchise systems. Qualitative and quantitative empirical academic peer-reviewed journal articles were included. Reviews were excluded because they are not empirical, but their references were checked to identify additional primary studies eligible for inclusion[5]. Other materials such as policy documents, opinion papers, books and case reports without detailed illumination of the research design were excluded for quality reasons because the rigor of their methods cannot be verified, they are not empirical scientific, and/or they are not certainly peer-reviewed. To ascertain that this criterion resulted in a representative overview of evidence not distorted by publication bias, a quick scan was conducted of the results presented in other materials (see search strategy and article selection). Studies about franchises in all healthcare

5 Reviews of Koehlmoos et al. 2009, 2011 were identified and checked to identify possible primary empirical studies eligible for inclusion.

sectors and in all countries were eligible for inclusion. Studies were excluded when they only used franchising as a case to examine a research question not related to franchising itself or when they used franchising only as one of many examined variables without detailed consideration of franchising. We did not use the research design itself as an exclusion criterion for this review. Multiple weaker studies that yield similar results also provide an indication of what franchising can effect and high quality studies are more difficult to conduct in this field. Reviewing high quality studies only would therefore impede our aim of providing a comprehensive overview of the state of evidence on outcomes of franchising so far.

Search strategy

To be sure that all relevant articles were identified, we searched 7 different major databases. PubMed/MEDLINE, the Cochrane Library, ABI/INFORM, Scopus, PsycINFO, Science Direct and Web of Science (Social Sciences Citation Index) were searched till July 2011. The searches did not include any limitations in dates of publication, geographical region, or language, but search terms were only in English. We developed our search strategy in PubMed/MEDLINE by combining MeSH terms (e.g., delivery of health care, health, aged, physicians) and free text (e.g., care, patient*, hospital*, treatment, mental, pharmac*, illness, nursing home*, cure, specialist*) related to healthcare AND the truncated free text term franchise* (relevant MeSH terms not available). This strategy was adapted for use in other databases. Our search procedure was checked by a university librarian. In addition to this database search, the references of included articles and of other reviews on similar and related subjects were hand searched to identify additional relevant empirical studies. We also searched for grey literature to ascertain that our inclusion of peer-reviewed empirical journal articles only would not result in skewed conclusions because of publication bias. We searched for non-published or non-peer-reviewed materials by checking references, searching Google, Google Scholar and Scopus, reviewing some of the personal websites of authors of included articles, contacting some of the authors, and searching the websites of Global Health Sciences and PSI for reports about social franchises in low- and middle-income countries.

Study selection and data extraction

To achieve a high-quality and unbiased review two researchers were involved in the study selection and data extraction process. The selection process started with a preliminary search in PubMed/Medline and a first rough selection of potentially relevant titles and abstracts by one reviewer. All articles that were obviously not relevant as they had another subject were excluded, whereas abstracts with any potential relevance were included. The resulting 68 abstracts were independently assessed by two reviewers by using the

predetermined selection criteria, and the resulting inclusion (n=29) and exclusion of abstracts was discussed. After this testing round, all of the databases were searched by one reviewer (n=1,482 hits), duplicates were removed (n= 438), and all obviously irrelevant titles and abstracts were excluded. Abstracts with any potential relevance were independently assessed by a second reviewer (n= 79) and doubts regarding inclusion were discussed. The resulting 35 abstracts were included for full-text review. Three articles that could not be found in full-text format were excluded[6]. The other 32 full-text articles were reviewed and summarized using a semi-structured data extraction form predetermined by two reviewers. The form included information about the aim, subject, focus and background of the article, the methodology (outcomes, intervention, definitions, research design) and the results of the study. In cases of exclusion or doubt regarding inclusion, a second reviewer was involved. The references of the included articles were checked for additional relevant studies, resulting in one additional study that was summarized by the data extraction form. In the end, 15 articles were included in the final analysis (see figure 1).

The search on grey literature did not result in a significant number of studies eligible for inclusion. Most of the identified materials were case reports of single franchise networks without detailed illumination of research strategy, did not focus on a comparative evaluation of outcomes of franchising, or were not empirical. Two unpublished studies did fit in our inclusion criteria (Plautz et al., 2003; Tsui et al., 2006). However, they did not show diverging results from our other studies, both were conducted in the same sector as the majority of the other included articles (reproductive health), and both found positive effects of franchising on utilization, hence providing no indication for publication bias. We therefore choose to keep only the empirical peer-reviewed academic journal articles in our results section.

We also determined the levels of evidence for identified outcomes of healthcare franchising. The quality of investigation of each single outcome in each study was independently appraised by two reviewers using the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) scale. This scale distinguishes four levels of quality of evidence: high (A), moderate (B), low (C), and very low (D) (see Box 1). In cases of doubt or disagreement, a third reviewer was consulted to reach consensus.

6 Chiguzo et al. 2008 *(delivering new malaria drugs through grassroots private sector)*, Parkin et al. 2008 *(quality of care in a franchised GP group)* and Yavner et al. (1998) (*the failure of the dental franchise industry)* could not be found in full-text.

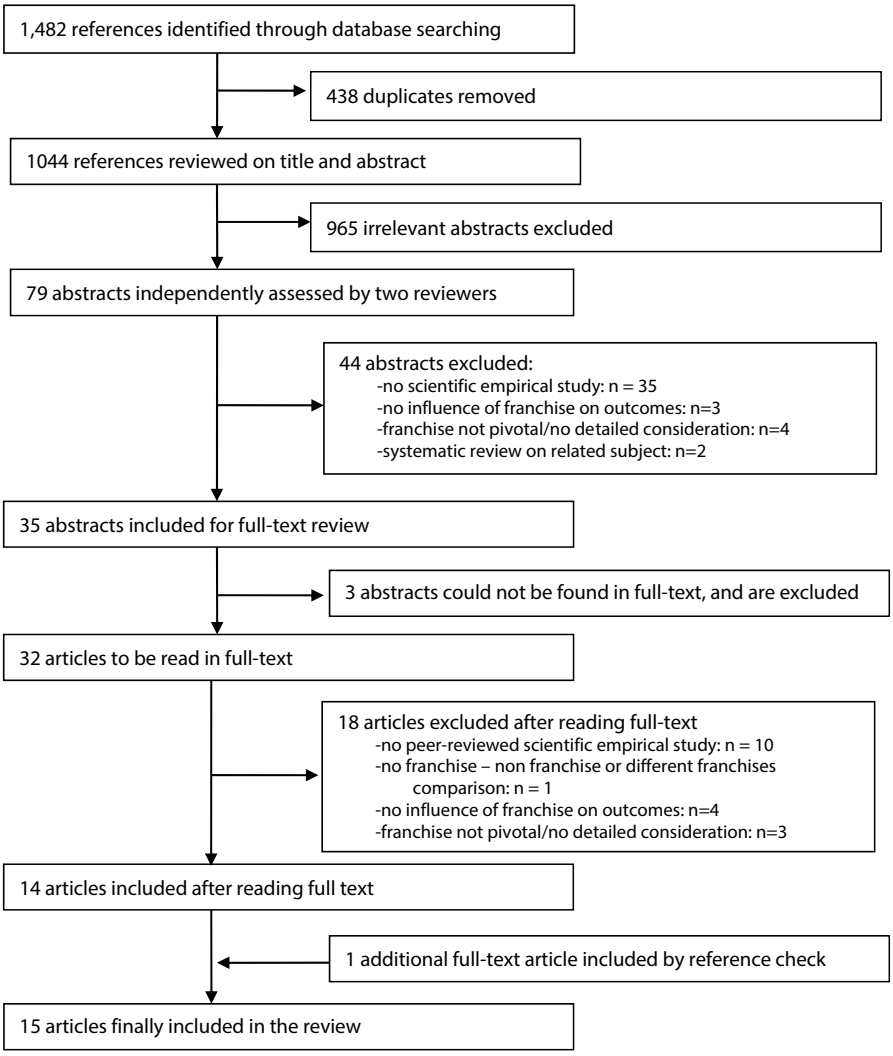

Figure 1: Selection process for systematic review

Box 1: Levels of quality of evidence using the GRADE rating scale

Level A: high
Level A consists of several high-quality studies with consistent results. Further research is highly unlikely to change the confidence in the estimated effect. This category comprises high-quality pre- and post-surveys, multi-center randomized controlled trials (RCT) and, in special cases, one large, high-quality multi-center trial.

Level B: moderate
Level B consists of several studies with some limitations and consistent findings or one high-quality study. Further research is likely to have an impact on the confidence of the estimated effect and may change the estimated effect. This category comprises one-center RCTs, RCTs with severe limitations, and pre-and post-surveys.

Level C: low
Level C consists of one study with acceptable quality or inconsistent results of several studies focusing on the same outcome. Further research is very likely to change the estimated effect and have an important impact on the confidence of the estimation. This category comprises high-quality qualitative studies, quasi-experimental designs, and pre- and post-surveys with limitations.

Level D: very low
Level D evidence implies that the estimated effect is very uncertain. This category comprises low-quality qualitative studies and pre-and post-surveys with severe limitations.

Limitations and strengths for determining evidence level (upgrade or downgrade)
Quality of evidence is lower for studies with limitations in study design and execution (risk of bias), unexplained inconsistency/heterogeneity in outcomes, indirectness, or imprecision of estimates. The quality of evidence is higher when effects are large and all plausible confounders would reduce the effect.

(adapted from Buljac-Samardzic et al. 2010 and GRADE Working Group 2004)

Data analysis

Statistical data could not be pooled for meta-analysis purposes due to the heterogeneity of franchise design, outcome conceptualizations, and the presence of both qualitative and quantitative research designs. We therefore conducted a narrative synthesis of the data (Popay et al., 2006). Following the recommendations of Popay et al. (2006) for such a synthesis, our analysis comprised the following steps.

As a first step, we examined each included study with regard to the following factors as described on our data extraction form: country, sector, methods, franchise design, type(s) of outcome(s), operationalization of each outcome, pivotal actor/stakeholder for each outcome, whether significances of outcomes were tested, and GRADE rating. At the second step in our analysis, we clustered outcomes that were directed towards the same type of result. This clustering led to 7 outcome categories: quality of services, accessibility of services, utilization of services, results for providers, client loyalty, client volumes, and efficiency. As a third step in our analysis, we described similarities and

differences in outcomes found within each of the outcome categories. In the final step, we used the variables from step 1 to search for explanations for the differences we found. In this step we also made a judgment of the overall quality of evidence (see box 1 GRADE) and overall results for each type of outcome.

Results

State of empirical research

Around half of the fifteen studies have focused on quality and utilization. A few studies have considered results for providers, client loyalty, client volumes and efficiency (see table 1). Most studies have investigated outcomes for customers/clients. Outcomes for professionals and organizations have received less attention.

Table 1: Outcomes investigated in included studies

Outcome	Times investigated (n)
Quality of services	9
Utilization of services	7
Accessibility of services	4
Results for professionals	3
Client loyalty	3
Client volumes	2
Efficiency	2

With regard to the methodologies used, studies have rarely employed qualitative (n=1) or mixed methods designs (n=1); rather, quantitative research dominates (n=13) (see table 2). Many of the outcomes are subjective (opinions) or self-reported measures, not objective numbers. The majority of studies have presented low levels of evidence (C or D on the GRADE scale).

Twelve of the fifteen studies have been conducted in low- and middle-income countries in Asia and Africa. Because many franchises in low- and middle-income countries have primarily social goals (health improvement) instead of financial goals, they are called social franchises (Qureshi 2010). Three studies have investigated outcomes in high-income countries, all in a pharmacy context.

The research covers a few healthcare sectors. There is an overrepresentation of research conducted in reproductive health/family planning services (n=11). The other investigated sectors are pharmacy (n=3) and tuberculosis care (n=1).

Regarding the design of the investigated franchise systems, the research is skewed towards fractional franchises (n=10). Fractional franchise means that "a targeted

package of goods and services is added to the services of the provider who maintains additional unfranchised product lines and services" (Bishai et al. 2008, p. 193). The rest are stand-alone franchises (n=5). A stand-alone franchisee exclusively provides franchised products/services (Stephenson et al., 2004). The precise franchise design is not always described in the articles.

Some studies have investigated the same franchise network. Both studies by Agha et al. (2007) investigated the same franchise network in Nepal; both studies by Ngo et al. (2009, 2010) investigated the same franchise network in Vietnam; Bishai et al. (2008), Qureshi (2010), Shah et al. (2011) and Stephenson et al. (2004) investigated the same franchise network in Pakistan; and Shah et al. (2011) and Stephenson et al. (2004) investigated the same franchise network in Ethiopia. However, at least 20 different franchise networks were analyzed in the fifteen studies.

Table 2: Studies on outcomes of healthcare franchising

				Franchise design					
Authors	**Healthcare sector**	**Country**	**Methods**	***Fractional / stand-alone***	***Contractual responsibilities***	***Business format: support***	***Business format: monitoring***	**Type of outcomes investigated**	**Stakeholder**
Agha et al., 2007a	Reproductive health services/ family planning	Nepal	Pre-post non-experimental design, survey. Sample: 491 persons of 24 facilities pre-test, 617 post-test.	Fractional	• Fee • Follow standards • Recruitment requirement	• Training • Marketing • Protocols • Contact with providers	Yes	Quality Access Loyalty	Customer Organization
Agha et al., 2007b	Reproductive health services / family planning	Nepal	Pre-post quasi-experimental design with non-equivalent control groups, survey. Sample: 35/32 providers, 491/435 franchise clients, 480 household, 394/298 control clients.	Fractional	• Fee • Follow standards • Recruitment requirement	• Training • Marketing • Protocols • Contact with providers	Yes	Quality Utilization Loyalty	Customer Organization
Bishai et al., 2008	Reproductive health services/ family planning	Pakistan	Cross-sectional survey. Comparison private franchise to non-franchise forms. Sample: 19801 clients, 2667 providers, 1718 facilities.	Fractional	• Fee • Follow standards • Serve low-income clients	• Training • Supplies and equipment • Marketing	Yes	Quality Access Efficiency	Customer Organization
Christensen & Curtiss, 1977	Pharmacy	USA	Cross-sectional survey. Comparison three franchises. Sample: 43 pharmacies.	Stand-alone	Not described	• Training • Marketing • Management and operational support	Not described	Results for providers	Professional
Decker & Montagu, 2007	Reproductive health services / family planning	Kenya	Cross-sectional survey of structured interviews, comparison non-franchise and franchise providers and clients. Sample: franchise: 295 clients, 102 providers. Non-franchise: 138 clients, 50 providers.	Fractional	• Fees • Follow standards • Recruitment requirements	• Training • Supplies and equipment • Low-interest loans	Not described	Utilization	Customer

Table 2: Studies on outcomes of healthcare franchising (continued)

				Franchise design					
Authors	**Healthcare sector**	**Country**	**Methods**	***Fractional / stand-alone***	***Contractual responsibilities***	***Business format: support***	***Business format: monitoring***	**Type of outcomes investigated**	**Stakeholder**
Dobson & Perepelkin, 2011	Pharmacy	Canada	Cross-sectional survey. Comparison franchise, independent, corporate. Sample: 646 pharmacies.	Stand-alone	Not described	Not described	Not described	Results for providers	Professional
Evans et al., 2009	Pharmacy	Canada	Longitudinal analysis of archival data, comparison franchise, independent, corporate. Sample: 8699 patients.	Stand-alone	Not described	Not described	Not described	Quality Loyalty	Customer Organization
Hennink & Clements, 2005	Reproductive health services/ family planning	Pakistan	Quasi-experimental study. 4 study and 2 control sites. 5338 base-line, 5502 end-line respondents.	Stand-alone	• Follow standards	• Subsidized treatment fund for poor	Not described	Utilization	Customer
Kozhimannil et al., 2009	Prenatal care	Philippines	Pre-post analysis of archival data of survey on population level + 15 interviews. Comparison pre-post + franchise and national insurance program. Sample: 4968 / 4802 pre-post.	Stand-alone	• Follow standards	• Various support	Not described	Quality Utilization	Customer
Lönnroth et al., 2007	Tuberculosis care	Myanmar	Analysis of archival case notification data + baseline and follow-up survey of patients. Baseline - follow-up comparison + non-franchise control group. Sample 243 patients.	Fractional	• Keep clinical records • Follow standards • Follow price structure • Recruitment requirements	• Training • Marketing • Products • Knowledge sharing	Yes	Quality Access Utilization	Customer

Table 2: Studies on outcomes of healthcare franchising (continued)

				Franchise design					
Authors	**Healthcare sector**	**Country**	**Methods**	***Fractional / stand-alone***	***Contractual responsibilities***	***Business format: support***	***Business format: monitoring***	**Type of outcomes investigated**	**Stakeholder**
Ngo et al., 2009	Reproductive health services/ family planning	Vietnam	Pre-post (3 months) qualitative study with interviews, focus groups with 7-10 staff and clients each, observations.	Fractional	• No fee required • Follow standards	• Upgrade equipment and infrastructure • Training • Quality standards • Marketing	Yes	Quality Results for providers	Customer Professional
Ngo et al., 2010	Reproductive health services/ family planning	Vietnam	Quasi-experimental design with comparable control group, pre-post surveys, analysis of longitudinal archival data. Sample: 1181 users.	Fractional	• No fee required • Follow standards	• Upgrade equipment and infrastructure • Training • Quality standards • Marketing	Yes	Utilization Client volumes	Customer Organization
Qureshi, 2010	Reproductive health services/ family planning	Pakistan	Cross-sectional survey with controls. Comparison private franchise to non-franchise forms. Sample: 822 providers and their clients.	Fractional	• Fee • Follow standards • Serve low-income clients	• Training • Supplies and equipment • Marketing	Yes	Utilization	Customer
Shah et al., 2011	Reproductive health services/ family planning	Pakistan and Ethiopia	Cross-sectional survey with controls. Comparison private franchise to non-franchise forms. Sample: 993/1305/369 facilities, 1113/1944/525 staff, 7431/4905/ 1537 clients in resp. Pakistan, India, Ethiopia.	Fractional	• Pakistan: fee, follow standards, serve low-income clients • Ethiopia: Not described	• Pakistan: training, supplies, equipment, marketing • Ethiopia: Training	• Pakistan: yes • Ethiopia: Not described	Quality Access Efficiency	Customer Organization
Stephenson et al., 2004	Reproductive health services/ family planning	Pakistan, India, Ethiopia	Cross-sectional survey with controls. Comparison private franchise to non-franchise forms. Sample: 993/1305/369 facilities, 1113/1944/525 staff, 7431/4905/ 1537 clients in resp. Pakistan, India, Ethiopia.	Fractional	• Pakistan: fee, follow standards, serve low-income clients • India: not described • Ethiopia: not described	• Pakistan: training, supplies, equipment, marketing • India: various support • Ethiopia: training	• Pakistan: yes • India, Ethiopia: not described	Quality Client volumes	Customer Organization

Outcomes of franchising in healthcare

Quality of services

Eight out of the nine studies on quality of services were conducted in low- and middle-income countries. The studies focus on a wide range of quality types: medical quality, quality of facilities and supplies, quality of the provider, client satisfaction, and overall quality. Most of these studies measured perceived or 'subjective' quality rather than 'objective' quality, and most used process indicators of quality rather than actual medical outcomes. Except for results on the quality of the provider, the level of existing evidence is low (see table 3). The evidence to date shows that franchising predominantly has either a positive effect or no effect on quality.

The two studies on quality of facilities and supplies show positive results of franchising (Agha et al., 2007b; Ngo et al., 2009).

Franchising has at least the same results for the quality of the provider and medical quality. In regard to the quality of the provider, the study with a moderate evidence level found that clients were handled just as well in non-franchised systems (Agha et al., 2007b), whereas two studies with slightly lower evidence levels found positive results (Agha et al., 2007a; Ngo et al., 2009). Also in regard to medical quality, only the studies with lower levels of evidence found a positive effect. Lönnroth et al. (2007) found franchising to have a positive effect on reducing treatment delays. Evans et al. (2007) found that franchises had higher adherence rates than corporate pharmacies; however, when compared with independent pharmacies, adherence rates were similar. Also in regard to other medical quality indicators, no differences were found between franchise and non-franchise (Agha et al., 2007b; Lönnroth et al., 2007; Kozhimannil et al., 2009).

Studies on client satisfaction and overall quality have more mixed and sometimes even negative results. Regarding client satisfaction, Ngo et al. (2009) and Agha et al. (2007b) found positive results. However, Stephenson et al. (2004) found better results for franchises compared to non-franchises in Pakistan, similar results in India and negative results in Ethiopia. In regard to overall quality, only a low quality study (D) found an overall positive effect (Bishai et al., 2008). Studies with a slightly higher level of evidence (C) found either no effect (Stephenson et al., 2004) or mixed results depending on the organization of comparison and the country of study (Shah et al., 2011). In both Pakistan and Ethiopia, franchise providers yielded more positive results than private non-franchise providers and less positive results than governmental organizations. The effect differed in a comparison with non-governmental organizations: in Pakistan, franchises performed better on overall quality; in Ethiopia, no difference was found between them.

Table 3: Quality of services

Type of quality	Indicator	Score*	Significance tested	GRADE	Author
Medical quality	Satisfaction quality service: medicine	0	Yes	B	Agha et al., 2007b
	Adherence to therapy	+/0	Yes	D	Evans et al., 2009
	Achievement of care standards	0	Yes	C	Kozhimannil et al., 2009
	Reducing treatment delays	+	No	D	Lönnroth et al., 2007
	Treatment success	0	No	C	Lönnroth et al., 2007
Quality of facility and supplies	Satisfaction quality service: physical look	+	Yes	B	Agha et al., 2007b
	Satisfaction quality service: privacy	+	Yes	B	Agha et al., 2007b
	Satisfaction quality service: range of services	+	Yes	B	Agha et al., 2007b
	Satisfaction quality service: cleanliness	+	Yes	B	Agha et al., 2007b
	Satisfaction quality service: equipment	+	Yes	B	Agha et al., 2007b
	Appearance and facilities	+	No	D	Ngo et al., 2009
Quality of provider	Providers caring manner	+	Yes	C	Agha et al., 2007a
	Providers expertise/reliability	+	Yes	C	Agha et al., 2007a
	Satisfaction quality service: good handling clients	0	Yes	B	Agha et al., 2007b
	Providers expertise/reliability	+	No	D	Ngo et al., 2009
	Providers caring manner	+	No	D	Ngo et al., 2009
Satisfaction of client	Satisfaction clients	+	No	D	Ngo et al., 2009
	Fewer complaints	+	No	D	Ngo et al., 2009
	Intention to return	+/0/-	Yes	C	Stephenson et al., 2004
	Are you overall satisfied with quality?	+	Yes	B	Agha et al., 2007b
Overall quality	Average score quality of provider, facilities and supplies, client satisfaction	+/0/-	Yes	C	Shah et al., 2011
	Is quality better than elsewhere?	0	Yes	C	Stephenson et al., 2004
	Average score quality of provider, facilities and supplies	+	No	D	Bishai et al., 2008

* + = positive, 0=no difference, - = negative

Accessibility

Studies on the accessibility of care services have only been conducted in developing countries and have focused on two types of access (table 4): physical access, which implies that those who are in need of care can reach the facility, and socio-economic

access, which means that all socio-economic groups are able to access care. To date, the level of evidence on access is relatively low.

Table 4: Accessibility of care services

Type of access	Indicator	Score*	Significance tested	GRADE	Author
Physical access	Proximity of location	+	Yes	C	Agha et al., 2007a
	Convenient location	+	Yes	C	Agha et al., 2007a
Socio-economic access	Access for the poor	+	No	D	Bishai et al., 2008
	Ability to reach the poor	+	No	D	Lönnroth et al., 2007
	Access for the poor	0/-	Yes	C	Shah et al., 2011

* + = positive, 0=no difference, - = negative

Franchising has a positive effect on physical access according to one C-level study (Agha et al., 2007a). The effects on socio-economic access are unclear. Only the two studies with the lowest evidence level showed a positive effect on socio-economic access (Bishai et al., 2008; Lönnroth et al., 2007). A study with a slightly higher evidence level (C) reported similar or even negative results for franchises compared to other organizational forms. In both Pakistan and Ethiopia, franchises yielded less socio-economic access than governmental organizations and yielded similar access than non-governmental organizations. The effect when compared with private non-franchise providers differed: in Ethiopia, franchises performed significantly worse on access; in Pakistan, no significant difference was found (Shah et al., 2011).

Utilization of services

All seven studies on utilization have been conducted in developing countries and have focused on the use of both early preventive care and healthcare (table 5). *Preventive care* is defined as services provided to prevent the occurrence of an undesirable medical condition, i.e., primary prevention, or to detect and diagnose those individuals with an existent disease who need care to prevent more significant morbidity, i.e., secondary prevention. *Healthcare (or tertiary prevention)* is defined as care for those who have a revealed (diagnosed) medical condition (e.g., Simeonsson, 1991). All but one of the studies presented a low level of evidence.

Based on two very low quality studies, franchising seems to have no relation with the utilization of *healthcare* (Agha et al., 2007b; Kozhimannil et al., 2009). The evidence so far shows that franchising has positive or no effects on the utilization of *preventive care*. The three studies with the lowest levels of evidence all showed positive effects on the utilization of primary (Decker & Montagu, 2007; Qureshi, 2010) and secondary

preventive care (Lönnroth et al., 2007). The two studies with a slightly higher level of evidence (C) found either positive effects on the utilization of primary preventive care or none at all. The franchise network studied by Agha et al. (2007b) showed a positive effect on utilization of preventive care. Depending on the franchisee site investigated in the franchise network studied by Hennink and Clements (2005), the unmet need for family planning successfully declined or remained the same. The use of family planning methods did not increase significantly after franchising occurred (Hennink & Clements, 2005). The study with the highest evidence level among them (B) studied the total use of preventive care and healthcare and showed that results depended on the measurement method used: the citizens did not report a change in use, but the franchise clinics reported an increase in use (Ngo et al., 2010).

Table 5: Utilization of care services

Type of utilization	Indicator	Score*	Significance tested	GRADE	Author
Use of preventive care (primary and secondary prevention)	Use of family planning methods	+	Yes	C	Agha et al., 2007
	Use of family planning methods	+	Yes	D	Decker & Montagu, 2007
	Use of family planning methods	0	Yes	C	Hennink & Clements, 2005
	Unmet need	+/0	Yes	C	Hennink & Clements, 2005
	Use of family planning methods	+	Yes	D	Qureshi, 2010
	Notification (detection) of tuberculosis	+	Yes	D	Lönnroth et al., 2007
Use of healthcare (tertiary)	Use of birth facility	0	Yes	D	Kozhimannil et al., 2009
	Use of antenatal care	0	Yes	D	Agha et al., 2007
Preventive care and healthcare	Use of reproductive health and family planning care	+/0	Yes	B	Ngo et al., 2010

* + = positive, 0=no difference, - = negative

Results for providers

The results for providers have been investigated in three studies: two in developed countries and one in a developing country. They focus on very different indicators, and the results among these studies differ. The level of evidence generated by these studies is very low (D) (table 6).

Healthcare professionals in Vietnam felt more effective in managing their relationships with clients because of training offered by the franchisor (Ngo et al., 2009). Franchisee pharmacists in Canada perceived themselves as having less authority and

autonomy compared with independent pharmacists but more authority and autonomy than corporate pharmacists (Dobson & Perepelkin, 2011). Pharmacists in the USA varied in their levels of satisfaction with their franchise system and the support services offered by their franchisors. Their overall satisfaction with the franchise system varied among systems, but it was predominantly medium to low. The same rule applies to reported satisfaction with different types of support services (Christensen & Curtiss, 1977).

Table 6: Results for providers, client loyalty, client volumes and efficiency

Outcome	Indicator	Score*	Significance tested	GRADE	Author
Results for providers	Franchisee satisfaction with franchise and services offered	+/-	No	D	Christensen & Curtiss, 1977
	Perceived authority (control (stress, satisfaction, workload), decision-making ability) and autonomy	+/-	Yes	D	Dobson & Perepelkin, 2011
	Effectiveness in dealing with complaints, concerns, objections of customers	+	No	D	Ngo et al., 2009
Client loyalty	First visit or return visit?	0	Yes	C	Agha, Gage & Balal, 2007
	First visit or return visit?	+	Yes	C	Agha et al., 2007
	> 75% medicines dispensed from same pharmacy	- /0	Yes	D	Evans et al., 2009
Client volumes	Clinic-reported client volumes	+	Yes	B	Ngo et al., 2010
	Monthly client volume	+	Yes	C	Stephenson et al., 2004
Efficiency	Costs of care per client	+/0/-	No	D	Bishai et al., 2008
	Costs of care per client	0/-	Yes	D	Shah et al., 2011

* + = positive, 0=no difference, - = negative

Client loyalty

The impact of franchising on client loyalty has been analyzed in Nepal and Canada in studies of low quality (C and D). The results differed between the countries, between different organizations of comparison and between studies with different quality levels (see table 6). Only the study with a very low quality level showed a negative effect: in this Canadian study, customers were less loyal to franchised pharmacies than to independent pharmacies, but equally loyal to corporate pharmacies (Evans et al., 2009). The studies with a slightly higher quality of evidence (C) in Nepal found either a positive or similar effect: Agha et al. (2007b) found customers to be significantly more loyal to new franchise clinics than to non-franchised clinics, whereas Agha et al. (2007a) found

customers to be just as loyal after franchise implementation as they were before. This last study, however, showed that the increased quality after implementation of the franchise network significantly predicted an increase in loyalty (Agha et al., 2007).

Client volumes

Studies on client volumes have only been conducted in developing countries, but in four different ones. All of the studies presented evidence of moderate to low quality. In all of the four countries, a positive association between franchising and client volumes was found (Ngo et al., 2010; Stephenson et al., 2004) (table 6).

Efficiency

The impact of franchising on efficiency—defined as costs of care per client—has only been studied in Pakistan and Ethiopia, and only with methodologies of low quality. In Ethiopia, franchising was less efficient than other studied organizational forms (Bishai et al., 2008; Shah et al., 2011). In Pakistan, franchises were just as efficient as non-governmental organizations; however, compared with governmental organizations, Shah et al. (2011) found franchises to be just as efficient, whereas Bishai et al. (2008) found franchises to be more efficient.

Discussion

In this study we have provided a systematic overview of outcomes of franchising in healthcare to determine the state of empirical scientific knowledge on the subject and the outcomes that have been found.

The review shows that the body of empirical knowledge is quite undeveloped. Only 15 peer-reviewed empirical studies were identified, the variety in healthcare sectors and types of outcomes studied is limited, research in developed countries is underrepresented, and the focus has been mainly on the customer and far less frequently on healthcare professionals or organizations. Given this existing body of knowledge, we cannot make strong conclusions or generalizations about what the actual value of franchising is. Some interesting patterns do, however, emerge. The evidence to date suggests that franchising can be valuable to healthcare practices, particularly in low and middle-income countries. The results of studies so far show that healthcare franchises predominantly perform better or at least as well as non-franchised healthcare entities on physical accessibility, utilization, client volumes and quality of services as it relates to facilities and supplies, the provider and client satisfaction. Franchising seems less positive for the efficiency of care delivery and results for providers (less autonomy, less authority, dissatisfaction with support services offered). With regard to the healthcare

sector, negative outcomes were only found in the reproductive health/family planning and pharmacy sectors. With regard to countries, negative results were only found in Canada, the USA, Pakistan, and, especially, Ethiopia; in all other low- and middle-income countries, franchises had similar or better results compared with non-franchises. The achieved outcomes did not seem to be different for fractional and stand-alone franchises.

We do not really know why some studies yielded positive results whereas others did not. This is partly due to the absence of detailed franchise design descriptions in some studies and to the small number of articles. In addition, the empirical knowledge gathered so far gives little insight into the reasons behind the comparative outcomes of healthcare franchising. Only Ngo et al. (2009) and Qureshi (2010) identified a contributive role of training. Training helped improve the quality of services and results for providers (Ngo et al., 2009) and also contributed to increased utilization of services (Qureshi, 2010).

The question is whether the results of franchising shown in this review will also apply to other healthcare sectors and to high-income countries. It is possible that the effects of franchising on quality, accessibility, utilization and client volumes in low- and middle-income countries are not primarily due to the organizational form of franchising per se, but rather to the extension of good quality healthcare supply as a consequence of the structural involvement and control of private-sector providers in the fulfillment of public goals (Montagu, 2002; Lönnroth et al., 2007). In an environment in which there are many unmet needs and in which the access to and quality of services is relatively low (Hennink & Clements, 2005), other organizational forms that consist of partially similar interventions, such as voucher systems (e.g., Prata et al., 2005), may also provide positive outcomes. Similarly, it may not be a coincidence that negative results for providers have only been found so far in developed countries, where professionals regularly have more access to equipment, resources and learning opportunities.

The scientific evidence to date seems to provide only a partial overview of the outcomes of healthcare franchising. The current empirical evidence pinpoints only now and then to some possible drawbacks of and difficulties with franchising, whereas both theory (see introduction) and practice reports mention them. Practice reports of single franchise networks in low- and middle-income countries tell that the franchisor only has limited ability to force compliance with service standards of the franchise and to control quality, whereas the quality of care is highly variable across clinics. It is also reported that provider skills range from excellent to poor, with some of them falling below minimum standards of the franchise, and that some franchisees ask higher than recommended prices for their services (e.g., Mc Bride & Ahmed, 2001; Montagu & Kinlaw, 2009). There is no systematic insight in the actual scope of these problems and their

effect on the comparative outcomes that franchises yield. Case reports and theory also highlight positive results for healthcare professionals that have not yet been confirmed in peer-reviewed academic studies. Moreover, the number of franchises in high-income countries (see introduction) as well as low- and middle-income countries is far larger than the ones that have been studied scientifically (see e.g., Schlein & Montagu, 2012). This all suggests that the current evidence base needs to be extended in order to get a comprehensive and representative scientific overview of the value of franchising in healthcare.

Our data analysis in this report also has a limitation due to the state of materials included. We selected outcomes as the starting point for our analysis, but we do not know whether and to what extent the case mixes, countries, health systems, and franchise systems investigated in different studies are comparable. However, this limitation is inherent to the limited information that has been provided on these aspects in the individual studies.

Research agenda

This review has shown that franchising in healthcare has largely been disregarded by scholars. More exploration and detailed investigation are therefore needed.

First, research should be conducted in other healthcare sectors beyond reproductive health/family planning and pharmacy. Outcomes may differ not only because of institutional and cultural differences between sectors, but also because it is more difficult to standardize and monitor in healthcare sectors that require a high degree of (medical) professional knowledge (Montagu, 2002).

Second, research is needed on more types of outcomes for all stakeholders because we do not know yet whether franchising can meet health demands in an efficient way to contain costs and enhance the health status of the society, provide a better working environment for the increasingly scarce healthcare professional, or improve the competitiveness of care providers. Researchers are advised to include the outcomes for all stakeholders in their studies to make trade-offs visible because there can be conflicts of interest between stakeholders, e.g., financially-driven franchisors and quality-driven healthcare professionals (e.g., Dobson & Perepelkin, 2011).

Third, scholars should proceed with comparing franchise with non-franchise forms that may partially meet similar challenges (e.g., voucher systems) to investigate whether, how and when franchising is the most suitable organizational form to beat the challenges in the health sector all over the world.

Fourth, future research should also focus on franchising in higher income countries. It is rather surprising that franchising—originating from an Anglo-Saxon context—has been investigated so little in the healthcare sector in high-income countries.

The outcomes in these countries might differ from those in low- and middle-income countries, not only because of differences in cultural, institutional and economic environments, but also because of differences in franchise design. In the social franchises established in low- and middle-income countries, the donors or franchisors frequently assume the largest risk in opening new units or establishing healthcare services, instead of the franchisees that normally assume risks in franchise organizations (Bishai et al., 2008; Lönnroth et al., 2007; Stephenson et al., 2004). This incentive difference may have an impact on outcomes.

Finally, future research should investigate the causes of outcomes of healthcare franchising. Attention should be paid to the combined roles of franchise design (e.g., stand-alone vs. fractional, type of support being offered to franchisees), the conduct of actors in the franchise system (e.g., the adherence to service protocols, provider skills) and the external context in which franchising is implemented.

In assuming this research agenda, scholars can build on the extensive knowledge that exists about franchising in sectors outside healthcare. Scholars should also guard for sound measures and designs in their research because, as this review showed, different studies on the same outcome in the same franchise network may yield different conclusions if they have different measures (Ngo et al. 2010), different research designs (Agha et al., 2007a and Agha et al., 2007b), or the presence/absence of testing of significances (Shah et al., 2011 vs. Bishai et al., 2008).

Conclusion

Franchising has the potential to be a valuable organizational strategy to clients, society and organizations, but the evidence base is yet too weak for firm conclusions. So far franchises have been shown to predominantly perform better or at least as well as non-franchised healthcare entities on physical accessibility, utilization, client volumes and some types of quality of care. However, there are also signals of some less positive effects that need further investigation before expansion of franchising is justified. Practitioners could further explore the merits of franchising by developing franchises for various types of healthcare. These developments should be accompanied with process and outcome evaluations to further assess the actual outcomes of franchising in healthcare in various contexts so as to justify continued investment in franchising as organizational form.

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Healthcare
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Chapter 3

Making Franchising Work: A Framework Based on a Systematic Review

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Abstract

There is a large and fragmented literature which examines the nature of franchising. This study aims to collect all the empirical evidence on the factors that make franchising work and to integrate this evidence in a framework. A narrative synthesis was performed of 126 peer-reviewed empirical journal articles. This review shows how the outcomes of franchising are determined by five major clusters of factors: ownership structure, business format design, contract design, behavior of the franchisor and the franchisee and their interaction, and the age and size of the system and its units. It identifies what franchisors and franchisees need to do to be successful and which evidence gaps and conflicting results remain. To yield better outcomes for both the franchisor and the franchisee, they should work on a recognizable brand name and a good working relationship; in addition, they should have suitable skills and attitudes as well as contractual exclusive territories. For further improvement of franchisee outcomes, high-quality franchisor support, decentralized decision-making, selection tools and fair contracts are essential. The effects of a high franchise proportion, active ownership, knowledge exchange and standardized operating instructions are contingent on other structural and contextual factors in the system. Conflicts and tying should be prevented. Hardly any research has been undertaken into which franchise designs are valued by customers. We have launched a research agenda for further research, from various theoretical perspectives, into the interactions between system elements, actors and contexts.

Introduction

In recent decades, the number of franchises in the world has increased considerably (Combs & Ketchen, 2003; Fulop & Forward, 1997). It is expected that franchising delivers a better financial performance, a more supportive working environment and/or higher survival chances than alternative organizational forms (Combs et al., 2004; Tuunanen & Hyrsky, 2001). Franchising comprises a contractual arrangement between two firms: the franchisor and the franchisee. In this arrangement, the franchisee buys the right to market goods or services under the franchisor's brand name (Blair & Lafontaine, 2005; Combs et al., 2004a). Business format franchising is the most commonly studied form of franchise. In this format, franchisees also receive various types of support, such as an operations manual, training and on-site guidance. Franchisees have to pay for this support and they are obliged to operate their businesses as prescribed by the franchisor (Falbe & Welsh, 1998; Komoto, 2005).

Despite the positive expectations, failure rates of new franchise initiatives are high. In the USA, it is estimated that 50-85% of these initiatives fail (Bates, 1998; Shane & Foo, 1999; Lafontaine & Shaw, 1998). Moreover, there is significant variation in the strategic and operational success of franchises. Some studies comparing franchising with alternative organizational forms show superior performance (e.g., Aliouche & Schlentrich, 2009; Frew & Jud, 1986; Yoo et al., 1998; Shane, 1996; Lewis & Anderson, 1999; Knight, 1986), whereas others show inferior or equal performance regarding financial performance, efficiency, survival and franchisee satisfaction (e.g., Stanworth et al., 2001; Benjamin et al., 2006; Bates, 1995a, 1998; Anderson et al., 1998; Grünhagen & Dorsch, 2003).

Research suggests that at least a part of these variations result from factors within franchise systems. With the use of the structure–process/conduct–outcome framework (e.g., Devaraj et al., 2006; Donabedian, 1966; Zinn & Mor, 1998), a distinction can be made between structural and process-related factors that shape results. Franchise practitioners need information about the structures and processes that can help them to be successful. Unfortunately, the evidence base is fragmented, complex and heterogeneous in terms of theoretical perspectives, methods and conceptualizations, providing only partial or even confusing advice for practitioners. Although reviews of the franchise literature have been conducted by Elango and Fried (1997), Fulop and Forward (1997) and Combs et al. (2004a), none of these authors have systematically built an overview that integrates all the evidence to support both practitioners and researchers. As a result, this paper has a double aim: first, to collect all the empirical evidence on the structural and process-related factors that influence the outcomes achieved within franchise systems for franchisors, franchisees and customers, and second, to bring this evidence together in an integrative framework. To this end, we

have conducted a systematic review, which gives practitioners an integrative insight into why some franchises succeed while others are less successful. Moreover, it identifies evidence gaps and conflicting results and provides a collective starting point for future research from various theoretical perspectives.

Research methods

We used a systematic approach in our review: we determined the inclusion criteria in advance, systematically searched for articles according to these criteria, and employed a systematic selection and extraction procedure. The research methods are described in detail below.

Data collection

The studies included investigated the relationship between the outcomes of franchising and franchise design or processes. *Outcomes* are defined as the results of an activity, plan or process within franchise systems. All types of outcomes were included, for example financial performance, survival, growth, and satisfaction. *Design* comprises all the structural and procedural aspects of the franchise arrangement. *Processes* refer to actors' behavior and interaction with each other. Studies on the external context were included if their authors considered context in relation to design or processes. Studies were only included if they were empirical studies published in peer-reviewed journals. Studies were excluded if they only used franchising as a case in investigating a research question unrelated to franchising itself. During the selection process, no distinction was made between business format and product/trade-name franchise because the boundaries between these two types are often blurred (e.g., Dnes, 1992) and because authors frequently do not specify which type of franchise is being studied. International expansion through franchising was excluded as this process involves quite different dynamics and managerial questions (e.g., Preble & Hoffman, 2006) and requires a specific set of capabilities (Fladmoe-Linquist, 1996). Including this aspect would have made the focus of this review too broad.

We searched Abi/Inform, Cochrane Library, EconLit (EBSCO), Emerald, PsycINFO, PubMed/Medline, Scopus and Web of Science for articles published before January 2011 without any other limitations with regard to publication date. The search was limited to articles in English. Every database except Emerald was searched using the term franchis* AND the following combination of terms: effect*, efficiency, impact, innovation*, outcome*, perform*, quality, satisfaction, survival, value. As Emerald did not allow a search using these truncated terms, we checked the journals included in all of the databases and identified those that were unique to Emerald. We then searched the

62 unique journals within Emerald using the term franchis*. In addition to conducting this database search, we checked the references of all of the included articles to identify additional relevant articles.

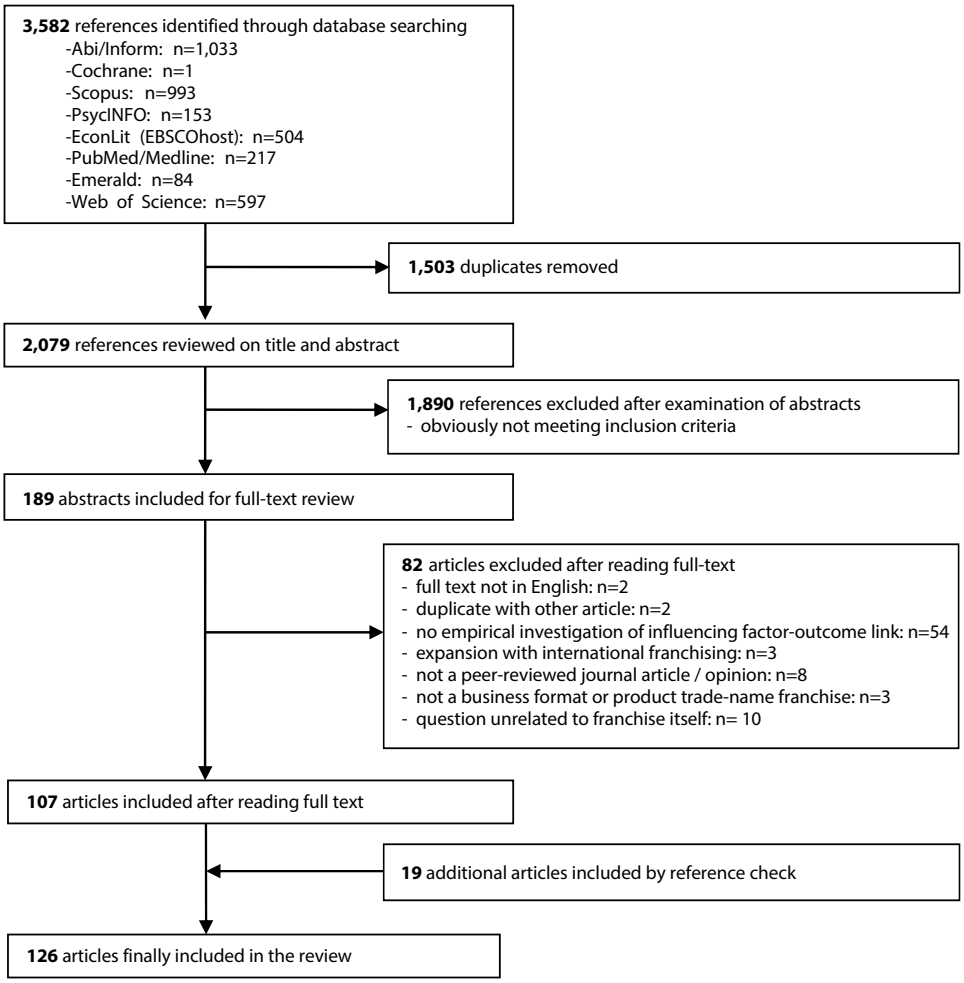

Figure 1: Selection process systematic review

To ensure a high-quality and unbiased review, three researchers were involved in the article selection and data extraction process. We started with an independent assessment and discussion of 40 abstracts by two reviewers to maximize validity. Subsequently, all databases were searched by one reviewer (n=3,582 hits), duplicates were removed, and the remaining abstracts (n=2,079) were reviewed. Abstracts with potential relevance were independently assessed by a second reviewer and doubts regarding inclusion

were discussed. Many abstracts (n=1,890) were excluded because they obviously did not meet the inclusion criteria[1]. The resulting 189 studies were reviewed in full-text and summarized by using a semi-structured data-extraction form. If there was doubt regarding inclusion, a second reviewer was involved; in case of persistent doubt a third reviewer was involved. This full-text reading reduced the selection to 107 articles (see Figure 1 for reasons for exclusion). By performing reference checks of the included articles, we found 19 additional relevant studies. Ultimately, 126 articles were included in our analysis (Figure 1).

Data analysis

A narrative synthesis was conducted of the review material. Due to the heterogeneous nature of the literature, meta-analysis was not possible. In a narrative synthesis, the relationships between studies with different foci, theories and methodologies are thematically explored (Mays et al., 2005; Popay et al., 2006). Following the recommendations of Popay et al. (2006), we conducted the following steps.

Firstly, we analyzed each study on the investigated design or process factors, operationalization of each factor, types of outcomes, operationalization of each outcome, theoretical perspective, country, industry, methodology, and actor perspective (franchisor, franchisee and customer). As a second step, we clustered the factors that referred to similar design or process elements. To accomplish this clustering, we relied on the definition of franchising as described in the introduction. This approach resulted in two major factor clusters: 'contract' and 'business format'. We also determined clusters by searching in studies for aspects that are central in major franchise disciplines. From an economic/organizational perspective, the major factor 'ownership structure' was established. From a social perspective, the focus of studies is on the individual behavior of the franchisor and franchisee and on their interaction (relationship). This perspective led us to establish the fourth major cluster, 'behavior and interaction'. The last cluster of factors, 'age and size', was determined by thematically analyzing the common themes of all factors that could not be grouped within one of the other four clusters[2]. Within the five major factor clusters, sub-clusters were identified by thematically analyzing the common themes of the factors studied (see the results section). Thirdly, outcomes related to the same type of result were clustered by sub-factor. The size and direction

1 Many abstracts were excluded because the term franchising was used with another meaning than the business format franchises we were interested in. For example, the term franchise is also used in the banking/ financing sector, it is used in the context of railways and other transportation, and it is used in sport leagues.

2 Many studies have included size and age variables as control variables in their studies. As such, size and age were not used as a criterion for initial selection, as doing so would have included many studies that were otherwise not relevant. This article therefore only reports on studies in which age and size were used as control variables if these studies were also included for one of the other four factor clusters.

of each outcome were determined for every study and were summarized using the following symbols: – (negative), 0 (no difference) or + (positive). If studies did not report on the statistical significance of their findings, symbols were still used in accordance with the outcomes reported by the authors. Finally, we described the similarities and differences between the outcomes for each sub-factor and searched for the reasons for the differences by using the variables from Step 1.

The designs of most of the studies did not allow us to determine causality in the analysis. Although terms such as 'influencing factors' may suggest causality, only the existence of some type of relationship can be ascertained.

Results: The state of empirical research

A total of 126 empirical studies have related design and process factors within franchising to outcomes. Aspects related to behavior and the interaction between the franchisor and the franchisee received the most attention (n=58). A small majority of the studies investigated outcomes at the franchisee level (n=74). Outcomes at the customer level were rarely investigated (n=2). Outcomes at the franchisee level were the dominant focus in studies on the business format (35 of 49 studies) and behavioral and interaction aspects (47 of 58 studies), whereas outcomes at the franchisor level received the most attention in studies of ownership structure (28 of 34 studies). Financial performance (n=21), survival (n=20), and growth (n=12) were the most frequently investigated outcome types at the franchisor level. Satisfaction (n=43) and financial performance (n=27) were most frequently considered in studies that investigated outcomes for franchisees (see Table S1 in the Appendix of this chapter for a more extensive overview).

One-third of the studies used the restaurant/food industry as empirical setting, either alone or in combination with one or two other industries. Another substantial number of studies (n=57) conducted their research in multiple industries. Studies were conducted in 17 countries, predominantly in North America and the UK (67%) and countries in continental Europe (17%). Only 9 studies were conducted in Asian or South American countries. Research on franchising in the US was ample (>60%).

More than one-third of the articles employed an economic perspective (35%). A quarter of all studies used agency theory as their theoretical perspective. A substantial number of studies (n=38) did not mention a theoretical perspective; instead, these studies constructed the theoretical foundation for the research based on prior research findings or undefined theories (Table 1)[3].

3 See Table S1 in the end of the chapter for a more detailed overview of the state of empirical research with regard to theoretical perspectives, countries, industries, outcome types, and methodology for the total base of articles and for each factor cluster.

Table 1: Summary of empirical research on outcomes of factors within franchising

Region		Sector		Research design		Type of theory	
North America:	62%	Restaurant/food:	32%	Quantitative:	80%	Economic:	35%
Europe (incl. UK):	22%	Hotel:	6%	Qualitative:	13%	Organizational:	15%
Oceania:	9%	Other:	19%	Mixed methods:	7%	Social-psychological:	19%
Asia:	5.5%	Various:	43%			Learning:	4%
South America:	1.5%					Not specified:	26%

The majority of the studies employed quantitative designs (n=101). The studies vary widely in sample size. Of the 101 studies, 28 studies investigated outcomes longitudinally. The qualitative (n=16) and mixed-method (n=9) studies also differed greatly in terms of the number of interviews used. Our subsequent analysis considers these methodological differences as possible explanations for the mixed outcomes that resulted from these studies.

Results: A framework of factors related to outcomes of franchising

As described in the data-analysis section, the analyses show that five major factors with multiple sub-factors are related to outcomes of franchising: the ownership structure that is chosen for the system and the units, the design of the business format, the design of the contract, the behavior of the franchisor and the franchisee and their interaction, and the age and size of the system and the units. We have mapped all these factors into a comprehensive framework with the five major factors as major building blocks and the sub-factors as the content of these blocks (see Figure 2). The results section of this paper is further structured along these five blocks of the framework.

A: The influence of ownership structure

Our analysis shows that outcomes are related to four choices regarding ownership structure (see Block A, Figure 2): whether both the franchisor and franchisees or only the franchisees own units (plural form versus pure franchise); the proportion of units owned by franchisees; whether each franchisee owns one or more units (single-unit versus multi-unit ownership); and whether the responsibility for the daily operations of the unit is delegated to a unit manager or not (passive versus active ownership). Structured information about each individual paper can be found in Table S2 in the appendix of this chapter.

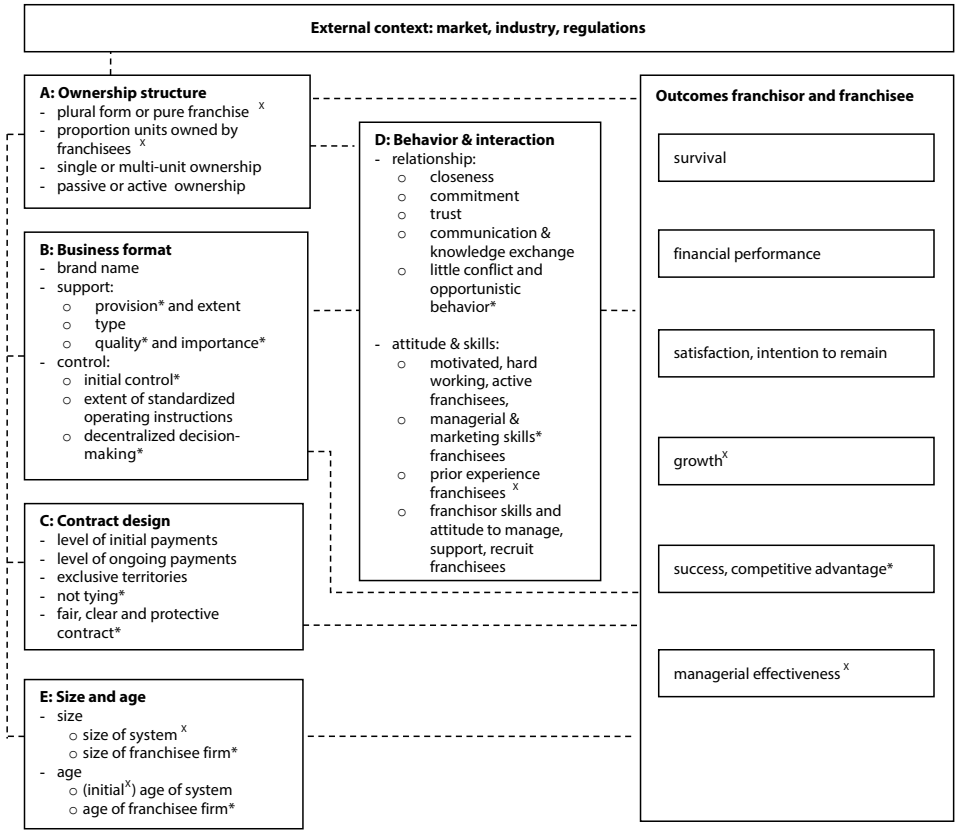

Figure 2: Model of factors related to outcomes based on review

Plural form versus pure franchise

Ten studies have compared the outcomes of plural forms with those of pure franchises. These studies were conducted in the US (n=5), France (n=4) and Spain (n=1). Seven studies used the restaurant/food industry as the empirical setting. All studies focused on the outcomes for the franchisor.

Four studies found that plural forms are more managerially effective because innovation, uniformity and economic efficiency are more attainable. The franchisees contribute to innovation because they have a greater incentive to perform well as independent entrepreneurs. The company-owned units facilitate the dissemination of innovation and help to increase uniformity, because they can be used as pilot sites that persuade franchisees to adopt new practices and as training sites for new franchisees. The use of the same control system further enhances uniformity (Bradach, 1997; Cliquet,

2000; Cliquet & Croizean, 2002; Dant & Kaufmann, 2003). Cliquet (2000) and Cliquet and Croizean (2002) found that the combined use of franchisees and company-owned units also leads to greater economic efficiency.

Besides managerial effectiveness, one study also found that the plural form outperforms pure franchise with regard to franchisor survival (Bordonaba-Juste et al., 2009). With regard to efficiency and financial performance, the results are mixed. Perrigot et al. (2009) found that plural forms are more efficient than predominantly pure systems, whereas Botti et al. (2009) found no significant difference. These contradictory results may be caused by differences in methodology, as Perrigot et al. (2009) used more variables to measure efficiency and employed a different cut-off point for the plural form measure. Regarding financial performance, both Hsu and Jang (2009) and Koh et al. (2009) found that franchisors gain more financially in plural forms. Srinivasan (2006) found this only to be true for some franchisors. For certain chains, intangible value is unaffected and small chains may even experience weaker financial performance if they also have high financial liquidity and a lasting advertising strategy (Srinivasan, 2006). All three studies considered the same outcome, industry and country; however, the study by Srinivasan was conducted earlier and used a larger sample and study period than the study by Koh et al. (2009). Moreover, Srinivasan considered contingent variables other than those used in the other two studies. Despite the overall greater effectiveness, franchisors with a plural form also meet with difficulties (Cliquet, 2000). The franchisors' interests associated with managing franchisees and company-owned managers are not always aligned, the risk of conflicts and management problems are higher, and demotivation and anxiety among franchisees is more common.

Proportion of units in chain owned by franchisees

Fourteen studies evaluated the optimal proportion of units owned by franchisees in plural form chains. These studies were conducted in the US (n=11), France (n=1) and Spain (n=2). Half of the studies were conducted in the restaurant/food industry. Eleven studies employed an agency perspective, either exclusively (n=1) or in combination with another perspective (n=10).

Two studies give estimates of the optimal proportion. As the targeted outcome and studied countries differ, so does the estimated proportion. The ideal proportion for survival in the Spanish restaurant industry was around 69 percent (Bordonaba-Juste et al., 2009), whereas the ideal proportion for financial performance in the US restaurant industry was between 37 and 46 percent (Hsu & Jang, 2009). Other studies made more general claims and found that a higher franchise proportion yields lower customer satisfaction and financial performance (O'Neill & Matilla, 2004; O'Neill et al., 2006). The effects on growth are unclear; whereas Shane et al. (2006) and Sen (1998) found

a positive relationship between proportion and growth, Kosová and Lafontaine (2010) found a negative relationship.

Various studies found that the optimal proportion is contingent on the environment, strategy, business format characteristics and system age. With regard to the environment, franchisors have higher financial outcomes and survival rates if they increase their franchise proportion (1) if their units are widely dispersed in different geographical markets (Hsu & Jang, 2009; Sorenson & Sørensen, 2001; Vazquez, 2007), (2) if they have started their operations in a strict legal environment (Shane & Foo, 1999), or (3) if they were one of the first entering franchise firms on their market and are currently relatively mature (Bordonaba-Juste et al., 2009). With regard to strategy, franchisors perform better financially if they align their franchise proportion with their financial and marketing strategies (Srinivasan, 2006) and do not use franchising as a strategy to gather resources, as such an approach prevents a proper fit between on the one hand proportion and on the other hand business format characteristics and geographical dispersion of units (Combs, Ketchen & Hoover, 2004b; Ketchen et al., 2006). With regard to the business format, if franchisors have highly valuable resources (Barthelemy, 2008; Vazquez, 2007) or tacit business practices that cannot be specified in the operations manual (Barthelemy, 2008), they obtain better financial and survival outcomes if they reduce their franchise proportion. Franchisors should increase the proportion if local knowledge is important in applying the business format on unit level (Vazquez, 2007). With respect to age, Kosová and Lafontaine (2010) found that, in order to enhance their survival chances, it is better for young systems to use a lower franchise proportion than mature firms.

Two US studies investigated whether company-owned units or franchised units are more suitable at the unit level, given a particular environment and strategy. Vroom and Gimeno (2007) found that chains have a greater advantage with company-owned units than with franchised units in concentrated markets, as company-owned units can generate higher revenues in such a situation. Yin and Zajac (2004) found that franchised units require complex rather than simple strategies for optimal financial performance, and that the opposite is true for company-owned units.

Single-unit versus multi-unit ownership

Nine studies investigated the outcomes of single-unit versus multi-unit ownership. All these studies were conducted in the US, and most took a franchisor perspective (n=7) and employed agency theory (n=6).

For franchisees, owning multiple units is more advantageous than owning only one. This results in better survival rates (Bates, 1998) and lower production costs because production experience is more easily transferred between units belonging to the

same owner (Darr et al., 1995). For franchisors, the results of multi-unit franchising are more equivocal. It lowers the chances of survival for new franchisors (Shane, 1998) but increases them for larger franchisors (Shane, 2001). Multi-unit and single-unit systems are similarly productive (Thompson, 1994). Three of the four studies on system growth found positive effects (Kaufmann & Kim, 1995; Kaufmann & Dant, 1996; Bradach, 1995). However, the study with the largest sample (1,201 as opposed to 169, 152, and 5 systems in the other three studies) did not find a significant effect in this regard (Clarkin & Rosa, 2005). According to Bradach (1995), multi-unit franchises can grow more easily because the re-use of existing franchisees implies that the franchisor receives the same fees while fewer resources have to be allocated to finding franchisees for new units. Moreover, he found that multi-unit franchisees make the system more effective by facilitating system-wide adaptation because franchisors have to persuade fewer franchisees to implement changes. However, these franchisees are slightly less effective in terms of local responsiveness (Bradach, 1995).

Passive versus active ownership

Passive ownership and multi-unit ownership are closely related; after all, when franchisees own multiple units, passive ownership must be allowed. However, four studies also considered specifically whether passive ownership is related to outcomes. Three of these studies employed an agency perspective and were conducted in the US. For franchisees in older and larger US restaurant chains, passive ownership is disadvantageous for their survival chances (Michael & Combs, 2008). For franchisors, the findings on survival are less straightforward. Although Shane (1998) found lower survival in systems that adopt passive ownership, Vazquez (2009) showed that such ownership is only negative in systems in which the operations manual is not specific and local knowledge is highly important. With regard to system growth, Clarkin and Rosa (2005) showed a positive effect.

B: The influence of the business format

Besides ownership structure, the business format appears the second influencing factor. Studies show that the outcomes of franchises are determined by the brand name, the format facilitators directed at support, and the format facilitators directed at control. Format facilitators are the operating and management structures that should ensure that franchisees deliver the products and services required by the franchisor (Kaufmann & Eroglu, 1998) (see Block B, Figure 2 and Table S3 in the appendix).

Brand name

All studies on the brand name (n=10) reported the positive effects of a strong recognizable brand name, regardless of the country or sector of investigation and the theoretical perspective that was used. For franchisors, the brand name is positively related to profits, sales, growth and survival (Gillis & Combs, 2009; Inma & Debowski, 2006; Shane & Spell, 1998). For franchisees, it has a positive impact on satisfaction, success and survival (Falbe & Welsh, 1998; Hing, 1996; Knight, 1986; Michael & Combs, 2008; Tuunanen & Hyrsky, 2001; Watson & Johnson, 2010; Pitt et al., 2003).

Support

The studies on the influence of the support provided to franchisees (n=49) considered the role of the provision and the extent of the support, the type of support, and the quality and importance of the support. Studies on the outcomes at the franchisee level (n=35) and of franchisee satisfaction (n=24) were the most common.

Irrespective of the industry, the country, and the operationalization of the support provision, studies always show positive effects on franchisee satisfaction, financial performance and survival (Abdullah et al., 2008; Dubost et al., 2008; Hing, 1995, 1999; Roh & Yoon, 2009; Tuunanen & Hyrsky, 2001; Rajagopal, 2007; Frazer & Winzar, 2005). However, franchisees' valuation of the support provision generally decreases over time (Tuunanen & Hyrsky, 2001; Grünhagen & Dorsch, 2003). The extent of the support provided also contributes to positive outcomes for franchisees. Franchisees are more satisfied and perform better financially if they are offered a large amount of support (Knight, 1984, 1986; Minguela-Rata et al., 2009, 2010). In contrast, offering extensive support is not directly beneficial for the franchisor. In Australia, it was found to have no impact on disruption rates (Frazer, 2001a; Frazer & Winzar, 2005), and in the US, it even had negative effects on survival rates (Shane, 1998, 2001; Shane & Spell, 1998).

The type of support provided to franchisees matters more for franchisors than for franchisees. Studies on the franchisee level all show positive or neutral effects of different support types; no type of support has negative effects. All studies on franchisee satisfaction found positive effects, irrespective of the type of support studied. Training (Hunt, 1973; Lusch, 1977; Merrilees & Frazer, 2006), franchisor representatives (Lusch, 1977), assistance in seeking suitable locations, product development and a ready-made concept (Hing, 1996) are all positively related to satisfaction. Marketing and brand support were also found to have a positive effect on satisfaction in various industries (Hing, 1996; Merrilees & Frazer, 2006; Lusch, 1977), although high-performing franchisees value these support types more than lower performers (Merrilees & Frazer, 2006). Nevertheless, not all support types have unequivocal positive effects on the financial performance and survival rates of franchisees. Financial assistance was found

to have no impact on financial performance (Churchill & Hunt, 1973), whereas training was found to have a positive effect on both financial performance (Michael & Combs, 2008; Minguela-Rata et al., 2010) and survival (Michael & Combs, 2008). Kalnins and Mayer (2004) found that the survival of restaurant franchisees can be improved by transferring local knowledge to franchisees, but not by transferring experience gained non-locally.

Studies on the franchisor level show more mixed results for the different support types. With regard to survival, Shane (2001) found positive effects of training, communication services and assistance to franchisees in seeking suitable locations. However, Grünhagen et al. (2008), who studied the relationship between multiple support types and the closing or conversion of outlets, found no effect of any support type in the US. In Germany, only insurance had a positive survival effect, whereas newsletters, internet services and field visits even resulted in more disruption (Grünhagen et al., 2008). Regarding system growth, the effect of support types is also mixed. Shane et al. (2006) found a positive effect of providing financial assistance to franchisees, although Clarkin and Rosa (2005) found no effect. Similarly, Leblibici and Shalley (1996) showed a positive effect of mechanisms to support the franchisor and franchisees in managing their working relationship, whereas Dandridge and Falbe (1994) found that this support type had no effect on growth. The only study on success, by Yang et al. (2005), found some indication that separate headquarters for innovation and administration with an ample support staff dedicated to innovation positively correlates with success.

Moreover, the quality of the support offered favourably affects franchisee outcomes. Six studies found positive relationships with satisfaction (Hunt & Nevin, 1974; Huang & Phau, 2009; Lewis & Lambert, 1991; Morrison, 1996; Spinelli & Birley, 1998) and success (Falbe & Welsh, 1998), irrespective of the country, sector, and operationalization used. Falbe and Welsh (1998) even reported that franchisors found system quality to be the most important factor in franchisee success. Franchisee satisfaction also increases when franchisees perceive the support to be instrumental (Lusch, 1977; Yavas & Habib, 1987) or helpful (Michie & Sibley, 1985). The influence of instrumental support on satisfaction is stronger if the quality of that support is high (Yavas & Habib, 1987). Interestingly, different franchisees within the same system can attach different quality and importance levels to the same support, resulting in different satisfaction levels (Huang & Phau, 2009).

Control

Fifteen studies considered the influence of format facilitators directed at control. These studies considered the role of initial control, standardized operating instructions and (de)centralized decision-making. Studies at the franchisee level (n=10) and with franchisee satisfaction as an outcome (n=7) were the most common.

Six studies indicated that the use of disclosure information and assessment methods to initially select franchisees with the right attitudes and expectations ultimately leads to greater franchisee satisfaction (Hing, 1995, 1999; Roh & Yoon, 2009; Tuunanen, 2002) and success (Morrison & Lashley, 2003), but not to more system growth (Clarkin & Rosa, 2005).

Five studies showed that greater use of standardized operating instructions for franchisees has no negative effects on franchisee outcomes but has mixed effects on franchisor outcomes[4]. At the franchisee level, both Kidwell et al. (2007) and Knott (2003) found that franchisor requirements regarding the use of specific practices and procedures positively contribute to financial performance. Kidwell et al. (2007) found that this positive effect occurred because the use of instructions curbed free-riding behavior among franchisees. Free-riding means "cutting costs by lowering product or service quality" while profiting from the brand reputation of the franchisor (Kidwell et al., 2007, p. 523), especially in cases of non-repeated trade. However, Komoto (2005), who only considered the effect of strictly following the operations manual, found that this strategy has no universal positive effect. In fact, it enhanced the financial performance of franchisees during their first five contract years but not in later years when local adaptation became performance-enhancing. At the franchisor level, the effects on financial performance depend on the ownership type. Significant investment in developing standardized operating routines enhanced performance in pure franchises but reduced performance in plural form chains (Gillis & Combs, 2009). One small-scale study found that a high level of standardization had no effect on growth (Leblebici & Shalley, 1996).

Five studies considered the impact of the extent of decentralized decision-making. At the franchisor level, centralized services decreased the exit chances of large systems: the larger the system, the larger the effect (Shane, 2001). However, at the franchisee level, decentralization of decision-making yields better outcomes. Irrespective of operationalization, industry and country, it is related to more perceived competitive advantage (Baucus et al., 1996), satisfaction (Baucus et al., 1996; Schul et al., 1985; Tuunanen & Hyrsky, 2001), and a better financial performance as a result of less free-riding behaviour (Kidwell et al., 2007).

C: The influence of contract design

The design of the contract is the third factor that influences outcomes. Besides provisions about format facilitators, six other contract elements were investigated: initial payments, ongoing payments, contract length, exclusive territories, tying and fairness (see Block C

4 Although various authors have also included the operations manual as a support service (previous section), it also has an important control function. It is both a support and a control tool.

Figure 2 and table S4 in the appendix). Of the thirty-seven studies, 75% were conducted in the US. Various industries were used as empirical setting.

Level of initial payments

Seventeen studies considered the effects of the level of initial payments at the franchisee (n=7) and franchisor (n=10) level. Initial payments are payments made by franchisees before they can open a new unit. All but one of the studies were conducted in various industries in the US.

At the franchisee level, three studies found the level of initial payments to be positively related to income (Churchill & Hunt, 1973) and survival (Bates, 1995b; Frazer & Winzar, 2005). Other studies reported negative and neutral relationships (Michael & Combs, 2008; Holmberg & Morgan, 2003; Jambulingam & Nevin, 1999). At the franchisor level, initial payments also have mixed effects. The effect on survival tends to be different for different types of payments. Higher levels of cash investment are positively related to the survival of new and large franchisors (Shane, 1998, 2001), whereas most studies found that the level of total investment/start-up costs had no effect (Shane, 1996, 1998; Lafontaine & Shaw, 1998; Kosová & Lafontaine, 2010; Castrogiovanni et al., 1993). Kosová and Lafontaine (2010) even found a negative relationship, especially for mature firms. Only Shane and Foo (1999) found a positive survival effect of start-up costs in states in which new systems are obliged to register. Initial payments also seem to have mixed effects on growth, as negative, neutral and positive relationships were identified in various studies (Shane et al., 2006; Kosová & Lafontaine, 2010; Shane, 1996; Castrogiovanni & Justis, 2002). Only one study considered financial performance and concluded that start-up costs should be relatively low (Gillis & Combs, 2009).

Level of ongoing payments

Nineteen studies investigated the influence of the level of ongoing payments. Although it is frequently argued that payments serve as an incentive for franchisees, in practice, higher levels of ongoing payments rarely have a positive effect at the franchisee level. On the contrary, predominantly negative relationships have been found with survival (Michael & Combs, 2008), financial performance (Frew & Jud, 1986), and satisfaction if the franchisees perceive the payments as too high (Abdullah et al., 2008; Frazer et al., 2007a; Hing, 1996; Knight, 1986; Tuunanen & Hyrsky, 2001). Only Benjamin et al. (2007) found that the effect on financial performance depends on the region. In certain regions, the payments are in balance with the gains of being part of the franchise system, whereas in other regions, franchisees profit more than they have to pay (Benjamin et al., 2007).

At the franchisor level, the majority of studies showed that the magnitude of ongoing payments has no effect on survival chances (Shane, 1996, 1998; Shane & Foo, 1999;

Lafontaine & Shaw, 1998), shareholder returns (Spinelli et al., 2003), or growth (Kosová & Lafontaine, 2010; Sen, 1993; Shane, 1996). One study even found that higher ongoing fixed fees negatively affect survival, at least for mature chains (Kosová & Lafontaine, 2010). Only a subset of the studies found positive effects on financial turnover (Chaudey & Fadairo, 2008, 2010) and the survival of large systems (Shane, 2001). Moreover, Kosová and Lafontaine (2010) found a positive relationship between advertising fees and survival, and a positive effect on growth from royalties and advertising fees in mature firms. Interestingly, Kaufmann and Dant (1996) found an overall positive effect of fees on growth, while Shane et al. (2006) reported larger increases in the size of systems that gradually lower royalty rates and that start with low fees and raise them over time.

Length, tying, exclusive territories, and fairness of contract

The roles of contract length, tying, exclusive territories and contractual fairness have also been investigated. Contract length appears to be unimportant to achieve positive outcomes. Of six studies, only Chaudey and Fadairo (2008, 2010) found a positive correlation between constraint contracts and results, and length was only one of the six variables in the constraint contracts measure. Moreover, tying agreements in the contract, i.e., obligatory central purchasing, are not important to the success of franchising. Three out of four studies showed that such agreements benefit neither the franchisor nor the franchisee (Hunt & Nevin, 1975; Hing, 1996; Michael, 2000). Only one small-scale Korean study found a positive relationship with satisfaction, but this was more related to the punctuality of deliveries by the prescribed supplier than to price levels (Roh & Yoon, 2009).

In contrast to the marginal roles of length and tying, three US studies showed that adopting exclusive territories within contracts positively affects the survival of both the franchisor and the franchisee (Azoulay & Shane, 2001; Michael & Combs, 2008), and positively influences the franchisees' financial performance because it prevents the establishment of new same-brand units that can capture revenues from existing neighboring franchisee units (Kalnins, 2004). Six studies highlighted the importance for franchisee satisfaction of contractual regulations (e.g., regarding termination and restrictions) that are clear, that do not exclusively benefit the franchisor's interests, and that are perceived by franchisees as reasonable given the benefits that they obtain from the franchisor (Abdullah et al., 2008; Dubost et al., 2008; Hing, 1996; Morrison, 1996; Tuunanen & Hyrsky, 2001; Withane, 1991).

D: The influence of behavior and interaction

Fifty-eight studies showed that the previous three 'hard' design elements alone cannot ensure positive outcomes. Good relationships between the franchisor and

the franchisees and the skills and attitudes of both parties also play an important role (see Figure 2, Block D, and Table S5 in the appendix). Evidence is primarily available for outcomes at the franchisee level (n=47), with satisfaction as the outcome measure (n=33).

The relationship between franchisor and franchisee

Several studies showed the importance of a good working relationship by investigating the following relationship characteristics: closeness of the relationship, commitment, trust, communication/information exchange, dependence, conflict and opportunistic behavior. Moreover, various studies showed that these relationship characteristics are related.

Studies focusing on various conceptualizations of closeness of the relationship consistently show that relationships between franchisors and franchisees always yield positive outcomes if they cooperate closely as partners with ample consideration for each other's tasks, roles, and needs. Positive effects were found on the success of both parties, franchisee satisfaction, intention to remain, financial performance, and competitive advantage (Baucus et al., 1996; Bordonaba-Juste & Polo-Redondo, 2008b; Brown & Dev, 1997; Huang et al., 2007; Huang & Phau, 2009; Rodriguez et al., 2005; Schul et al., 1985; Schul, 1987; Spinelli & Birley, 1998; Kidwell et al., 2007; Rajagopal, 2007; Morrison & Lashley, 2003; Clarkin & Rosa, 2005; Watson & Johnson, 2010). One study focused on the relationships between franchisees and showed that cooperation and interaction in a particular region improves financial performance, but supra-regional interaction does not (Ehrmann & Meiseberg, 2010).

Franchisor-franchisee relationships with higher levels of trust predominantly yield superior performance. Five studies showed a positive relationship with franchisor and franchisee satisfaction and the intention to remain, irrespective of the country, industry and type of trust examined (Bordonaba-Juste & Polo-Redondo, 2004, 2008a; Chiou et al., 2004; Dubost et al., 2008; Dickey et al., 2007). Nevertheless, trust may be more important in some situations than in others. From the franchisee perspective, a high level of trust only has a significant positive effect at the beginning of the relationship, and not in the long term (Bordonaba-Juste & Polo-Redondo, 2008a). At the franchisor level, trust only has a positive effect on financial performance in plural form chains, and not in pure franchises (Gillis & Combs, 2009).

Moreover, studies show almost unequivocally that high-quality, frequent communication and information exchange between franchisors and franchisees reduce the probability of negative franchisee exit (Frazer & Winzar, 2005). Moreover, it has a positive effect on franchisee satisfaction, intention to remain, success and perceived competitive position across countries and industries and regardless of the methodology used (Abdullah et al., 2008; Bordonaba-Juste & Polo-Redondo, 2008b; Chiou et al., 2004;

Dubost et al., 2008; Hing, 1996; Lee et al., 2008; Rodriguez et al., 2005; Falbe & Welsh, 1998; Gassenheimer et al., 1996). Only Gillis and Combs (2009) indicated possible negative effects of exchanging knowledge. This study found that franchisor investment in knowledge exchange reduced financial performance in pure franchise chains but increased it in plural form chains.

Where the franchisor-franchisee relationship is characterized by higher levels of dependence, franchisees are found to enjoy higher levels of satisfaction and better performance (Lewis & Lambert, 1991; Bordonaba-Juste & Polo-Redondo, 2008b). In addition, higher levels of commitment between the franchisor and franchisee yield higher satisfaction levels, higher levels of the intention to remain, and greater managerial effectiveness (Bordonaba-Juste & Polo-Redondo, 2004, 2008ab). The only negative effect was on franchisee financial performance (Bordonaba-Juste & Polo-Redondo, 2004). Studies consistently showed the negative effects of relationships in which the franchisor and franchisee behave opportunistically and experience high levels of conflict rather than work with each other's interests in mind (Gassenheimer et al., 1996; Kidwell et al., 2007; Lusch, 1976; Phan et al., 1996; Rodriguez et al., 2005; Schul, 1987; Tuunanen, 2002; Frazer, 2001b; Frazer & Winzar, 2005).

Some of the preceding studies showed that these relationship characteristics are closely related, which suggests that the development of one characteristic can be stimulated by another. Franchisors and franchisees can enhance their level of cooperation by communicating better and more frequently, particularly when the franchisees are not heavily dependent on the franchisor (Rodriguez et al., 2005). Close cooperation, in turn, is associated with lower levels of conflict (Schul, 1987) and opportunistic behavior (Kidwell et al., 2007) and stimulates the development of trust (Bordonaba-Juste & Polo-Redondo, 2004) and commitment (Bordonaba-Juste & Polo-Redondo, 2008b). Partners can achieve more commitment by being more interdependent and by expressing more solidarity with each other (Bordonaba-Juste & Polo-Redondo, 2008b), by exchanging information (Bordonaba-Juste & Polo-Redondo, 2004, 2008b; Watson & Johnson, 2010), and by building trust (Bordonaba-Juste & Polo-Redondo, 2004, 2008a). Commitment can also help to build trust (Dickey et al., 2007). Communication and information exchange moderates the negative impact of opportunistic behavior on franchisee satisfaction (Gassenheimer et al., 1996) and stimulates the development of commitment (Bordonaba-Juste & Polo-Redondo, 2004, 2008b; Watson & Johnson, 2010) and trust (Bordonaba-Juste & Polo-Redondo, 2004, 2008a; Chiou et al., 2004; Watson & Johnson, 2010).

Attitudes and skills of franchisee and franchisor

Multiple studies revealed that the skills and attitudes of the franchisor and the franchisee are important for the success of franchising. Franchisees that are highly motivated and willing to work hard and make sacrifices are more likely to survive and succeed, as are

their franchisors (Bates, 1995ab; Clarkin, 2008; Frazer & Winzar, 2005; Frazer et al., 2007a; Merrilees & Frazer, 2006; Jambulingam & Nevin, 1999; Parsa et al., 2005; Watson, 2008). Franchisees experience better financial performance, a greater likelihood of success and more satisfaction if they have good management and marketing capabilities and if they are able to align their own strategies and management efforts with those of the franchisor (Merrilees & Frazer, 2006; Clarkin, 2008; Frazer & Winzar, 2005; Knight, 1986; Parsa, 1999; Parsa et al., 2005; Falbe & Welsh, 1998; Withane, 1991). It is unclear whether entrepreneurial characteristics and risk taking are also important; some studies showed positive effects (Hing, 1995, 1999; Withane, 1991), whereas others showed negative (Fenwick & Strombom, 1998) or neutral effects (Fenwick & Strombom, 1998; Hing, 1995, 1999; Jambulingam & Nevin, 1999; Knott, 2003). Franchisees' prior skills and experience appear to be less important than current capabilities. Experience, whether in self-employment, management, business or industry, rarely has a positive effect (Bates, 1995ab; Frazer et al., 2007a; Knight, 1986; Hunt, 1973; Fenwick & Strombom, 1998; Knott, 2003; Gassenheimer et al., 1996; Hing, 1995, 1999; Jambulingam & Nevin, 1999). Two studies even found a negative effect on returns (Knott 2003) and on franchisee satisfaction (Tuunanen & Hyrsky, 2001). Only four studies found a positive effect on the success and survival of franchisees (Frazer & Winzar, 2005; Knight, 1986; Michael & Combs, 2008) and franchisors (Shane, 1998).

Franchisors need the skills necessary to successfully manage relationships, provide the support that franchisees need, and recruit suitable franchisees. Otherwise, they may leave franchising or experience reduced success (Frazer, 2001b; Kirby & Watson, 1999; Knight, 1986; Stanworth et al., 2001; Watson, 2008). Franchisors should also be able to choose the right strategies to influence the behavior of their franchisees. Franchisors can rely on the contract and on threats (i.e., coercive strategies) or can primarily use support services and communication activities (i.e., non-coercive strategies). Studies unequivocally found better outcomes at the franchisee level when franchisors primarily relied on non-coercive strategies (Frazier & Summers, 1986; Hunt & Nevin, 1974; Lusch, 1977; Michie & Sibley, 1985; Parsa, 1996, 1999; Yavas & Habib, 1987).

E: The influence of size and age

Fifty studies showed that the initial and current size of the system (n=21), size of the franchisee firm (n=12), initial (n=6) and current system age (n=22), and age of the franchisee firm (n=18) are related to outcomes (see Figure 2, Block E, and Table S6 in the appendix).

Size of system and franchisee firm

The size of an existing chain when it starts franchising affects neither franchisor survival nor growth (Azoulay & Shane, 2001; Lafontaine & Shaw, 1998; Shane, 1996). However, once the chain has started franchising, a larger system size has mixed effects. Of the six studies that considered the influence on financial performance, five found a beneficial effect (Gillis & Combs, 2009; O'Neill & Mattila, 2004; Inma & Debowski, 2006; Hsu & Jang, 2009; Koh et al., 2009). Shareholder returns are the only exception to this trend (Spinelli et al., 2003). A methodologically strong study found a negative effect on growth (Kosová & Lafontaine, 2010). Two small-scale studies found neutral or positive effects (Leblebici & Shalley 1996; Inma & Debowski, 2006). In addition, the survival chances of franchises in Spain are affected positively or not at all by increases in size (Vazquez, 2007, 2009; Bordonaba-Juste et al., 2009). Positive effects were also found in four out of six studies in the US. Only Kosová and Lafontaine (2010) found a negative effect, but for young firms only. It is likely that the differences in findings in the US are due to the correction for unobserved chain heterogeneity in the study of Kosová and Lafontaine (2010), as this correction reversed their finding from positive to negative. This suggests that a negative effect of size for young firms is probable. Negative effects were also found in Australia, although these studies focused on disruption and not on real exit (Frazer, 2001a; Frazer & Winzar, 2005).

The size of franchisee firms also appears to be relevant, at least to their survival and financial performance. Their survival chances are higher if they own a larger number of outlets (Parsa et al., 2005; Bates, 1995ab). Of the seven studies that investigated the relationship with financial performance, four found a positive effect (Brand & Croonen, 2010; Frew & Jud, 1986; Benjamin et al., 2007; Churchill & Hunt, 1973), whereas the other three found no effect or a negative effect (Knott, 2003; Ehrmann & Meiseberg, 2010; Yin & Zajac, 2004). These differences may be due to the different operationalization of size used in two of the latter studies and to differences between industries. Satisfaction and competitive position were found to be unaffected or even negatively affected by a larger franchisee size (Gassenheimer et al., 1996; Spinelli & Birley, 1998).

Age of system and franchisee firm

No harmful effect was found for franchisors if they waited longer before starting franchising in an existing chain. Franchisors that extensively pilot their concept are more likely to succeed (Stanworth et al., 2004). Three studies also found higher survival rates for chains that are older at franchise start (Bordonaba-Juste et al., 2009; Kosová & Lafontaine, 2010; Lafontaine & Shaw 1998), but two other studies did not share this finding (Shane, 1996; Azoulay & Shane, 2001). These differences may be due to differences in sample sizes; the positive studies used larger samples than the studies

that found no effect, which makes a positive effect more likely. The age of a chain at franchise start was found to have either a positive (Kosová & Lafontaine, 2010) or no effect on growth (Shane, 1996).

As systems age, the outcomes for franchisors are affected, but it is not exactly clear how. None of the outcomes becomes unequivocally more positive. Four of the seven studies examining the relationship with financial performance found positive effects (Chaudey & Fadairo, 2008, 2010; Thompson, 1994; Spinelli et al., 2003), but the other three studies reported negative effects (Sorenson & Sørensen, 2001; Price, 1993; Inma & Debowski, 2006). This difference may be due to different ways of measuring and in particular to the way in which the last two studies measured age as part of a broader typology. Koh et al. (2009) showed that the financial effect of age disappears after some time. Studies on survival demonstrated mostly positive effects in the US and Spain (Shane & Foo, 1999; Shane, 1998, 2001; Kosová & Lafontaine, 2010; Vazquez, 2007; 2009), but negative and no effects in Australia (Frazer, 2001a; Frazer & Winzar, 2005). One US study also found a negative effect (Castrogiovanni et al., 1993). The variations in these findings may be due to the focus on disruption and to the measurement at unit level in the latter three studies, rather than on survival of the whole system. With respect to growth, studies showed that franchise system age has either a negative effect or no effect (Castrogiovanni & Justis, 2002, Inma & Debowski, 2006; Kosová & Lafontaine, 2010; Leblebici & Shalley, 1996; Kaufmann & Dant, 1996).

Ageing of franchisees and their outlets does not leave their outcomes unaffected, but the direction of the effect is not clear. Opposite effects were found on competitive advantage (Gassenheimer et al., 1996; Baucus et al., 1996) and financial performance (Baucus et al., 1996; Ehrmann & Meiseberg, 2010; Knott, 2003; Komoto, 2005; Yin & Zajac, 2004; Benjamin et al., 2007; Fenwick & Strombom, 1998; Darr et al., 1995), without any consistent patterns in sector, country and type of financial performance. Franchisee satisfaction remains the same (Gassenheimer et al., 1996; Jambulingam & Nevin, 1999) or even decreases over time (Grünhagen & Dorsch, 2003; Tuunanen & Hyrsky, 2001). Survival chances generally either stay similar or increase over time (Bates, 1995ab; Parsa et al., 2005; Kalnins & Mayer, 2004); they only decrease when an existing unit is bought from another owner (Bates, 1998).

Discussion and conclusion

This systematic review aimed at collecting all the empirical evidence on the structural and process-related factors that influence the results achieved within franchise systems, and to bring this evidence together in an integrative framework. We can conclude that franchisors and franchisees must consider multiple factors, thus ensuring an adequate fit between franchise design elements, individuals and the external context to make

franchising work for themselves. Franchisors and franchisees should work on the development of a recognizable brand name and a high-quality working relationship, and they should make sure that they are both sufficiently skilled and motivated to generate better outcomes. Moreover, franchisors should provide site selection assistance and exclusive territories to franchisees, but they should not tie supplies. To further enhance franchisee outcomes, franchisors should offer high-quality instrumental support, use substantial tools to select potential franchisees, decentralize decision-making, provide fair and clear contracts, and use support services and communication rather than contractual threats to influence franchisee behavior. The provision of a large number of support services also benefits franchisees. However, this does not benefit franchisors. Whether franchisors should have a high franchise proportion, discourage passive ownership and/or invest in knowledge exchange and standardized operating routines to further enhance their own outcomes depends on their overall system design and the external context. The roles of multi-unit ownership, payments, size and age are as yet unclear. We have mapped all of these findings into a comprehensive framework that depicts the factors that jointly drive success in franchising (see Figure 2 in the results section)[5].

Although the research findings presented in this review indicate that there are multiple factors that generally enhance success, the findings also show that outcomes in franchising are dependent on the compatibility and cohesion of different system design elements, the behavior of and relationship between actors in the system, and the context. More specific, neither ownership structure is universally appropriate or inappropriate, but the results are dependent on size, the market, business format design and age. Building trust and stimulating knowledge exchange may be more effective in plural form chains, whereas standardization may be better for results in pure franchises. Different support services seem to be valued to varying degrees among the different franchisees, systems, industries and countries, and the valuation may worsen over time. The impact of the magnitude of payments can be contingent on the system age and size, and also the inconclusive impact of age and size across studies may be a function of the lack of attention to the broader system. The cohesion of all these elements implies that it is important that researchers pay more attention to the interactions among different elements of the system, their combined effects and their relationship to the external context (contextualized systems approach; see e.g., Chenhall & Langfield-Smith, 1998).

We do not yet know what factors determine the success of franchising for customers. This scarcity of empirical research from the customer perspective is surprising, given that the ultimate success of franchising is dependent on customer appreciation. Although data regarding financial performance and survival may indicate whether customers

5 It should be noted that the framework only depicts the relationships that have been found to date. There may also be other relevant factors. Current evidence does not allow us to determine whether the dotted lines in the framework from factors to outcomes are causal. Thus, further extensive empirical research is needed.

value a particular franchise, we do not know what it is exactly that customers value about franchise systems. This lack of information constitutes a clear gap in knowledge (see also e.g., Dant, 2008).

The contribution of theoretical perspectives to the evidence

The diversity and complexity of the franchising literature makes it difficult to develop a single, overarching framework of the success factors involved. Researchers, even those from similar disciplines, have framed and operationalized similar factors differently. By compiling all of the empirical studies within one framework for the first time, our review may provide a valuable resource to scientists with different perspectives for future research and aims to make an important contribution to the current literature.

Various theories have primarily delivered complementary insights into what makes franchising work, despite their diverse means of framing the factors involved. Our review shows that the agency perspective (e.g., Vazquez, 2007; Combs et al., 2004b) has helped researchers to predict the influence of ownership structures, business format design and, to a lesser extent, contractual arrangements, age and size. Resource theories have often been used to complement agency theory (e.g., Combs et al., 2004; Hsu & Jang, 2009) in the study of ownership structures and have correctly indicated the impact of business format design and behavior in several studies. Relational/social-psychological theories (e.g. social exchange, relational marketing) (e.g., Dubost et al., 2008; Bordonaba-Juste & Polo-Redondo, 2008b) have contributed significantly to our understanding of how the actions and interactions of the franchisor and the franchisee shape success. To a lesser extent, these theories have shown which characteristics of the business format are helpful. Learning and knowledge perspectives have only been employed in a small number of studies, but have been quite fruitful (e.g., Minguela-Rata et al., 2009, 2010; Sorenson & Sørensen, 2001). Given the central position of knowledge transfer to franchising (e.g., Paswan & Wittman, 2009), it is surprising that these perspectives have not been used more often. Contingency principles have taught us that not all factors have similar effects in all situations (e.g., Yin & Zajac, 2004; Srinivasan, 2006). Multiple other perspectives have been used in a limited number of studies. For further research with a systems approach, we suggest researchers combine economic-based approaches (e.g., agency theory), organizational approaches (e.g., strategic), and social-psychological perspectives (e.g., relational exchange, expectancy, and entrepreneurship theory).

Reflections on the literature and research agenda

In this review, we have identified various gaps that merit further research as well as multiple promising avenues for further investigation. We urge scholars to further

investigate the interaction between different system design elements, people and contexts to gain better insight into what makes franchising work. As indicated by this review, the relationships are complex between ownership structure, business format design, contract design, age, size, and behavior and interactions, and the outcomes of franchising. This implies not only that the effects of individual design and process elements are difficult to determine, but also that the effects of these elements may actually vary in different systems. These contingencies and the lack of attention to such interactions and linkages in some studies may explain the differences in the results obtained in this field. Therefore, we argue that the evidence regarding what makes franchising work could be enhanced and that some of the ambiguities in the current evidence could be eliminated if researchers considered the effects of different design and process elements in relation to each other and to the external context. The studies by Srinivasan (2006), Inma and Debowski (2006), Kosová and Lafontaine (2010) and Gillis and Combs (2009) are a few examples of how such research can be conducted. Such research will also allow a better determination of the transferability of evidence to other industries and countries and the provision of more focused decision-support to practitioners.

We recommend that researchers identify the synergies between and within ownership structures, business format elements, contract elements, behavioral and interaction aspects, age and size as factors in outcomes of franchising. Researchers should also look for neutralizing effects (e.g., can the positive effect of support neutralize the negative effect of payments; see Michael & Combs, 2008). We also suggest further study into the relative importance of different factors in shaping outcomes. For example, Dubost et al. (2008) found intangible relationship issues to be as important as or more important than support services, whereas Abdullah et al. (2008) found the opposite to be true in another industry and country. We also recommend investigating the outcomes for franchisor, franchisees and customers in relation to each other, i.e., multi-level investigation, as trade-offs may exist (e.g., in the extent of support; see e.g., Shane, 2001, and Minguela-Rata et al., 2010), the perceptions of the actors may differ, and the outcomes for one actor may have consequences for the actions and outcomes of other actors (e.g., Bordonaba-Juste & Polo-Redondo, 2004, 2008a). To date, only a few studies have conducted this type of combined research, although Elango and Fried called for such studies as early as 1997. Consequently, we also recommend that the factors that have only been investigated from either the franchisee or the franchisor perspective be examined from both perspectives. In addition, we recommend that researchers employ more mixed-method designs in addressing these research challenges, as such designs will help them to further develop theories regarding what makes franchising work (e.g., Creswell, 2003).

A contextualized approach will also help researchers to determine whether it is truly problematic that the current empirical studies mostly focus on the US and the restaurant/food sector or whether the results of such studies can be generalized to other countries and industries with similar systems. We suggest here, among other topics, research on multi-unit franchises, as such firms are often larger in the US than in smaller (European) countries, and size may have an impact on the benefits and drawbacks of using this ownership structure (Shane, 2001).

This review has revealed two additional gaps in the evidence at the franchisee level that require further attention. First, few studies on outcomes at the franchisee level used more than only satisfaction measures[6], whereas ultimately 'hard' results, such as financial performance and survival, are also important. Secondly, although the research findings suggest that franchisees play an active role in making their franchises successful (e.g., Merrilees & Frazer, 2006; Jambulingam & Nevin, 1999; Parsa, 1999), studies at the franchisee level have primarily focused on what franchisors should do to create better outcomes for their franchisees (see all the studies on support, control, and contracts). It is crucial that researchers also examine how franchisees can make their own unit(s) more successful. Some relevant research questions are: how can franchisees most successfully exploit their business format (see e.g., Merrilees & Frazer, 2006 for a starting point) and how can the frequency, quality and type of interaction between franchisees within a system contribute to their success (see Ehrmann & Meiseberg, 2010 for a starting point).

We also argue that the gap in our understanding of what makes franchising work for customers must be filled, as this knowledge will be extremely relevant for practitioners and will enable them to make their systems more successful (see e.g., Dant, 2008 for relevant questions to investigate).

In addition to making these broader recommendations, we suggest that researchers address two important but not yet properly investigated topics: the level of uniformity and knowledge transfer within franchise systems. This review suggests that controlling all franchisee decisions is not beneficial despite the basic principle of uniformity in franchising (Kaufmann & Eroglu, 1998). Further insight is required into the optimal equilibrium between uniformity/control and adaptation/autonomy, given a particular business format design and context (see Cox & Mason, 2007, Cochet et al., 2008, and Dant & Gundlach, 1998 for a starting point). In addition to agency theory (e.g., Kidwell et al., 2007) and knowledge perspectives (e.g., Komoto, 2005), complexity theory (e.g, Anderson, 1999; Burnes, 2005) and organizational ecology (e.g., Burgelman, 1991) could provide interesting new perspectives for this research. We also recommend research

6 Satisfaction measures have almost exclusively been used to investigate the effects of qualitative & instrumental support, initial control, decentralized decision-making, fair and protectory contracts, commitment, trust, communication, and dependence on outcomes at the franchisee level.

on the most effective mechanisms for transferring different types of knowledge and on the outcomes of knowledge and innovations that are generated by franchisees and franchisors (see Paswan & Wittmann, 2009; Dyer & Nobeoka, 2000; Cumberland & Githens, 2012 for a starting point). Other relevant topics include the effectiveness of different selection methods to identify suitable franchisees (HRM perspective) (see for a starting point e.g., Ryan & Tippins, 2004, Rynes et al., 2002, Wright & Boswell, 2002, in combination with the studies on franchisee attitudes and skills mentioned in this review) and the best ways to develop close relationships within franchise systems (see e.g., Rodriguez, 2005; Rahatullah & Raeside, 2008).

Finally, some of the empirical studies presented here have strengths that should be preserved in future research. These strengths include the use of longitudinal designs in studies of survival and growth and the use of methods that control for age and size. Moreover, because many challenges and relationships are not unique to the franchising context, research can benefit from a wide range of other studies on inter- and intra-organizational cooperation. Generating connections with other fields may also encourage mutual learning.

Limitations

Although we conducted a systematic review, an absence of publication bias cannot be guaranteed as this review was limited to empirical peer-reviewed journal articles written in English. Moreover, the diversity of perspectives used to study franchising resulted in a multitude of outcome conceptualizations that we had not anticipated, and we used rather broad outcome concepts in our databases search. Consequently, our initial search did not identify all relevant articles. An extensive reference check that identified many additional relevant articles resolved this limitation. A limitation of our analysis is that the level of evidence presented in the studies was not rated. This choice could have distorted our overview to some extent. However, such a distortion was prevented as we considered the methodologies used if different studies presented different results. Readers can evaluate the possible interpretative elements in our thematic analysis by examining the extensive tables provided online, which present the findings of individual studies. By focusing on factors within franchise systems, we largely disregarded the influence of general economic and commercial factors within countries and industries. Clearly, these factors can also affect outcomes (see, e.g., Shane & Foo, 1999). Finally, franchisors and researchers who are interested in successful international expansion may use this review as a starting point but should also consider the literature on the factors that influence such expansion because these factors were not examined exhaustively in this review (see for a starting point e.g., Grewal et al., 2011; Frazer, Merrilees & Bodey, 2007b).

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Appendix: Additional supporting information of the systematic review

Table S1: Overview of studies on outcomes of factors within franchising

	All studies	Ownership structure	Business format aspects	Contractual aspects	Behavioral and interaction aspects	Age and size (firm and system level)
Number of studies	126	34	49	37	58	50
Methodology:						
Quantitative	101	29	38	32	43	47
Qualitative	16	4	4	2	10	1
Mix	9	1	7	3	5	2
Outcome type*:						
FO: financial	21	13	2	4	2	11
FO: survival	20	6	6	8	6	15
FO: growth	12	3	5	7	1	6
FO: success	6	1	3	0	5	0
FO: managerial effectiveness	7	5	0	0	2	0
FE: financial	27	3	10	5	16	10
FE: survival	9	2	3	5	6	8
FE: satisfaction & intention to remain	43	0	24	12	33	7
FE: success, competitive advantage, overall performance	8	0	5	0	7	2
CUS: satisfaction	2	2	0	0	0	0
Industries:						
Restaurant/food	41	17	15	7	16	17
Automobile, gasoline	5	0	3	0	5	0
Hotel	8	6	0	1	1	0
Real estate brokerage	4	0	1	2	2	2
Other retail/services	15	2	5	3	12	4
Various	57	12	25	25	24	28
Not described	2	0	2	0	1	0
Countries:						
USA	77	26	26	28	30	34
CAN	5	2	4	3	4	2
AUS	11	0	9	2	6	5
ESP	9	3	2	0	4	3
FRA	8	5	1	3	1	2
UK	6	0	2	0	5	1

*FO = franchisor, FE = franchisee, CUS = customer

Table S1: Overview of studies on outcomes of factors within franchising (continued)

	All studies	Ownership structure	Business format aspects	Contractual aspects	Behavioral and interaction aspects	Age and size (firm and system level)
Countries:						
Other European countries	6	0	4	1	5	3
Other Oceania	1	0	0	0	1	1
Asian countries	7	0	4	2	5	1
South American countries	2	0	2	0	1	0
Theoretical perspectives:						
Agency	34	20	7	12	7	19
Resource (constraint, dependence etc)	20	13	6	4	2	9
Efficient contracting	1	1	1	1	0	1
Transaction costs	4	0	1	1	3	2
Relational (e.g. social exchange, relational marketing)	20	0	7	0	17	3
Learning, knowledge	6	2	4	0	0	4
Contingency	2	2	0	0	0	1
Entrepreneurial	4	1	3	1	2	2
Strategic	4	1	2	0	2	1
Legal	1	0	1	1	0	1
Other	19	7	5	2	7	8
None / not specified	38	1	17	20	28	12

*FO = franchisor, FE = franchisee, CUS = customer

Table S2: Studies on outcomes of ownership structure

Design or process factor	Actor	Operationalization factor	Outcome type	Operationalization outcome	Industry	Country	Theory/ perspective	Method	Author
Plural form versus pure franchise	FO	Use of plural form	managerial effectiveness +	system-wide adaptation , uniformity	restaurant/ food	USA	agency, resource, new theory building	QL	Bradach, 1997
		Use of plural form	managerial effectiveness +/-	+uniformity, responsiveness, adaptation, efficiency, flexibility, demonstration. – conflicts, two management methods, demotivation, anxiety	food, hotel, cosmetics	FRA	theory built by Bradach 1997	QL	Cliquet, 2000
		Use of plural form	managerial effectiveness +/-	control and stimulation, strategic & managerial advantages	cosmetics	FRA	theory built by Bradach 1997	QL	Cliquet & Croizean, 2002
		Use of plural form	managerial effectiveness +	perceived benefits for insight and control	restaurant/ food	USA	signaling, resource	QN	Dant & Kaufmann, 2003
		Plural form vs predominantly pure (>70% franchised)	efficiency +	input (ranking, age, size, royalties) / output (occupancy, sales)	hotel	FRA	theory built by Bradach and Cliquet	QN	Perrigot et al., 2009
		Plural form vs predominantly pure (>75% franchised)	efficiency 0	input (costs, coverage, age) / output (sales)	hotel	FRA	price trust authority	QN	Botti et al., 2009
		Plural form use vs pure (inverted U-shape proportion)	financial +	ROA, ROA, stock	restaurant/ food	USA	agency, resource	QN	Hsu & Jang, 2009
		Plural form use vs pure (inverted U-shape proportion)	financial +	stock, ROS, ROE over 6 years	restaurant/ food	USA	diversifaction	QN	Koh et al., 2009
		Plural form use vs pure	financial +/-	stock over 10 years	restaurant/ food	USA	contingency, agency, transaction	QN	Srinivisan, 2006
		Plural form use vs pure (inverted U-shape proportion)	survival +	8-year exit franchisor	restaurant/ food, fashion	ESP	agency	QN	Bordonaba-Juste et al., 2009

Table S2: Studies on outcomes of ownership structure (continued)

Design or process factor	Actor	Operationalization factor	Outcome type	Operationalization outcome	Industry	Country	Theory/ perspective	Method	Author
Proportion	FO	Proportion franchised	growth +	no. of outlets over time	various	USA	various	QN	Shane et al., 2006
		Proportion franchised	growth +	no. of outlets added	restaurant/ food	USA	agency, resource	QN	Sen, 1998
		Proportion franchised	growth -, survival -/0	growth %, exit	various	USA, CAN		QN	Kosová & Lafontaine, 2010
		Proportion franchised	survival +/-	8-year franchisor exit	restaurant/ food, fashion	ESP	agency	QN	Bordonaba-Juste et al., 2009
		Proportion franchised	survival +/-	17-year new system survival	various	USA	institutional, economic	QN	Shane & Foo, 1999
		Proportion franchised	financial, survival +/-	sales growth, 3-year outlet discontinuance	various	ESP	agency, resource	QN	Vazquez, 2007
		Proportion franchised	financial +/-	ROA, ROA, stock	restaurant/ food	USA	agency, resource	QN	Hsu & Jang, 2009
		Proportion franchised	financial +/-	ROA/ROS	various	FRA	agency, resource	QN	Barthelemy, 2008
		Proportion franchised	financial +/-	sales, returns, stock	restaurant / food	USA	agency, resource	QN	Combs et al., 2004b
		Proportion franchised	financial +/-	sales, returns, stock	restaurant / food	USA	agency, resource	QN	Ketchen et al., 2006
		Proportion franchised	financial +/-	stock over 10 years	restaurant/ food	USA	agency, contingency	QN	Srinivasan, 2006
		Proportion franchised	financial +/-	sales growth	restaurant/ food	USA	learning, agency	QN	Sorenson & Sørensen, 2001
		Proportion franchised	customer satisfaction - financial -	guest satisfaction, rates, occupancy	hotel	USA	signaling, agency	QN	O'Neill & Mattila, 2004
		Proportion franchised	customer satisfaction - financial -	guest satisfaction, rates, occupancy	hotel	USA	agency, resource	QN	O'Neill et al., 2006

Table S2: Studies on outcomes of ownership structure (continued)

Design or process factor	Actor	Operationalization factor	Outcome type	Operationalization outcome	Industry	Country	Theory/ perspective	Method	Author
Proportion	FE	Franchise with complex strategy	financial +	sales	restaurant/ food	USA	structural contingency	QN	Yin & Zajac, 2004
		Franchise in concentrated market	financial -	revenues of unit	hotel	USA	strategic delegation	QN	Vroom & Gimeno, 2007
Multi-unit	FE	Owning more than one unit	survival +	5-year new franchisor survival	restaurant/ food, various	USA	agency	QN	Bates, 1998
		Same vs different owner	financial +	unit cost of production	restaurant/ food	USA	knowledge, learning	QN	Darr et al., 1995
	FO	Multi-unit vs single-unit	managerial effectiveness +/-	effectiveness in fulfilling managerial challenges of growth +, system adaptation +, responsiveness -, uniformity 0	restaurant/ food	USA	agency, resource	QL	Bradach, 1995
		Use of area developers and sub-franchise	growth 0	growth rate, no. projected outlets	various	USA, CAN		Mix	Clarkin & Rosa, 2005
		Use of area developers and sub-franchise	growth +	system growth rate	various	USA	agency, resource	QN	Kaufmann & Kim, 1995
		Proportion multi-unit franchisees	growth +	system growth rate	restaurant/ food	USA	agency, resource	QN	Kaufmann & Dant, 1996
		Use of sub-franchise	survival +	exit large franchisors	various	USA	efficient contracting	QN	Shane, 2001
		Use of master franchise	survival -	exit new franchisors	various	USA	agency	QN	Shane, 1998
		Use of sub-franchise	financial 0	administrative productivity	various	USA	life cycle, agency	QN	Thompson, 1994
Passive	FE	Permitting passive ownership	survival -	3-year failure % of outlets	restaurant/ food	USA	agency	QN	Michael & Combs, 2008
	FO	Permitting passive ownership	growth +	individual growth %, no. projected outlets	various	USA, CAN		Mix	Clarkin & Rosa, 2005
		Permitting passive ownership	survival -	long-term new franchisor exit	various	USA	agency	QN	Shane, 1998
		Permitting passive ownership	survival 0 / -	3-year discontinuance % of outlets (chain performance)	various	ESP	agency	QN	Vazquez, 2009

Table S3: Studies on outcomes of business format design

Design or process factor	Actor	Operationalization factor	Outcome type	Operationalization outcome	Industry	Country	Theory/ perspective	Method	Author
Positioning towards customers									
Brand name	FE	Recognizable brand name, advertising	success +	franchisee success as perceived by franchisor	various	USA, CAN, MEX	agency, resource, cross-cultural	QN	Falbe & Welsh, 1998
		Well-known brand name	satisfaction +	satisfaction with benefits	restaurant/ food	AUS		QN	Hing, 1996
		Recognizable brand name	satisfaction +	perceived advantages	various	USA, CAN		Mix	Knight, 1986
		Recognizable brand name	satisfaction +	perceived advantages	various	FIN		QN	Tuunanen & Hyrsky, 2001
		Internal brand management performance	satisfaction +	perceived value of brand	not described	AUS	marketing	QN	Pitt et al., 2003
		Availability of brand name	satisfaction +	franchise relationship benefits	not described	UK	relational marketing	QL	Watson & Johnson, 2010
		Invest in stronger brand name	survival +	3-year failure % of outlets	restaurant/ food	USA	resource	QN	Michael & Combs, 2008
	FO	Recognizable brand name	financial +	profits	various	USA, CAN	agency, plural form	QN	Gillis & Combs, 2009
		Recognizable brand name	financial, growth+	sales, profit, ROI, growth	various	AUS	agency, resource	QN	Inma & Debowski, 2006
		Recognizable brand name	survival +	long-term new franchisor exit	various	USA	agency	QN	Shane & Spell, 1998
Format facilitators									
Support : provision of support	FE	Good initial and ongoing support services	satisfaction +	overall franchisee satisfaction	education	MYS		QN	Abdullah et al., 2008
		Initial and ongoing support	satisfaction +	financial and job satisfaction	various	FRA	relational marketing	Mix	Dubost et al., 2008

Table S3: Studies on outcomes of business format design (continued)

Design or process factor	Actor	Operationalization factor	Outcome type	Operationalization outcome	Industry	Country	Theory/ perspective	Method	Author
Format facilitators									
Support : provision of support	FE	Initial and ongoing support	satisfaction+	satisfaction, remain intention	restaurant/ food	AUS	buying behavior model	QN	Hing, 1995, 1999
		Initial and ongoing support	satisfaction +	satisfaction	restaurant/ food	KOR		Mix	Roh & Yoon, 2009
		Ongoing franchisor support	satisfaction +	perceived advantages	various	FIN		QN	Tuunanen & Hyrsky, 2001
		Products & services offered to franchisee	financial +	demand, sales, reference price	food	MEX		QN	Rajagopal, 2007
	FE/FO	Provision of support	survival +	negative franchisee exit	various	AUS		QL	Frazer & Winzar, 2005
Support: extent of support	FE	Sufficient no. of support	satisfaction +	perceived problems (reversed)	various	CAN		Mix	Knight, 1984
		Sufficient no. of support	satisfaction +	perceived problems (reversed)	various	USA, CAN		Mix	Knight, 1986
		No. of support services	financial+, satisfaction +	sales, satisfaction with financials and competitiveness	various	ESP	knowledge	QN	Minguela-Rata et al., 2009
		No. of initial and ongoing support services	financial 0/+, competitive 0/+	value (importance &satisfaction) of financial recovery, competitiveness	various	ESP	knowledge	QN	Minguela-Rata et al., 2010
	FO	No. of support types, manual pages, training days. hrs start-up support	survival 0	system disruption	various	AUS	life cycle perspective	QN	Frazer, 2001a
		No. headquarters staff per outlet	survival 0	negative exit franchisees	various	AUS		QN	Frazer & Winzar, 2005
		No. headquarters staff per outlet	survival -	long-term large franchisor exit	various	USA	efficient contract	QN	Shane, 2001

Table S3: Studies on outcomes of business format design (continued)

Design or process factor	Actor	Operationalization factor	Outcome type	Operationalization outcome	Industry	Country	Theory/ perspective	Method	Author
Format facilitators									
Support: extent of support	FO	No. headquarters staff per outlet	survival -	12-year new franchisor exit	various	USA	agency	QN	Shane & Spell, 1998
		No. of support services	survival -	12-year new franchisor exit	various	USA	agency	QN	Shane & Spell ,1998
		No. of support services	survival -	long-term new franchisor exit	various	USA	agency	QN	Shane, 1998
Support: type	FE	Ready-made concept, promotion, product development, location analysis	satisfaction +	satisfaction with benefits	restaurant/ food	AUS		QN	Hing, 1996
		Marketing and management support	satisfaction +	perceived value	service, restaurants	AUS	marketing	QL	Merrilees & Frazer, 2006
		Marketing, training, representative	satisfaction +	overall satisfaction	automobile	USA	instrumentality	QN	Lusch, 1977
		Training programs	financial +	franchisee income	restaurant/ food	USA		QN	Hunt, 1973
		Initial & ongoing training (quick, simple)	financial +/0, competitive 0	value (importance &satisfaction) of financial recovery, competitiveness	various	ESP	knowledge	QN	Minguela-Rata et al., 2010
		Initial franchisee training	survival +	3-year failure % of outlets	restaurant/ food	USA	resource	QN	Michael & Combs, 2008
		Financial assistance	financial 0	franchisee income	restaurant/ food	USA		QN	Churchill & Hunt, 1973
		Type of knowledge in business format	survival +/0	10-year survival	restaurant/ food	USA	knowledge	QN	Kalnins & Mayer, 2004
	FO	Various types of services	survival +/0/-	system disruption	various	USA, DEU	agency, resource	QN	Grünhagen et al., 2008

Table S3: Studies on outcomes of business format design (continued)

Design or process factor	Actor	Operationalization factor	Outcome type	Operationalization outcome	Industry	Country	Theory/ perspective	Method	Author
Format facilitators									
Support: type	FO	Training, communication, site selection	survival +	long-term large franchisor exit	various	USA	efficient contract	QN	Shane, 2001
		Financial assistance	growth 0	growth rate, projected outlets	various	USA, CAN	entrepreneurial	Mix	Clarkin & Rosa, 2005
		Financial assistance	growth +	no. of outlets over time	various	USA	various	QN	Shane et al., 2006
		Use of advisory councils	growth 0	system growth	various	USA	entrepreneurial	Mix	Dandridge & Fable, 1994
		Use of franchisee councils	survival +/0	system disruption	various	DEU, USA	agency, resource	QN	Grünhagen et al., 2008
		council, association, arbitration, committee	growth +	3-year net change no. of units	various	USA	legal, economic	QN	Leblebici & Shalley, 1996
		Separate innovation &administration headquarters, much innovation staff	success +	success	various	USA	strategic management	QL	Yang et al., 2005
Support: quality	FE	System quality	success +	franchisee success as perceived by franchisor	various	USA, CAN, MEX	agency, resource, cross-cultural	QN	Falbe & Welsh, 1998
		Perceived system quality	satisfaction+	satisfaction, would choose again	various	AUS	various	QN	Huang & Phau, 2009
		Perceived quality of support services	satisfaction +	overall satisfaction	restaurant/ food	USA		QN	Hunt & Nevin, 1974
		Adequacy of franchisor provided services	satisfaction +	dissatisfaction (reversed)	various	USA	relational exchange, transaction cost	QN	Spinelli & Birley, 1998
		Franchisor performance on support	satisfaction +	overall satisfaction system	restaurant/ food	USA		QN	Lewis & Lambert, 1991

Table S3: Studies on outcomes of business format design (continued)

Design or process factor	Actor	Operationalization factor	Outcome type	Operationalization outcome	Industry	Country	Theory/ perspective	Method	Author
Format facilitators									
Support: quality	FE	Met expectations support	satisfaction +	franchisee job satisfaction	various	USA		QN	Morrison, 1996
Support: importance	FE	Instrumentality of assistances	satisfaction +	overall satisfaction	automobile	USA	instrumentality	QN	Lusch, 1977
		Instrumentality of assistances	satisfaction +	satisfaction	automobile	SAU	relational marketing	QN	Yavas & Habib, 1987
		Helpfulness of support	satisfaction +	satisfaction with franchise	farm implement	USA	relational marketing	QN	Michie & Sibley, 1985
Control: initial control	FO	Disclosure of earnings and sales	growth 0	growth %, projected outlets	various	USA, CAN	entrepreneurial	Mix	Clarkin & Rosa, 2005
	FO/FE	Strict selection procedure	success +	success franchisor/ franchisee	restaurant/ food	UK	resource, efficiency	QL	Morrison & Lashley, 2003
	FE	No. of initial assessment methods	satisfaction +	satisfaction, remain intention	restaurant/ food	AUS	buying behavior model	QN	Hing, 1995, 1999
		Providing disclosure information	satisfaction +	satisfaction, remain intention	restaurant/ food	AUS	buying behavior model	QN	Hing, 1995, 1999
		Providing disclosure information	satisfaction +	satisfaction	restaurant/ food	KOR		Mix	Roh & Yoon, 2009
		Providing disclosure information	satisfaction +	overall satisfaction	various	FIN		QN	Tuunanen, 2002
		Proper franchisee assessment process	satisfaction +	overall satisfaction	various	FIN		QN	Tuunanen, 2002
Control: standardized operating instructions	FE	Level of formalization (extent of rules & procedures for how to operate)	financial +	perceived & objective (sales revenue) (indirect via free-riding)	gasoline	NOR	agency, social exchange	QN	Kidwell et al., 2007

Table S3: Studies on outcomes of business format design (continued)

Design or process factor	Actor	Operationalization factor	Outcome type	Operationalization outcome	Industry	Country	Theory/ perspective	Method	Author
Format facilitators									
Control: standardized operating instructions	FE	Use of explicit practices (routines) and franchisor requirement to use them	financial +	total returns, net owner income	quick printing	USA	resource-based view	QN	Knott, 2003
		Following standard operation manual	financial +/0	profit growth	various	JPN	organizational learning	QN	Komoto, 2005
	FO	Explicit operating and conduct provisions	growth 0	system growth rate	various	USA	legal, economic	QN	Leblebici & Shalley, 1996
		Level of investment in standardized operating routines	financial +/-	profits	various	USA, CAN	resource, agency	QN	Gillis & Combs, 2009
Control: extent of decentralized decision-making	FE	Decentralized decision-making (e.g. about opening hours, purchasing, salaries)	financial +	perceived and objective (sales revenue) (indirect via free-riding)	gasoline	NOR	agency, social exchange	QN	Kidwell et al., 2007
		Decision-making discretion (e.g. no strict procedures &decision approval)	satisfaction + competitive +	overall satisfaction, perceived system competitive advantage	restaurant / food	USA	entrepreneurial, strategic	QN	Baucus et al., 1996
		Autonomy in task performance (e.g. freedom making procedures & changes)	satisfaction +	overall satisfaction with franchise arrangement	real estate brokerage	USA	organizational behavior, marketing	QN	Schul et al., 1985
		Autonomy & responsibility	satisfaction +	perceived disadvantages	various	FIN		QN	Tuunanen & Hyrsky, 2001
	FO	Centralized services (purchasing, data-processing, inventory control) (reversed)	survival +	long-term large franchisor exit	various	USA	efficient contracting	QN	Shane, 2001

Table S4: Studies on outcomes of contract design

Design or process factor	Actor	Operationalization factor	Outcome type	Operationalization outcome	Industry	Country	Theory/ perspective	Method	Author
Initial payments	FE	average non-real estate investment	survival 0	franchisee turnover/ termination	various	USA	entrepreneurial	QN	Holmberg & Morgan, 2003
		initial investment	survival -	3-year failure % of outlets	restaurant/ food	USA	agency, resource	QN	Michael & Combs, 2008
		equity invested at start-up	survival +	continue operations	various	USA		QN	Bates, 1995a, b
		start-up costs	survival +	negative franchisee exits	various	AUS		QN	Frazer & Winzar, 2005
		initial investment	satisfaction -	satisfaction with business decision	various	USA	agency	QN	Jambulingam & Nevin, 1999
		initial investment	financial +	franchisee income	restaurant/ food	USA		QN	Churchill & Hunt, 1973
	FO	cash investment	survival +	long-term exit large franchisors	various	USA	efficient contract	QN	Shane, 2001
		cash investment	survival +	long-term exit new franchisors	various	USA	agency	QN	Shane, 1998
		start-up costs	survival 0	no. of units closed in system	various	USA		QN	Castrogiovanni et al., 1993
		money needed to open outlet	survival +	17-year new franchisor exit	various	USA	institutional, economic	QN	Shane & Foo, 1999
		start-up costs franchisee	survival 0	5-year new franchisor survival	various	USA		QN	Lafontaine & Shaw, 1998
		total investment	survival 0	long-term new franchisor exit	various	USA	agency	QN	Shane, 1998
		initial investment	survival 0, growth 0	10- year survival, growth no. of outlets	various	USA	agency	QN	Shane, 1996
		start-up costs	growth +	% change in no. of units over 5 years	various	USA	agency, resource	QN	Castrogiovanni & Justis, 2002
		initial fee	growth 0	% change in no. of units over 5 years	various	USA	agency, resource	QN	Castrogiovanni & Justis, 2002

Table S4: Studies on outcomes of contract design (continued)

Design or process factor	Actor	Operationalization factor	Outcome type	Operationalization outcome	Industry	Country	Theory/ perspective	Method	Author
Initial payments	FE	average non-real estate investment	survival 0	franchisee turnover/ termination	various	USA	entrepreneurial	QN	Holmberg & Morgan, 2003
		initial investment	growth -	no. of outlets in the system over time	various	USA	various	QN	Shane et al., 2006
		capital required, initial fee	growth 0/-, survival-/0	growth %, exit from franchising	various	USA, CAN		QN	Kosová & Lafontaine, 2010
		start-up costs	financial -	profits	various	USA, CAN	agency	QN	Gillis & Combs, 2009
Ongoing payments	FE	financial attractiveness (reasonable fees, costs)	satisfaction +	overall satisfaction	education	MYS		QN	Abdullah et al., 2008
		fees	satisfaction 0/-	satisfaction, perceived as burden	various	AUS		QL	Frazer et al., 2007a
		fees, royalties	satisfaction -	satisfaction with theoretical limitations	restaurant/ food	AUS		QN	Hing, 1996
		fees	satisfaction -	dissatisfaction/ perceived problems	various	USA, CAN		Mix	Knight, 1986
		fees	satisfaction -	perceived disadvantages (reversed)	various	FIN		QN	Tuunanen & Hyrsky, 2001
		fees, royalties	financial 0/-/+	net margins	real estate	USA		QN	Benjamin et al., 2007
		royalties, advertising fees	financial -	costs, sales	real estate	USA		QN	Frew & Jud, 1986
		royalty rate	survival -	3-year failure % of outlets	restaurant/ food	USA	agency	QN	Michael & Combs, 2008
	FO	constraint contracts (high payments, length)	financial +	turnover per franchise network	various	FRA	agency	QN	Chaudey & Fadairo, 2010

Table S4: Studies on outcomes of contract design (continued)

Design or process factor	Actor	Operationalization factor	Outcome type	Operationalization outcome	Industry	Country	Theory/ perspective	Method	Author
Ongoing payments	FO	royalty rates, fees	financial 0	shareholder returns	various	USA	agency, resource	QN	Spinelli et al., 2003
		royalty rate, fee	growth 0/-	no. of outlets in the system over time	various	USA	various	QN	Shane et al., 2006
		fees, royalties	growth 0	growth in no. of outlets	various	USA	agency, labor	QN	Sen, 1993
		fees	growth +	system growth rate	restaurant/ food	USA	agency, resource	QN	Kaufmann & Dant, 1996
		fees, advertising rates	growth 0, survival 0	outlet growth, 10-year new system survival	various	USA	agency	QN	Shane, 1996
		royalty rates, advertising fee	growth +/0, survival 0/+	growth %, exit from franchising	various	USA, CAN		QN	Kosová & Lafontaine, 2010
		ongoing fixed fee	growth -/0, survival 0/-	growth %, exit from franchising	various	USA, CAN		QN	Kosová & Lafontaine, 2010
		royalty rates	survival +	long-term large system exit	various	USA	efficient contract	QN	Shane, 2001
		royalty rate	survival 0	long-term new system exit	various	USA	agency	QN	Shane, 1998
		fee & royalty growth	survival 0	17-year new franchisor exit	various	USA	institutional, economic	QN	Shane & Foo, 1999
		royalty rate, fee	survival 0	5-years survival of new franchisors	various	USA		QN	Lafontaine & Shaw, 1998
Contract length	FE	contract length	satisfaction 0	satisfaction with present franchise	pharmacy	USA		QN	Christensen & Curtiss, 1977
	FO	contract length	system growth 0	net change in no. of units	various	USA	legal, economic	QN	Leblebici & Shalley, 1996
		contract length	survival 0	long-term large system exit	various	USA	efficient contract	QN	Shane, 2001
		contract length	survival 0	exit new franchisors over multiple years	various	USA	agency	QN	Shane, 1998
		constraint contracts (long-term & high payments)	financial +	turnover per franchise network	various	FRA	agency	QN	Chaudey & Fadairo, 2008

Table S4: Studies on outcomes of contract design (continued)

Design or process factor	Actor	Operationalization factor	Outcome type	Operationalization outcome	Industry	Country	Theory/ perspective	Method	Author
Contract length	FO	contract length	financial 0	shareholder returns	various	USA	agency, resource	QN	Spinelli et al., 2003
Exclusive territories	FO	exclusive territories	survival +	exit franchising by franchisor	various	USA	transaction costs, agency	QN	Azoulay & Shane, 2001
	FE	allowing same-brand units in existing units' vicinity	financial -	franchisee revenues over 10 year period	hotel	USA		QN	Kalnins, 2004
		exclusive territories	survival +	3-year failure % of outlets	restaurant/ food	USA	agency	QN	Michael & Combs, 2008
Tying	FE	costs of prescribed supplies	satisfaction -	satisfaction with franchise limitations	restaurant/ food	AUS		QN	Hing, 1996
		central purchasing required	satisfaction +	satisfaction	restaurant/ food	KOR		Mix	Roh & Yoon, 2009
		tying, price & number tied	financial, satisfaction -	franchisee income, satisfaction with system	restaurant/ food	USA		QN	Hunt & Nevin, 1975
	FO	tying agreements	financial 0	profits	restaurant/ food	USA	economic	QN	Michael, 2000
Fairness and franchisee protection	FE	assurance (e.g. contract fairness, protection)	satisfaction +	overall satisfaction	education	MYS		QN	Abdullah et al., 2008
		procedural fairness (fairness royalties, contract, autonomy)	satisfaction +	job satisfaction, financial satisfaction	various	FRA	relational marketing	QN	Dubost et al., 2008
		perceived fairness of contract	satisfaction +	satisfaction with benefits and limitations	restaurant/ food	AUS		QN	Hing, 1996
		perceived fairness of restrictions	satisfaction +	job satisfaction	various	USA		QN	Morrison, 1996
		difficult termination, unclear	satisfaction -	perceived disadvantages	various	FIN		QN	Tuunanen & Hyrsky, 2001
		exclusionary clauses, little protection against franchisor	satisfaction -	complaining by franchisees, negative feeling	food, service,	CAN		QL	Withane, 1991

Table S5: Studies on outcomes of behavior and interaction

Design or process factor	Actor	Operationalization factor	Outcome type	Operationalization outcome	Industry	Country	Theory/ perspective	Method	Author
The relationship									
Closeness of relationship	FE	consensus on goals, values and means	satisfaction, financial, competitive +	overall satisfaction, expected financial, competitiveness	restaurant/ food	USA	entrepreneur, strategic	QN	Baucus et al., 1996
		solidarity (behavior directed toward preserving relationship)	satisfaction +	overall satisfaction	various	ESP	relational exchange	QN	Bordonaba-Juste & Polo-Redondo, 2008b
		degree of partnership (preservation, role integrity, conflict harmonization)	satisfaction, financial, competitive +	satisfaction, sales, profitability, perceived performance	hotel	USA	relational marketing	QN	Brown & Dev, 1997
		close cooperation of franchisee with franchisor	satisfaction, intention to remain +	overall satisfaction, intention to remain	various	TWN	transaction, relational exchange, conflict	QN	Huang et al., 2007
		highly cooperative relationship	satisfaction, intention to remain +	overall satisfaction, intention to remain	various	AUS	transaction, relational exchange, conflict	QN	Huang & Phau, 2009
		cooperation (achieve mutual outcomes)	satisfaction +	social and economic satisfaction	various	ESP	relational marketing	QN	Rodriguez et al., 2005
		need consideration, initiating structure	satisfaction +	satisfaction with franchise	real estate	USA	path goal theory	QN	Schul, 1987
		consideration for franchisee needs	satisfaction +	satisfaction with franchise	real estate	USA	organization behavior	QN	Schul et al., 1985
		initiating structure of franchisor	satisfaction +	satisfaction with franchise	real estate	USA	organization behavior	QN	Schul et al., 1985
		poor cooperation and mutual commitment	satisfaction -	dissatisfaction (reversed)	various	USA	rel. exchange, transaction	QN	Spinelli & Birley, 1998

Table S5: Studies on outcomes of behavior and interaction (continued)

Design or process factor	Actor	Operationalization factor	Outcome type	Operationalization outcome	Industry	Country	Theory/ perspective	Method	Author
The relationship									
Closeness of relationship	FE	unclear role integrity, solidarity, mutuality	satisfaction -	dissatisfaction (reversed)	various	USA	rel. exchange, transaction	QN	Spinelli & Birley, 1998
		interaction and cooperation frequency	financial +	sales revenue (indirect effect)	gasoline	NOR	agency, social exchange	QN	Kidwell et al., 2007
		degree of fit franchisor and franchisee	financial +	demand, sales, reference price	food	MEX		QN	Rajagopal, 2007
		franchisee embeddedness in regional cluster	financial +	sales growth	fashion, travel	DEU	soc.network, endogenous	Mix	Ehrmann & Meiseberg, 2010
	FO/FE	sensitivity, partnership, support initiatives	success+	franchisor & franchisee success	restaurant/ food	UK	resource	QL	Morrison & Lashley, 2003
		partnership, cooperation, collaboration	success +	relationship & performance	various	USA,CAN		QL	Clarkin & Rosa, 2005
	FO	partnership	success +	enduring successful relationship	not described	UK	relational marketing	QL	Watson & Johnson, 2010
		listening, mutual respect	success +	enduring successful relationship	not described	UK	relational marketing	QL	Watson & Johnson, 2010
Commitment	FE	commitment	satisfaction 0, intention to continue +, financial -	overall satisfaction, intention for long-term, financial performance	various	ESP	relational marketing	QN	Bordonaba-Juste & Polo-Redondo, 2004
		commitment	satisfaction +, intention to continue +	overall satisfaction, intention for long-term	various	ESP	relational marketing	QN	Bordonaba-Juste & Polo-Redondo, 2008[a]
		commitment	satisfaction +	overall satisfaction	various	ESP	relational exchange	QN	Bordonaba-Juste & Polo-Redondo, 2008b

Table S5: Studies on outcomes of behavior and interaction (continued)

Design or process factor	Actor	Operationalization factor	Outcome type	Operationalization outcome	Industry	Country	Theory/ perspective	Method	Author
The relationship									
Commitment	FO	commitment	satisfaction, intention continue, effectiveness +	fo satisfaction, intention remain, management & control success	various	ESP	relational marketing	QN	Bordonaba-Juste & Polo-Redondo, 2004
		commitment	satisfaction, intention to continue +	franchisor satisfaction, long-term intention	various	ESP	relational marketing	QN	Bordonaba-Juste & Polo-Redondo, 2008a
Trust	FE	trust	satisfaction +, intention to continue +, financial +	overall satisfaction, intention for long-term, financial performance	various	ESP	relational marketing	QN	Bordonaba-Juste & Polo-Redondo, 2004
		trust	satisfaction, intention to continue +/0	overall satisfaction, intention for long-term	various	ESP	relational marketing	QN	Bordonaba-Juste & Polo-Redondo, 2008a
		trust	satisfaction , intention to remain +	overall satisfaction, intention for long-term	convenient	TWN	relational marketing	QN	Chiou et al., 2004
		trust	satisfaction +	satisfaction, relationship quality	restaurant/ food	USA	relational contracting	QN	Dickey et al., 2007
		trust	satisfaction +	financial and job satisfaction	various	FRA	relational marketing	Mix	Dubost et al., 2008
	FO	trust	satisfaction, intention continue, effectiveness +	fo satisfaction, intention remain, management & control success	various	ESP	relational marketing	QN	Bordonaba-Juste & Polo-Redondo, 2004
		trust	franchisor satisfaction, intention to continue +	franchisor satisfaction, long-term intention	various	ESP	relational marketing	QN	Bordonaba-Juste & Polo-Redondo, 2008a
		investing in trust	financial +/0	profits	various	USA, CAN	resource	QN	Gillis & Combs, 2009

Table S5: Studies on outcomes of behavior and interaction (continued)

Design or process factor	Actor	Operationalization factor	Outcome type	Operationalization outcome	Industry	Country	Theory/ perspective	Method	Author
The relationship									
Communication and information exchange	FE	social interaction	satisfaction +	overall franchisee satisfaction	education	MYS		QN	Abdullah et al., 2008
		information exchange	satisfaction +	overall satisfaction	various	ESP	relational exchange	QN	Bordonaba-Juste & Polo-Redondo, 2008b
		communication	satisfaction +, intention to remain 0	overall satisfaction, intention for long-term	convenient	TWN	relational marketing	QN	Chiou et al., 2004
		franchisee communication participation	satisfaction +	financial and job satisfaction	various	FRA	relational marketing	Mix	Dubost et al., 2008
		frequent communication	satisfaction +, intention to remain +	satisfaction, remain intention	restaurant/ food	AUS		QN	Hing, 1996
		respectful information sharing, meetings, non-coercive communication	satisfaction +, intention to remain +	satisfaction, intention to remain and advocacy attention	convenience	TWN	relational marketing	QN	Lee et al., 2008
		formal and informal communication	satisfaction +/0	social +, economic satisfaction 0	various	ESP	relational marketing	QN	Rodriguez et al., 2005
		franchisee communication	success +	franchisee success as perceived by franchisor	various	USA,CAN, MEX	agency, resource, cross-cultural	QN	Falbe & Welsh, 1998
		participative communication		competitive position, satisfaction	restaurant/ food	USA	transaction, rel. exchange	QN	Gassenheimer et al., 1996
	FO	investing in knowledge-sharing routines	financial +/-	profits	various	USA, CAN	resource	QN	Gillis & Combs, 2009
		level and quality of communication	survival +	level of franchisee exits	various	AUS		QL	Frazer & Winzar, 2005

Table S5: Studies on outcomes of behavior and interaction (continued)

Design or process factor	Actor	Operationalization factor	Outcome type	Operationalization outcome	Industry	Country	Theory/ perspective	Method	Author
The relationship									
Dependence	FE	total interdependence	satisfaction +	overall satisfaction	various	ESP	relational exchange	QN	Bordonaba-Juste & Polo-Redondo, 2008b
		interdependency asymmetry	satisfaction 0	overall satisfaction	various	ESP	relational exchange	QN	Bordonaba-Juste & Polo-Redondo, 2008b
		credits provided to franchisor	satisfaction +	overall satisfaction	restaurant/ food	USA		QN	Lewis & Lambert, 1991
		franchisee financial dependence	overall performance +	performance on various aspects	restaurant/ food	USA		QN	Lewis & Lambert, 1991
Opportunism and conflict	FE	opportunistic behavior of franchisor and franchisee towards each other	competitive, satisfaction -	perceived competitive position, satisfaction system	restaurant/ food	USA	transaction, relational exchange	QN	Gassenheimer et al., 1996
		free riding behavior (opportunism)	financial -	perceived & revenues	gasoline	NOR	agency, social exchange	QN	Kidwell et al., 2007
		frequency of disagreement	financial -	ROA, asset turnover	automobile	USA		QN	Lusch, 1976
		perceived franchisor suasion tactics	financial -/0	franchisee profits -, sales 0	commercial truck	USA	agency, strategy, socio	QN	Phan et al., 1996
		conflict	satisfaction -	social and economic satisfaction	various	ESP	relational marketing	QN	Rodriguez et al., 2005
		level of conflict	satisfaction -	satisfaction with franchise	real estate	USA	path goal theory	QN	Schul, 1987
		level of conflict	satisfaction -	overall satisfaction	various	FIN		QN	Tuunanen, 2002
	FO	disputes with franchisees	survival -	franchisor discontinuance	various	AUS		QL	Frazer, 2001b
		level of conflict in system	survival -	level of franchisee exits	various	AUS		QN	Frazer & Winzar, 2005

Table S5: Studies on outcomes of behavior and interaction (continued)

Design or process factor	Actor	Operationalization factor	Outcome type	Operationalization outcome	Industry	Country	Theory/ perspective	Method	Author
Franchisor and franchisee attitude and skills									
Franchisee attitude and skills for managing a firm	FE	entrepreneurial competence, orientation	financial 0/-	sales, ROA	retail sport	NZL		QN	Fenwick & Strombom, 1998
		entrepreneurial: achievement need, internal control, ambiguity tolerance, role	satisfaction +/0	satisfaction, post-purchase intention	restaurant/ food	AUS	buying behavior model	QN	Hing, 1995, 1999
		innovative attitude (new products)	satisfaction +	satisfaction with decision	various	USA	agency	QN	Jambulingam & Nevin, 1999
		risk taking by franchisee	financial 0	total returns, net owner income	quick printing	USA	resource-based view	QN	Knott, 2003
		business risk taking	satisfaction 0	satisfaction with decision	various	USA	agency	QN	Jambulingam & Nevin, 1999
		risk taking, promotion, search info	success +	franchisee success	food, service	CAN		QL	Withane, 1991
		high marketing & management capabilities	financial +	sales turnover, profitability	restaurant/ service	AUS	marketing	QL	Merrilees & Frazer, 2006
		franchisee implementation strategy	financial+/0, satisfaction0	revenues (sales), profits	restaurant/ food	USA		QN	Parsa, 1999
		congruence franchisor power source and franchisee implementation strategy	financial +, satisfaction +	revenues, profits, satisfaction	restaurant/ food	USA		QN	Parsa, 1999

Table S5: Studies on outcomes of behavior and interaction (continued)

Design or process factor	Actor	Operationalization factor	Outcome type	Operationalization outcome	Industry	Country	Theory/ perspective	Method	Author
Franchisor and franchisee attitude and skills									
Franchisee attitude and skills for managing a firm	FE	no. of HR practices applied by franchisee	financial 0	share of wages, absenteeism	department store	NLD	HRM	QN	Brand & Croonen, 2010
		franchisee willingness and ability	financial +, success +	revenues, success, exit	service	USA		QL	Clarkin, 2008
		franchisee activities (e.g. leadership, able to explain concept)	success +	franchisee success as perceived by franchisor	various	USA,CAN, MEX	agency, resource, cross-cultural	QN	Falbe & Welsh, 1998
		management ability, willingness, success desire, family, people skills, financials	success +	franchisee as perceived by franchisor and franchisee	various	USA, CAN		Mix	Knight, 1986
		manage family, skills, energy, drive, marketing, passion, knowledge, finance	success +	successfull and failed owners	restaurant/ food	USA		QL	Parsa et al., 2005
		working full-time in business	survival +	remain in operation	various	USA		QN	Bates, 1995a, b
		driven, ambitious, confidence	financial +	sales turnover, profitability	service, food	AUS	marketing	QL	Merrilees & Frazer, 2006
		personal commitment	satisfaction +	satisfaction with decision	various	USA	agency	QN	Jambulingam & Nevin, 1999
		inappropriate skills and personality	survival -	level of franchisee exits	various	AUS		QL	Frazer & Winzar, 2005
		desire independence, disconnection system	survival -	franchisee exit	various	AUS		QL	Frazer et al., 2007a
		requiring industry experience	survival +	3 year continuance outlets %	restaurant/ food	USA	agency	QN	Michael&Combs, 2008
		prior management experience	survival 0	remain in operation	various	USA		QN	Bates, 1995a, b

Table S5: Studies on outcomes of behavior and interaction (continued)

Design or process factor	Actor	Operationalization factor	Outcome type	Operationalization outcome	Industry	Country	Theory/ perspective	Method	Author
Franchisor and franchisee attitude and skills									
Franchisee attitude and skills for managing a firm	FE	business inexperience, prior employment	survival -	level of franchisee exits	various	AUS		QL	Frazer & Winzar, 2005
		employment history, depth of research	survival 0	franchisee exit	various	AUS		QL	Frazer et al., 2007a
		prior management & business experience	success 0/+	success of franchisee (perceived)	various	USA, CAN		Mix	Knight, 1986
		previous related experience	financial 0	franchisee income	restaurant/ food	USA		QN	Hunt, 1973
		prior management experience / founder	financial 0	sales, ROA	retail sport	NZL		QN	Fenwick & Strombom, 1998
		prior management, industry experience	financial -/0	total returns, net owner income	quick printing	USA	resource-based view	QN	Knott, 2003
		experience in the industry	satisfaction, competitive 0	competitive position, satisfaction		USA	transaction, rel. exchange	QN	Gassenheimer et al., 1996
		prior self-employment	satisfaction -	perceived disadvantages	various	FIN		QN	Tuunanen & Hyrsky, 2001
		industry & managerial experience	satisfaction 0	satisfaction, remain intention		AUS	buying behavior	QN	Hing, 1995, 1999
		prior experience, self-employment	satisfaction 0	satisfaction with decision	various	USA	agency	QN	Jambulingam & Nevin, 1999
	FO	not strong work ethic franchisees	survival -	level of franchisee exits	various	AUS		QL	Frazer & Winzar, 2005
		work at minimum, non-compliant	survival -	franchisee exit	various	AUS		QL	Frazer et al., 2007a
		motivation of franchisees	success, survival +	success, failed in franchising	various	UK		QL	Watson, 2008
		requiring experience	survival +	long-term new franchisor exit	various	USA	agency	QN	Shane, 1998

Table S5: Studies on outcomes of behavior and interaction (continued)

Design or process factor	Actor	Operationalization factor	Outcome type	Operationalization outcome	Industry	Country	Theory/ perspective	Method	Author
Franchisor and franchisee attitude and skills									
Franchisor attitude and skills in managing a franchise system	FO	motivating/ monitoring/ recruitment problems	survival -	franchisor discontinuance	various	AUS		QL	Frazer, 2001b
		inability to manage, underestimation support level, difficulties recruiting	survival -	threats to franchisor survival	various	UK		QL	Kirby & Watson, 1999
		shortage of suitable applications	success -	problems experienced	various	USA, CAN		Mix	Knight, 1986
		unprepared for symbiotic interdependence	survival -	failed in franchising	various	USA, UK		QL	Stanworth et al., 2001
		management stress, difficulties recruiting	survival -, success -	failed, success in franchising	various	UK		QL	Watson, 2008
	FE	use of coercive influence strategies	satisfaction -	satisfaction, intention to dissolve	automobile	USA		QN	Frazier & Summers, 1986
		use of coercive sources (e.g. threat)	satisfaction -	satisfaction with franchise	restaurant/ food	USA		QN	Hunt & Nevin, 1974
		use of coercive influence strategies	satisfaction -	franchisee system satisfaction	automobile	USA		QN	Lusch, 1977
		use of coercive power sources	satisfaction -	overall satisfaction	farm	USA	relational marketing	QN	Michie & Sibley, 1985
		coercive influence strategies	satisfaction 0	satisfaction with franchise	automobile	SAU	relational marketing	QN	Yavas & Habib, 1987
		noncoercive influence strategies	satisfaction +	satisfaction with franchise	automobile	SAU	relational marketing	QN	Yavas & Habib, 1987
		franchisor's use of economic power	satisfaction - financial 0	overall satisfaction, income	restaurant/ food	USA		QN	Parsa, 1996
		franchisor's use of economic power	financial -, satisfaction -	revenues, profits, satisfaction	restaurant/ food	USA		QN	Parsa, 1999

Table S6: Studies on outcomes of franchisor and franchisee age and size

Factor	Actor	Operationalization factor	Outcome type	Operationalization outcome	Industry	Country	Theory/ perspective	Method	Author
Franchisor and franchisee size									
Initial system size	FO	outlet no. at franchise start	survival 0	franchisor exit	various	USA	transaction, agency	QN	Azoulay & Shane, 2001
		outlet no. at franchise start	survival 0	new franchisor 5-year survival	various	USA		QN	Lafontaine & Shaw, 1998
		outlet no. at franchise start	growth, survival 0	outlet growth, 10-year survival	various	USA	agency	QN	Shane, 1996
Franchise system size	FO	no. of outlets in chain	financial -	shareholder returns	various	USA	agency, resource	QN	Spinelli et al., 2003
		no. of outlets in chain	financial +	profits	various	USA, CAN	agency, plural form	QN	Gillis & Combs, 2009
		no. of rooms	financial +	occupancy level (sales)	hotel	USA	signaling, agency	QN	O'Neill & Mattila, 2004
		total assets of system	financial +	ROE, ROA, stock	restaurant/ food	USA	agency, resource	QN	Hsu & Jang, 2009
		log of sales	financial +	ROS, ROE, stock	restaurant/ food	USA	diversification	QN	Koh et al., 2009
		growers vs three other groups	financial, growth +	sales, profit, ROI, growth	various	AUS	agency, resource	QN	Inma & Debowski, 2006
		no. of outlets in chain	growth 0	3 year change in no. of units	various	USA	legal, economic	QN	Leblebici & Shalley, 1996
		no. of outlets	growth -, survival -/0	growth %, exit over 21 year	various	USA, CAN		QN	Kosová & Lafontaine, 2010
		no. of outlets in chain	survival -	system disruption	various	AUS	life cycle	QN	Frazer, 2001a
		no. of outlets in chain	survival -	negative franchisee exits	various	AUS		QN	Frazer & Winzar, 2005
		no. of outlets in chain	survival +	3 year continuance outlets %	various	ESP	agency, resource	QN	Vazquez, 2007, 2009
		no. of outlets in chain	survival +	17-year new franchisor exit	various	USA	institutional, economic	QN	Shane & Foo, 1999

Table S6: Studies on outcomes of franchisor and franchisee age and size (continued)

Factor	Actor	Operationalization factor	Outcome type	Operationalization outcome	Industry	Country	Theory/ perspective	Method	Author
Franchisor and franchisee size									
Franchise system size	FO	no. of units in chain	survival +	long-term exit large systems	various	USA	efficient contract	QN	Shane, 2001
		no. of outlets in chain	survival +	long-term exit new franchisors	various	USA	agency	QN	Shane & Spell, 1998
		no. of outlets in chain & state	survival +	long-term exit new franchisors	various	USA	agency	QN	Shane, 1998
		no. of outlets in chain	survival 0	no. of units closed in system	various	USA		QN	Castrogiovanni et al., 1993
		no. of outlets	survival 0	8 year exit	restaurant/ food	ESP	agency	QN	Bordonaba-Juste et al., 2009
Franchisee firm size	FE	store size (sales revenues t-1)	financial -	sales	restaurant/ food	USA	contingency	QN	Yin & Zajac, 2004
		square feet	financial 0	returns, total income	quick printing	USA	resource-based view	QN	Knott, 2003
		no. of employees	financial 0	sales growth	fashion, travel	DEU	social network, endogenous	Mix	Ehrmann & Meiseberg, 2010
		no. of employees	financial +	share of wages, absenteeism	department store	NLD	HRM	QN	Brand & Croonen, 2010
		no. of employees	financial +	sales	real estate	USA		QN	Frew & Jud, 1986
		no. of employees	financial +	revenues	real estate	USA		QN	Benjamin et al., 2007
		no. of units owned	financial +	franchisee income	restaurant/ food	USA		QN	Churchill & Hunt, 1973
		no. of units	satisfaction -	dissatisfaction (reversed)	various	USA	relational exchange, transaction costs	QN	Spinelli & Birley, 1998

Table S6: Studies on outcomes of franchisor and franchisee age and size (continued)

Factor	Actor	Operationalization factor	Outcome type	Operationalization outcome	Industry	Country	Theory/ perspective	Method	Author
Franchisor and franchisee size									
Franchisee firm size	FE	no. of units owned	satisfaction 0, competitive 0	satisfaction system, perceived competitive position	restaurant/ food	USA	transaction cost, relational exchange	QN	Gassenheimer et al., 1996
		no. of units owned	survival +	ownership turnover of unit	restaurant/ food	USA		QN	Parsa et al., 2005
		no. of employees	survival +	remain in operation	various	USA		QN	Bates, 1995a, b
Franchisor and franchisee age									
Initial system age	FO	chain age at franchise start	growth, survival 0	outlet growth, 10-year survival	various	USA	agency	QN	Shane, 1996
		no. of years experience at start	growth+, survival +	growth %, exit from franchising	various	USA, CAN		QN	Kosová & Lafontaine, 2010
		chain age at franchise start	survival 0	franchisor exit	various	USA	transaction, agency	QN	Azoulay & Shane, 2001
		no. of years experience at start	survival +	franchisor exit over 8 years	restaurant/ food	ESP	agency	QN	Bordonaba-Juste et al., 2009
		chain age at franchise start	survival +	new franchisor 5-year survival	various	USA		QN	Lafontaine & Shaw, 1998
		piloting of concept	success +	new systems' success chance	various	UK	resource	QL	Stanworth et al., 2004
Franchise system age	FE	franchising experience	survival 0	3-year proportion failed outlets	restaurant/ food	USA	agency, resource	QN	Michael & Combs, 2008
	FO	length of time in franchising	survival 0	turnover of units	various	USA		QN	Holmberg & Morgan, 2003
		long time in franchise vs enduring company start or rapid franchise start	financial -	Z-score (profits, assets, liability in equation)	restaurant/ food	USA		QN	Price, 1993

Table S6: Studies on outcomes of franchisor and franchisee age and size (continued)

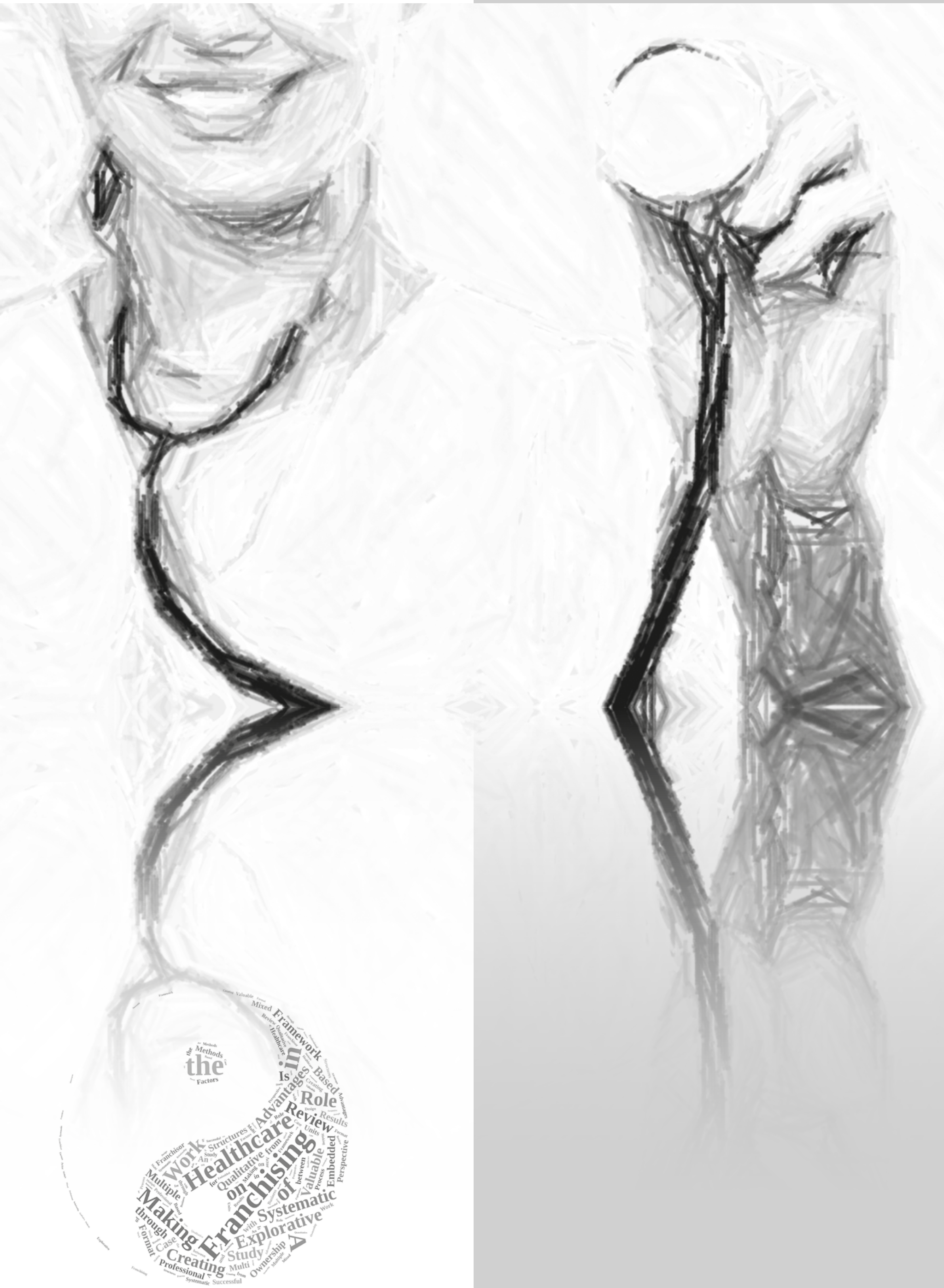
Factor	Actor	Operationalization factor	Outcome type	Operationalization outcome	Industry	Country	Theory/ perspective	Method	Author
Franchisor and franchisee age									
Franchise system age	FO	age of network	financial +	turnover per network	various	FRA	agency	QN	Chaudey & Fadairo, 2008, 2010
		franchising experience	financial +	administrative productivity	various	USA	life cycle, agency	QN	Thompson, 1994
		tenure of CEO	financial +	shareholder returns	various	USA	agency, resource	QN	Spinelli et al., 2003
		no. of years in franchising	financial 0/+	ROS/ROE: +/0, stock: 0	restaurant/ food	USA		QN	Koh et al., 2009
		no. of years in franchising	financial -	sales growth	restaurant/ food	USA	learning, agency	QN	Sorenson & Sørensen, 2001
		matures vs three other groups	financial, growth -	sales, profit, ROI, growth	various	AUS	agency, resource	QN	Inma & Debowski, 2006
		no. of years in franchising	growth -	5 year % change in no. outlets	various	USA	resource, agency	QN	
		no. of years in franchising	growth 0	3 year change in no. of units	various	USA	legal, economic	QN	Leblebici & Shalley, 1996
		no. of years	growth 0	system growth rate	restaurant/ food	USA	agency, resource	QN	Kaufmann & Dant, 1996
		no. of years in franchising & in business	growth -, survival +	growth %, exit from franchising	various	USA, CAN		QN	Kosová & Lafontaine, 2010
		no. of years in franchise	survival -	system disruption (reversed)	various	AUS	life cycle	QN	Frazer, 2001a
		no. of years in franchise	survival -	no. of units closed in system	various	USA		QN	Castrogiovanni et al., 1993
		no. of years franchising	survival +	17 year exit new franchisor	various	USA	institutional, economic	QN	Shane & Foo, 1999
		no. of years since start	survival +	long-term exit large systems	various	USA	efficient contract	QN	Shane, 2001

Table S6: Studies on outcomes of franchisor and franchisee age and size (continued)

Factor	Actor	Operationalization factor	Outcome type	Operationalization outcome	Industry	Country	Theory/ perspective	Method	Author
Franchisor and franchisee age									
Franchise system age	FO	no. of years since start	survival +	long-term exit new systems	various	USA	agency	QN	Shane, 1998
		chain age	survival +	3 year continuance outlets %	various	ESP	agency, resource	QN	Vazquez, 2007, 2009
		no. of years with franchisees	survival 0	negative franchisee exits	various	AUS		QN	Frazer & Winzar, 2005
Franchisee firm age	FE	no. of years in the system	competitive +	perceived competitive position of system	restaurant/ food	USA	transaction cost, relational exchange	QN	Gassenheimer et al., 1996
		no. of years in system	competitive, financial -	perceived competitive advantage, financial perform.	restaurant/ food	USA		QN	Baucus et al., 1996
		months since opening	financial -	profit growth	various	JPN	organization learning	QN	Komoto, 2005
		no. of years store existence	financial -	sales	restaurant/ food	USA	contingency	QN	Yin & Zajac, 2004
		no. of years firm existence	financial +	revenues	real estate	USA		QN	Benjamin et al., 2007
		no. years since present form	financial 0	sales, ROA	retail sport	NZL		QN	Fenwick & Strombom, 1998
		no. of years firm existence	financial 0	returns, total income	quick printing	USA	resource-based view	QN	Knott, 2003
		no. of years firm existence	financial 0	sales growth	fashion, travel	DEU	social network, endogenous	Mix	Ehrmann & Meiseberg, 2010
		degree production experience	financial +	unit cost production	restaurant/ food	USA	knowledge, learning	QN	Darr et al., 1995

Table S6: Studies on outcomes of franchisor and franchisee age and size (continued)

Factor	Actor	Operationalization factor	Outcome type	Operationalization outcome	Industry	Country	Theory/ perspective	Method	Author
Franchisor and franchisee age									
Franchisee firm age	FE	time in weeks	financial 0	unit cost production	restaurant/ food	USA	knowledge, learning	QN	Darr et al., 1995
		no. of years in the system	satisfaction 0	satisfaction system	restaurant/ food	USA	transaction costs, relational exchange	QN	Gassenheimer et al., 1996
		no. of years firm existence	satisfaction 0	satisfaction with business decision	various	USA	agency	QN	Jambulingam & Nevin, 1999
		no. of years in system	satisfaction -	value perceptions	restaurant/ food	USA	relational exchange	QN	Grünhagen & Dorsch, 2003
		no. of years in system	satisfaction -	perceived advantages	various	FIN		QN	Tuunanen & Hyrsky, 2001
		no. of years firm existence	survival +	discontinue operations	various	USA		QN	Bates, 1995a, b
		no. of years firm existence	survival +	ownership turnover of unit	restaurant/ food	USA		QN	Parsa et al., 2005
		no. of years firm existence	survival 0	10-year survival	restaurant/ food	USA	knowledge	QN	Kalnins & Mayer, 2004
		conversion: purchase existing unit from previous owner	survival -	remain in operation	restaurant/ food, various	USA	agency	QN	Bates, 1998


Franchising
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Making
Systematic
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Framework
Advantages
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Chapter 4

Creating Advantages through Franchising in Healthcare: A Qualitative, Multiple Embedded Case Study on the Role of the Business Format

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Abstract

Background. Business format franchising is an organizational form that originates from the business sector. It is increasingly used in healthcare, being a promising organizational form for improving the competitiveness and efficiency of organizations, the quality of care, and the professional work environment. However, evidence is lacking concerning how these healthcare franchises should be designed to actually deliver the promised benefits. This study explores how the design of the central element in franchising, the business format (i.e., brand name, support systems, specification of the products and services), helps or hinders the achievement of positive results.

Methods. A qualitative comparative embedded case study was conducted. The cases focused on three Dutch healthcare franchises providing mental healthcare, hospital care and care for the intellectually disabled. The data were collected through document analyses, observations, and 96 in-depth, semi-structured interviews with franchisors and unit actors (franchisees, unit managers, professionals). The interviews were recorded and transcribed verbatim. A conceptual model based on a systematic review of studies in other industries was used as an initial method for coding the data. New inductive codes were used to enrich and extend the analysis. The data were subjected to within-case and cross-case comparative thematic analyses.

Results. Different business format designs have different effects on results, as perceived by franchisors and unit actors. The analysis revealed how this variation in perceived effects can be explained by different dynamics with regard to system-wide adaptation, local adaptation, professionals' resistance to change, ease of knowledge sharing, bureaucracy, overhead, uniform brand presentation, accelerating effects and reliable performance levels. The analysis resulted in a new typology of four types of business formats, showing how combinations of business format elements facilitate or hinder the achievement of different types of results.

Conclusions. Practitioners using healthcare franchising as a model to improve client-related, strategic, organizational and professional results should carefully consider how to design their business format in order to facilitate the achievement of desired results. The developed typology can be used as a starting point for these practitioners and as a basis for future scholarly research. Further quantitative research is recommended to confirm the results.

Introduction

The organizational model of franchising is increasingly applied by healthcare organizations to overcome challenges such as increasing competition (Cutler, 2002), rising expenditures (Berwick and Hackbarth, 2012), deficiencies in quality of care (IOM, 2001), poor diffusion of innovations (Nembhard et al., 2009) and unsatisfied professionals (Gigantesco et al., 2003). Franchising originates from trade and industry and involves a contractual arrangement between two firms: the franchisor and the franchisee. The franchisee buys the right to provide health care services with the use of the franchisor's business format (Blair & Lafontaine, 2005). The business format consists of a brand name, support systems, and specification of the products and services that need to be delivered (Falbe & Welsh, 1998; Komoto, 2005). Franchisees deliver services at locations close to clients while being supported with tried-and-tested practices, knowledge sharing facilities, and other operational and management support as described in the business format (Christensen & Curtiss, 1977; Hogan et al., 2006; Montagu, 2002). In some franchise systems, certain units are owned by the franchisor and operated by employed managers who use the same business format as franchisees. Currently, in the USA, there are at least 35 healthcare franchises in sectors such as elderly and home care, eye and hearing care, (para)medical care, and mental health care[1], 21 in the Netherlands, and 15 in both the UK[2] and Canada.[3] Fifty-three social healthcare franchises in various Asian and African countries were documented in 2011 (Schlein & Montagu, 2012).

Those who start operating a healthcare franchise expect it to be a successful model, either for commercial or social reasons. Two types of franchises are used in which actors partially have similar expectations. The first is a model with small-scale independent entrepreneurs (i.e., a stand-alone model) (Stephenson et al., 2004). In developed countries, this type is often used as an alternative to large bureaucratic healthcare organizations. Actors expect that the combination of local entrepreneurship and support through the business format stimulates the professional satisfaction, efficiency and quality of care. This is thought to be achieved by restoring the autonomy of professionals in care provision while supporting them with effective practices and developed innovations (Hogan et al., 2006; Montagu, 2002). Additionally, providers expect that the shared positioning with a brand name and clearly defined services may assist in the creation of competitive advantages (Knott et al., 2008; Agha et al., 2007b). In the second type of model, existing organizations become a franchisee for part of their

1 http://www.entrepreneur.com/franchises/healthcare/indexhlth.html, http://www.bison.com/Healthcare_Franchises, http://www.franchisedirect.com/healthcareseniorcarefranchises/15 retrieved 24 May 2013

2 http://www.franchisesales.co.uk/search/care-services-franchise-health-care-franchises, http://www.franchisedirect.co.uk/carefranchises/175, retrieved 24 May 2013

3 http://canada.franchisesales.com/search/health-care-franchise-2, http://canada.franchisesales.com/search/care-franchise 24 May 2013

care services (i.e., fractional model). Franchisees who choose this model also expect to improve their competitive position, quality of care, efficiency, financial performance and professional work environment. They expect to achieve these results through proven practices from the business format, the operational support (Christensen & Curtiss, 1977), the shared branding (Agha et al., 2007b), the possibilities for knowledge sharing and development (Knott et al., 2008; Agha et al., 2007b), and the access to innovations originating from the franchisor and other franchisees (Knott et al., 2008).

However, difficulties may also arise. Franchising requires uniformity to achieve economies of scale and to build a strong brand name. This can reduce professionals' autonomy and decrease their work satisfaction or the quality of care for customized services (Montagu, 2002). Moreover, professionals can misuse their powerful roles to resist the implementation of certain business format elements that are necessary to reach competitive advantage and efficiency but are not in the professionals' interests (Montagu, 2002). Controlling the quality of services provided by professionals may also be difficult for the franchisor because he may lack the specialized knowledge to do so, yet the system's reputation depends on the quality of services provided (Knott et al., 2008; Montagu, 2002).

Although increasingly pursued, healthcare franchising seems to produce varying results. Both positive (Christensen & Curtiss, 1977; Agha et al., 2007a; Evans et al., 2009; Ngo et al., 2009, 2010) and negative outcomes (Christensen & Curtiss, 1977; Evans et al., 2009; Shah et al., 2011) have been found for clients, professionals and organizations in both developed and developing countries. Determining what accounts for these differing results is becoming increasingly important, as interest in franchising is growing. A recent systematic review showed that studies on this issue in healthcare are scarce (Nijmeijer, Fabbricotti & Huijsman, 2014a). However, studies in other industries have indicated that variations in the business format design between franchises explain the varying results across franchises. The business format influences results across franchises because it defines what support units receive (Grünhagen et al., 2008; Tuunanen and Hyrsky, 2001), how much control they experience (Gillis & Combs, 2009; Knott, 2003) and how strong the brand name is (Gillis & Combs, 2009; Tuunanen & Hyrsky, 2001). The question is whether these findings will apply to healthcare as well. We therefore empirically explore the following question: *How is the business format design perceived to facilitate or hinder the achievement of positive results with franchising, and why?*

Objectives of the study

This study aims to contribute to the knowledge on how the organizational model of franchising can be effectively applied in healthcare. To this end, we qualitatively explore the views of franchisors and unit actors (franchisees, professionals, unit

managers) regarding the help or hindrance of their business format design – a key element in franchising – in realizing strategic, organizational, professional and client-related results. We explore their experienced relationship between the design of business format elements and the achievement of results and their explanations for the perceived relationship. The analysis provides in-depth insight regarding which designs of a business format are likely to promote positive results and which other structural, strategic and behavioral decisions may have to be made in the franchise system to ensure that the desired results are achieved. We integrate our findings in a model that can be used as a starting point by franchise practitioners and as a basis for future research.

Conceptual model to explore the role of the business format in healthcare franchises

A systematic analysis of studies that have investigated the influence of the business format in other sectors (see systematic review of Nijmeijer, Fabbricotti & Huijsman, 2014b, p. 8-10 for a detailed overview) have indicated that multiple business format elements affect the achievement of results. We used these insights to build a conceptual foundation for exploring the role of the business format in healthcare.

Insights from other sectors show that the design of two business format components influences the results achieved within franchises. The first is the 'front' of the business format, which constitutes elements related to the positioning toward customers (Kaufmann & Eroglu, 1998). The positioning toward customers comprises the brand name strength and the franchise concept, which includes the collection of the attributes of the products and services of the franchise and the presentation thereof (Kaufmann & Eroglu, 1998). This component determines the attractiveness of the business format to customers (Kaufmann & Eroglu, 1998) and has been shown to be important for realizing positive strategic and organizational results for franchisors (Gillis & Combs, 2009) and franchisees (Michael & Combs, 2009; Hing, 1996).

The second component is the 'back' of the business format and comprises the format facilitators. These are the operating and management structures that aim to ensure that unit actors deliver the services in their units as defined in the positioning component and to build a strong brand name (Kaufmann & Eroglu, 1998). Studies in other sectors have shown that the design of two types of facilitators influences results: support services and control systems. Support services include elements that assist unit actors in starting up and operating a unit (e.g., training). Control includes the specifications and limitations from the franchisor to ensure that unit actors behave as deemed necessary (e.g., rules on client contact).

Studies have indicated that design differences in the type, amount and quality of support services are a major reason for varying results across franchise systems. First, support services only positively affect results if they are of sufficient quality because low-quality support is less helpful (Lewis & Lambert, 1991). Second, only those franchisors that provide appropriate types of support positively affect their own strategic and organizational results (Grünhagen et al., 2008; Shane et al., 2006) and as well as the franchisees' satisfaction and performance (Michael & Combs, 2008; Merrilees & Frazer, 2006). The types of support that are appropriate to franchisees partially depend on what the franchisees want or need. For example, Merrilees and Frazer (2006) found that marketing support was appropriate to promote results for higher-performing franchisees, whereas training and operational management support were more appropriate for younger and lower-performing franchisees. Third, studies showed that results across franchises vary because of differences in the amount of support provided. While extensive support can benefit franchisee results (Minguela-Rata et al., 2009), it can have negative effects for franchisors, supposedly because developing and providing extensive support is expensive and labor-intensive (Shane, 1998).

Studies have indicated that differences in control levels are another reason for varying results across franchises. The design of three control elements was found to affect results: the selection of franchisees, the level of standardization and the level of centralized decision-making. First, studies have shown that the use of ample information and assessment methods to select franchisees with the right attitudes and expectations reduces the likelihood of unsatisfied franchisees who will quickly abandon the franchise (Tuunanen, 2002) and increases success (Morrison & Lashley, 2003). However, such strict selection can hinder rapid growth in system size (Clarkin & Rosa, 2005). Second, studies have shown that greater use of standardized operating instructions has financial benefits for franchisees, presumably because these steer them toward the tried-and-tested practices of the franchisor and to act in the interests of the clients and the entire system (Kidwell et al., 2007; Knott, 2003). However, standardization may only be beneficial in the first contract years. In later years, franchisees' adaptation to the local context may be more beneficial (Komoto, 2005). For franchisors, greater standardization may also have negative effects, as it can undermine the franchisees' innovation efforts (Gillis & Combs, 2009). Third, more centralization may be positive for a franchisor (Shane, 2001), while franchisees may benefit more when decision-making is more decentralized (Kidwell et al., 2007; Baucus et al., 1996) because it reduces opportunistic behavior (Kidwell et al., 2007).

Methods

Research design

We conducted a qualitative multiple embedded case study. Several cases were investigated at several levels of analysis (Yin, 2003). The levels of analysis included both the franchisor level and the unit level, as research has shown that studying both is necessary to fully understand the processes and results created within franchise systems (Elango & Fried, 1997). Qualitative research enabled us to explore these franchises in-depth and build a theory of *how* and *why* different business format elements are perceived to affect the achievement of results in a rarely investigated organizational form in healthcare – a franchise. The use of three franchise systems in three different healthcare sectors enabled us to confirm our findings (replication) and to identify diverging patterns across settings, thereby reaching more explanatory power and generalizability (Yin, 2003; Eisenhardt, 1989; Halinen & Törnroos, 2005). Within-case comparisons further enhanced the validity (Yin, 2003). A conceptual model was used to focus attention on particular themes, to achieve a deeper analysis of an unexplored phenomenon and to extend theory (Yin, 2003).

Research setting

We conducted our study in the Netherlands, where approximately 21 healthcare franchises exist. Depending on the service provided, the franchises are reimbursed through (compulsory social) health insurance or private payments. Franchises providing hospital care, in-patient mental health care and in-patient long-term care for the disabled, youth and elderly are prohibited from working for-profit under Dutch law. Franchises providing other types of care officially can work for-profit, but many of them still do not have profit-making as their ultimate or only goal. Franchising is often used to improve quality, costs, and the work environment of care professionals.

Our cases were theoretically sampled as is recommended for a multiple case study (Patton, 1990). First, we chose franchises providing different types of healthcare because scholars have theoretically assumed that this difference may play a role in how the business format is designed, the behavior of actors and the experienced results (Montagu, 2002). Second, we selected systems with existing organizations as franchisees (fractional model) and systems that started-up with individual entrepreneurs (stand-alone model) because it has been hypothesized that the existing work methods, culture and involvement of a larger-scale organization in a fractional model may lead to different requirements and effects of support and control in the business format (Agha et al., 2007b). We only used cases that had operated for at least three years and that were willing to share their sensitive insights.

Table 1: Description of cases

	System 1	System 2	System 3
Background information			
Service	Mental healthcare	Hospital care (eye-care)	Care for the intellectually disabled
Year of establishment	2004	Franchise since 2007, system started in 2003	2003
Motive for franchising	Gain stronger position in more competitive market through high-quality, efficient care	Gain stronger position through provision of high-quality, efficient care in increasingly competitive market	Founded by a father who was highly dissatisfied with the quality of regular care for his intellectually disabled son
Type of franchise	Fractional: a portion of the care delivery of mental healthcare organizations is franchised.	Fractional: eye care departments of general hospitals are franchised.	Stand-alone: two care professionals operate a small-scale full-time living facility.
Number of units	26, owned by 4 franchisees. Units are daily operated by employed managers.	14, of which 11 franchised and 3 owned by the franchisor	107, of which 99 franchised and 8 owned by the franchisor
Payment method of care provided in units	(Obligatory) health insurance reimbursement, complemented with personal contribution of clients.	(Obligatory) health insurance reimbursement, complemented with personal contribution of clients	Personal budget of clients provided by governmental regional care offices following the Exceptional Medical Expenses Act
Contractual payments	All franchisees are shareholder of the franchise. All costs are proportionally divided and paid.	Fixed initial fee for quick scan/research before joining franchise. Ongoing annual fee comprising fixed base fee + variable fee per FTE ophthalmologist.	Fixed initial fee and fixed annual ongoing fee.
Business format: positioning			
Positioning toward customers	Specialized evidence-based ambulatory care provision to adults with an optimistic approach visible through office-like interiors, a specialized focus and excellent accessibility	Providing the entire spectrum of ophthalmology care in an excellent manner through regional and national cooperation, competent people, hospitable attitude, modern and smooth operations, and fine communication.	Providing care and living in a small-scale beautiful house with family-like atmosphere where disabled individuals can live as normal a life as possible with ample opportunities to do pleasant activities and receive love and attention

Table 1: Description of cases (continued)

	System 1	System 2	System 3
Business format: support services			
Support services provided to units	Branding, logo, website, folders, intranet, shared access system, operations manual (process improvement), routine outcome measurement (measure client progress), benchmarking, training, knowledge sharing / development structures	Branding, logo, intranet, website, publicity, frequent advisory support of franchisor representative to implement the operations manual with many ideas about process improvement, benchmarking, training, possibilities for shared purchasing, structures for knowledge sharing / development	Branding, logo, intranet, website, other publicity, facilitation of care building, facilitation of a loan, administration system, benchmarking, initial training, advisory support/coaching, lobby government, structures for knowledge sharing / development
Business format: level of control			
Initial control	Low	Low to medium	Medium, initially low

Level of standardized operating instructions in the franchise	• Care processes: medium to high
	  ○ fixed treatment programs, standardized intake (became looser), standardized pathways in treatment programs
	• Non-care processes: medium to high (became looser)
		• Care processes: low, moving to medium
		  ○ Protocols of professional bodies; currently works on certification of care pathways (e.g., which treatments, control moments)
		• Non-care processes: low, tries to move to medium
			• Care processes: low to medium
			  ○ standardization of some boundary conditions: no. of customers allowed; guidelines about day-time care, medication lists, fixation
			• Non-care processes: medium

Level of centralized decision-making	• Care: now low on franchisee level (four franchisees are together franchisor), was more centralized at start), low-medium centralized from unit perspective • Non-care: now medium centralized from unit perspective; level differs per franchisee.	• Care: low • Non-care: relatively low (almost all aspects that impact the franchisees are decided in consultation or by the hospital)	• Care: low • Non-care: medium

The selected franchises provide mental healthcare (system 1), hospital eye-care (system 2) and care for the intellectually disabled (system 3). A description of the cases regarding the elements of interest in this study is provided in Table 1. As shown in this table, system 1 and 2 both started franchising to obtain a stronger positioning in a market that became increasingly competitive as a consequence of changing policies and regulations by the Dutch government. They also aimed to improve the quality and efficiency of care in existing organizations, both for idealistic and competitively instrumental reasons. Under Dutch law, both systems are obliged to work not-for-profit. System 3 was founded to provide a qualitatively better alternative to regular care for the intellectually disabled. The system officially is a for-profit system.

Data collection

The data were collected through semi-structured interviews, observations, and document analyses. These methods were used complementarily and improved validity through data triangulation (Yin, 2003; Eisenhardt, 1989). Interviews were appropriate for gathering rich data about the actual design of the business format elements and the dynamics underlying their effects, as we could ask for experiences, perceptions and feelings (Patton, 1990). To limit bias and acquire a representative overview, we purposively selected our interviewees based on characteristics that were shown to affect behavior and experienced results in prior research. Franchisor representatives with different functions were selected, as were units with varying ages (experience in the system) and operating in different geographical regions. Within each of the units, respondents with different functions were interviewed. All of the units and individuals who were selected for an interview were willing to participate; thus, selection bias is unlikely. A total of 96 interviews with 87 respondents (24 franchisor representatives, 37 professionals, 55 franchisee representatives, 14 company-owned managers; some respondents had two roles) were conducted between 2009 and 2012. Some respondents were interviewed more than once to obtain additional information and to check for developments over time.

A predetermined topic list based on the conceptual model was used during the interviews to increase the reliability and validity (see Table 2). The interviews lasted 1.5 hours on average and were recorded and transcribed verbatim. Documents were analyzed to prepare the interviews and to complement and triangulate the interview findings. Observations of meetings and daily practice were used to stimulate new lines of inquiry, to triangulate, and to obtain additional insights by observing the effects of the control and support elements in practice (e.g., discussion about the benefits of more control). During the observations and document analyses, the topic list from the interviews was used to ensure consistency.

Table 2: Topic list used in the interviews, observations, and document analyses

1) experienced results of franchising;
2) perceived contribution of their business format design, and more specifically: a) franchise concept, b) the brand name, c) perceived quality, type, amount of support, d) level of control (selection, standardization, decision-making rights), and – if relevant – the reason for choosing these designs;
3) dynamics that result from these designs that explain the perceived effect;
4) other aspects that lead to differing results despite using the same business format.

This study took a managerial and organizational perspective. Neither ethical approval of an Institutional Review Board nor written informed consent was required for this study according to the Dutch relevant legislation (law on medical scientific research with people (WMO), formal criteria Erasmus Medical Ethical committee[4]) because no medical data were used and patients were not involved in any way.

Data analysis

The data were thematically analyzed. Themes were derived both deductively, using the theory from other industries, and inductively. We started by connecting deductively derived codes to the data. We subsequently refined the analyses by inductively applying new codes. We then used within-case comparison techniques to enrich and deepen the analyses. The consequent analysis was written down per case in a case report that was member-checked with case representatives to verify, adapt and complement the analysis. We then searched for consistent and distinct patterns among the three cases to further develop the analyses (Eisenhardt & Graebner, 2007; Miles & Huberman, 1994). To verify and complement the analyses, the results of the between-case comparisons were member-checked in an advisory board meeting with representatives of all of the cases.

Results

We first describe how the actors in the case study systems perceive their business format design to affect their achievement of positive results with franchising overall. We then analyze how actors feel that their pursued positioning, support services and level of control contribute to these experienced effects, as well as what dynamics explain these perceived effects.

4 http://www.erasmusmc.nl/commissies-cs/metc-cs/573270/reikwijdte [in Dutch]

The experienced effects of the business format design in healthcare franchising

Consistent with differences in the design of the business format of the three case study systems, actors across systems differ in their perceptions of how their business format contributes to the achievement of positive results with franchising. Generally, the actors feel that their business format mainly either stimulates the achievement of positive results or has no impact. Only some perceive that the design of their business format hinders their financial performance, as well as the quality of care and work satisfaction in one system (see Table 3).

Table 3: Perceived influence of the business format on the achievement of various results within franchises over time*

Franchise system	Actor	Competitive advantage	Financial performance & efficiency	Survival	Growth	Quality of care	Work satisfaction
1	Franchisee and manager	+/0	+/0/-	+/0	+	+/0/-	+/0/-
	Professional	+/0	+/0	0	n.a.	+/0/-	+/0/-
2	Franchisor	+	First years: -, now: +	+	+	+	n.a.
	Franchisee and manager	+/0	+/0/-	+/0	n.a.	+	+/0
	Professional	+/0	+/0	+/0	n.a.	+	+/0
3	Franchisor	+	First years: -, now: +	+	+	+	n.a.
	Franchisee and manager	+	+/0/-	+	n.a.	+	+/0
	Professional	0	0	0	n.a.	+	+/0

* see table 1 for a description of the design of the business format of each of the cases
+ = perceived as facilitating to achieve this result type, - = perceived as hindering to achieve this result type, 0 = no perceived effect on the achievement of this result type. In determining the score, the focus was on shared agreements and disagreements. When respondents within the same actor-group varied in their opinion or when all respondents reported both positive and negative effects, a +/- sign was assigned.

As can be expected, franchisors primarily perceive positive effects of their business format design in achieving the types of results important to them: growth, competitive advantage, survival, quality of care, and financial performance after the initial years of establishment. Franchisees perceive stimulating effects as well, but they also see more negative or lack of effects. The franchisees in system 3 – who, in contrast to the other systems, all started a new unit with the use of the business format – are the most positive overall. Except for work satisfaction, for which some experience no effect, and for financial performance, for which some observe no or a hindering effect, the franchisees

report experiencing only stimulating effects of their business format in achieving positive results. Some of the franchisees of system 2 – who engage the business format as an "additional tool" in their organization – also do not see a contribution to their competitive advantage and survival. The same applies to system 1, but here, some also perceive a hindering effect on achieving a high quality and work satisfaction, mainly during the initial years of the establishment of the franchise. Unit managers and professionals primarily perceive similar effects as the franchisees. This is not surprising as they work with the same business format and many professionals also fulfill a role as franchisee or unit manager. Therefore, we use the term 'unit actor' to commonly refer to franchisees, and the terms unit managers and professionals when a finding applies to all of them.

Positioning toward customers: Perceived influences on results

How franchises position themselves toward customers is perceived to play an important part in the results of franchising. Specifically, the brand name strength and the concept play significant roles.

Strength of the brand

The respondents consistently reported that a strong brand name is advantageous, particularly through providing a strong position toward health insurers and the (local) government. A strong brand name legitimizes the preservation of financing for the franchised care, which basically increases the likelihood of survival, positive financial performance for units, and competitive advantages. Nevertheless, a strong brand name provides no guarantee for financing in a regulated healthcare environment with changing policies and regulations. A strong brand name is also believed to stimulate the quality of care and the work satisfaction because it provides a sense of belonging and additional motivation to perform well: *"It is nice to belong to something, you carry out a message together, and you have a strong brand name behind you that you need to keep strong together, work hard to keep that brand name strong, that nothing happens that will harm the brand." (franchisee system 3).* Consequently, when a brand name is strong (as in system 3), it is regarded as a valuable resource and as a major reason for purchasing a franchise. When a brand name is not yet sufficiently strong in the perceptions of the unit actors (as in system 2), it is felt that the business format could offer more advantages. The actors initially expected that they would also gain by attracting more clients with their brand. However, this assumption appeared not entirely true for systems 1 and 2 due to production limits forced by insurers and the government to contain costs and because healthcare insurers continued purchasing care of all healthcare providers in the hospital and mental healthcare sector rather than purchasing larger volumes of care

of only a selection of better-performing healthcare providers. As a franchisee of system 1 puts it, *"We designed [our franchise formula] based on content but also particularly on strong logistics and service because we were convinced that patients will vote with their feet when we deliver high quality care and that the market will come to us, as is normal in a market where you do a better job than others. But we do not have a normal market."* Despite the advantages of branding, franchisees also consider branding as a risk because the mistakes of others can also affect them. However, no respondent considers this risk to outweigh the advantages.

Concept

Consistent with the theoretical framework, documents and interviews highlighted the importance of a concept including health care services that are valued by clients, purchasers (e.g., insurers), and referring providers. It seems that clients are attracted to a franchise because they like the concept, not particularly because it is a franchise. In system 1, respondents report that many clients found the optimistic approach, specialized treatment programs and office-like interiors to be attractive, and clients of system 3 were said to value the idea of a small-scale family-like atmosphere in a nice house where clients live as normal a life as possible. However, the cases show that governmental and political influences in healthcare can lower the demand or viability of the franchise, even if clients value the concept; system 1 received lower demand after the introduction of a financial contribution for clients, intended budget cuts for care for the intellectually disabled would have resulted in the discontinuance of new units, and production limits in hospital care reduced the possibilities of helping more patients. The concept also partly determines whether (potential) unit actors find the franchise attractive. The franchisees and a part of the professionals of system 1 liked the idea of specialized evidence-based care provision, while others disliked this idea and resisted changing their work methods; some even left. Hospitals and doctors found the idea of preserving the entire spectrum of eye-care and striving for excellence attractive. Many unit actors in system 3 were attracted to the idea of providing care in an autonomous unit after being disappointed in regular institutions.

Thus, the positioning component of the business format plays an important role in how franchises are valued. However, the support services and control systems in the business format should support realizing this positioning in practice. Therefore, the remainder of this section focuses on how support and control affect the achievement of positive results.

Support services: Perceived influences on results

Interviews, documents and observations consistently indicated that appropriate support services in regard to quality, type and amount facilitate the achievement of positive results with franchising. What exactly is appropriate partially differs for different types of results, for unit actors with different attitudes, skills and ages, for different types of franchise (fractional or stand-alone) and healthcare services, and for different perceived levels of contractual payments. We elaborate on these findings below.

A certain level of support services is perceived to positively relate to strategic, organizational, professional and client-related results for several reasons. First, for the franchisor, the provision of such support helps them to grow, create competitive advantages and survive by retaining and attracting unit actors to the system. Second, for franchisees, the support involves less risk and a stronger positioning in an environment of increasing competition and budget cuts from the government and insurers. Particularly for those franchisees that start up a new unit (system 3), the support also decreases the resources needed: *"If you do it by yourself (…) a) you need the financial resources, and b) you are far more vulnerable and you need to find out everything by yourself. And when something happens, you have nothing to rely on; you have no back-up."* Third, unit actors feel that such support helps them to deliver high-quality, efficient care with less burden to themselves because they have to spend less resources in determining appropriate work methods: *"We could learn our lessons, we knew where we had to go, and we had the tools to do it." (professional system 1)*. Moreover, when ample support in non-care related activities is provided by the franchise, unit actors have to spend less resources in execution. As a franchisee of system 3 describes it, *"I do not have to spend too much time with non-care-related tasks, such as quality policies, but I can spend ample time providing care. I find that I now already spend too much time doing administration (…) Imagine the time that is spent when you have to do it all by yourself."* Fourth, the cases show that the knowledge and experiences embedded in the support services accelerate improvement and implementation in local units because it is not necessary to *"reinvent the wheel everywhere"* and it persuasively shows the unit actors better working methods by peers. Fifth, the support steers the behavior of unit actors toward desirable performance levels and a uniform presentation, which is perceived to help stimulate quality of care, survival and competitive advantage.

However, from the perspective of both the franchisors and unit actors, the amount of support should not be too large. First, for the franchisor, extensive support requires a great deal of overhead, rendering the franchise relatively inefficient and expensive. As the franchisor of system 3 puts it, *"We need to remain efficient; we want to keep our overhead at 4.5%. So that implies that you must also dare to let it go."* When the franchise system ages, more support can be provided with the same level of overhead, owing to

greater experience and more developed services. According to the franchisor of system 2: *"We notice that over time our investments in new franchisees become lower. You can do it much more efficiently. You have much higher standards and ready-to-use material."* Second, excessive support can hinder the quality of care, efficiency, competitive advantage, and work satisfaction in situations where local adaptation is important, such as in services that are complex and/or require customization and in units in which the franchised practices are added to existing and non-franchised practices (fractional model). The support then contains non-feasible and non-valuable practices for local units. As a franchisee of system 2 explains: "*By adding your own input, you keep it with your own culture, your philosophy, what fits within your own [unit].*" Third, extensive support can lead to the resistance and dissatisfaction of unit actors, particularly when it is presented as fixed and obligatory in a professionalized healthcare system like system 1. Unit actors then experience the support as a set of external work methods that they did not invent or own, feel violated in their autonomy, and feel that their opinions and capacities are not taken seriously. As several professionals of system 1 describe: *"The question was, do you unthinkingly copy it. In other words, you do not have to think anymore; you can do it this way, while people also felt the need to participate in thinking about the developments," and "Who says that they know it better?"* Ultimately, the desirable level of support depends on the extent to which unit actors want to bring in their own ideas. As a franchisee of system 2 stated: *"You have the feeling that it is partially something of your own because you have collaborated on developing it."*

The positive effects of support are experienced only when the support is perceived to be of the appropriate type and quality, while the negative effects are aggravated when the type and quality is perceived to be inappropriate. Some support types are generally perceived to be helpful in achieving positive results across all systems: the operations manual, performance measurement and benchmarking, a franchisor representative (account manager), and support that aids in profiling for clients, insurers and the government in an increasingly competitive and complex environment (e.g., via website, lobby, and folders). For other support types, the perceived appropriateness differs for the two types of franchise organizations: whereas support in process improvement was valued by existing organizations that have become franchisees (system 1 and 2, fractional type), support in building rent, a bank loan, and a shared administration system was felt to be most important by franchisees that started up as a new unit (system 3, stand-alone type). The appropriate type, quality and amount of support also differs across unit actors within the same system. Actors that differ in their performance levels, length of stay, and skills and attitudes have varying needs. Starting and less skilled unit actors primarily find support in starting up their units or implementing the formula helpful for realizing positive results. Older and higher-performing ones are more interested

in marketing, profiling, maintenance, and continuous knowledge exchange, and also desire a lower amount of support: *"I know that I can call them when I need them. And that is enough. You can do it more by yourself." (franchisee system 3).* In addition, some unit actors find it sufficient to share knowledge through the operations manual, the franchisor account managers, and professional scientific bodies. Others find facilitation of knowledge sharing meetings one of the most important tools in making a franchise cooperation valuable to professional healthcare organizations: *"Those program councils with [professionals], they are very stimulating groups. People really like to participate in that. It is a very important medium of knowledge exchange for us. That is the place where it all happens." (franchisee system 1).* Unit actors also differ in whether they find training to be a valuable support type. Given these differences in the evaluation of support types, unit actors within the same system cannot all be satisfied in the same ways.

Franchisors and franchisees also evaluate the ultimate effects of the support services in relation to the level of contractual payments. From both the franchisor and franchisee perspectives, the contractual payments must enable the franchisor to provide high-quality support, develop improvement and innovations to maintain the value and competitiveness of the support services, and ensure brand recognition. When the franchisees perceive that they obtain inappropriate support in return for the level of contractual payments paid, they evaluate the overall contribution of the business format to their satisfaction and financial performance negatively. As the use and valuation of support services varies across unit actors within the same franchise system as a consequence of the variation in age, performance, attitudes and skills, so does the perceived reasonableness of contractual payments. In all of the systems, some of the franchisees express doubt about the worth of their payments, *"It is a lot of money that you pay, if you use that money yourself you can also accomplish much things",* and fees have been a frequent topic of discussion. This discussion also regularly includes a discussion about the 'ethical' nature of asking fees in a societal sector like healthcare. Others within the same system feel that their payments are reasonable and are ultimately paid back by the efficiency gains of the support obtained, reducing the costs of healthcare overall, *"When you see our turnover and you can use the (…) support. If you see what they have achieved in those few years (…) In relation to that, you can be satisfied. And that you have to pay for it…if I were to try to achieve that by myself, I would not have succeeded."*

Level of control: Perceived influences on results

Largely in line with our theoretical framework, our analysis shows that a certain level of control helps to ensure that actors deliver services as defined by the positioning component, either through the selection of new franchisees or through standardized instructions and centralized decision-making. Furthermore, our respondents in

healthcare highlighted the importance of a certain level of monitoring and enforcement in this endeavor. However, excessive control appears to have a hindering effect on the achievement of positive results with franchising. Several process dynamics explain why both very high and very low levels of control are thought to have a negative effect. The most appropriate level of control seems partially situation-dependent. We elaborate on these findings below.

Control through the selection of new franchisees

Actors in all of the systems feel that a stricter selection of potential franchisees – either via a strict procedure or via self-selection through providing extensive information about the franchise – stimulates the achievement of a strong competitive position and high client satisfaction. It is thought to do so because consistently high performance levels can be better guaranteed. As the franchisor of system 3 describes: *"I think that you have to set high standards for which franchisees you want to include in your system, and even then it sometimes can go wrong with a franchisee (…) You want to have as much success as possible for your [clients]."* Through enlarging the chance of having suitable franchisees with the right expectations, stricter selection is also felt to stimulate franchisee satisfaction. As less satisfied and lower performing franchisees require greater time investments from the franchisor, stricter selection also stimulates the efficiency of support provision. However, the beneficial effects of strict selection can contrast with achieving competitive and efficiency advantages through system growth, a goal that benefits from less control. Like a franchisee of system 3 illustrates: *"At one moment, the speed of growth…with 20 new locations a year, you need to have 20 franchisees. Tensions arise. And then you actually select franchisees too easily; you select people that you regret in retrospect."* An initial focus on growth can then complicate the achievement of consistent quality levels and a uniform formula implementation. As the franchisor of system 2 stated: *"When it is a franchise that everybody can join, what does it say then, that you are a member of the franchise? Because we want to position ourselves as a network that provides excellent care, and you say that all locations provide that excellent care."*

Control through standardized operating instructions and centralized decision-making

The case study systems differ in their level of standardized operating instructions for care and non-care activities as well as in the level of centralized decision-making (see table 1). The franchisors and unit actors from these varying systems reach a consistent conclusion: both extensively high and low levels of standardization and centralized decision-making are disadvantageous, although the optimal level differs across systems and result types. As our analysis indicates that the process dynamics underlying the role

of standardization and centralized decision-making are largely similar, we describe the role of these two control elements in one section.

A certain level of standardization and centralized decision-making of both care and non-care processes is thought to facilitate the achievement of competitive advantages, survival and quality of care by steering the behavior of unit actors toward desirable, solid performance levels and uniform presentation throughout the system: *"Franchisees also say, I'd love to know what we must do and arrange at minimum, that my [unit] is OK, but that of my neighbor-franchisee is OK as well, because when something goes wrong there I have a problem too, we work with the same brand name." (franchisor system 3)*. Therefore, unit actors request more control when they perceive it as being too low, like in system 2: *"You want to guarantee that when I arrive at a [franchise] location, I should get the same service, the same access, the same quality of care; you have to decide upon that with each other. It cannot be that you come to one place…. (…) This is what we want to guarantee; this is what we deliver."* Such a uniform presentation and predictable performance is felt to be particularly important when the franchise positions itself toward customers with predictable, efficient services, as in system 1, or when it is the desire of purchasers. More standardization and centralized decision-making also help stimulate the quality of care, work satisfaction, efficiency, competitive advantage, and survival by reducing the resources unit actors have to spend on choosing and applying appropriate and innovative work methods, allowing a stronger focus on the actual care provision. As the franchisor of system 3 stated: *"As a franchisor we are very good in deciding and organizing everything around the unit and [franchisee], to make their unit work. And we select the franchisees on their suitability for care provision, in that respect they can do whatever they want."* Additionally, standardization and centralized decision-making stimulate results because they ensure a shared basis between units that makes system-wide adaptation, knowledge sharing, and performance monitoring relatively easier and more efficient.

However, the level of standardization and centralized decision-making should not be too high. For franchisors, extensive control leads to inefficiencies on the system-level as a consequence of the overhead and bureaucracy required. Moreover, it can harm growth because many professionals do not feel attracted to systems that they perceive as leaving little room for their own ideas, even if this feeling does not reflect reality, as in system 2: *"You give away a part of your right to say, and our physicians wanted to stay independent. They do not like the [franchisor] telling them what to do. The question of whether the franchise would improve our care delivery has hardly been a topic of discussion. It was quite easy: our physicians wanted to keep their autonomy and independence." (potential franchisee in a newspaper)*. On the unit level, extensive standardization and centralized decision-making restricts local adaptation. This hinders creating local competitive advantages, quality of care, efficiency and work satisfaction

when customization to the customers' needs is pivotal, according to the positioning component in the business format or the characteristics of the healthcare service: *"It is so personal what happens; care is such an individual, personal thing that you really need to have freedom to have an impact" (franchisor system 3)*. Excessive franchisor control also hinders achieving these positive result types when local adaptation of the franchised practices to the characteristics of the local unit is important, such as in units that offer both franchised and non-franchised services (fractional franchise type) or units that differ in size. The franchise then becomes an inefficient bureaucracy that wastes staff and money in developing and implementing products that are not valuable and feasible in the local context, like in the initial years in system 1: *"They (...) said that everything needed to be done exactly as they did it in the [original] unit. But I cannot implement the same row of care pathways as they have there when I do not have as many care professionals as they have. That is impossible."* These characteristics can also lead to dissatisfaction among unit actors and resistance to change among professionals because they may feel that they have insufficient autonomy, that their ideas and expertise are unimportant or not taken seriously, and/or that they are no longer owners of their work. Such a situational misfit ultimately reduces the actual steering possibilities and uniformity of the formula.

In all, the findings suggest that higher levels of centralized decision-making and standardization are advantageous for topics that apply to the entire system and are thus more efficient to arrange centrally, as well as for those topics that are important for a uniform image or to realize the intended positioning toward customers. The levels should be lower for topics that require local adaptation to fulfill the customers', professionals' and local unit's needs.

Control through monitoring and enforcement

All our case study systems monitor the quality and/or financial performance of units to reveal whether they perform as intended (e.g., via audits, benchmarking, measuring client satisfaction and waiting times). Both franchisors and unit actors argue that such monitoring is always important for results because it provides valuable opportunities for learning and steering. However, particularly when support and control levels are lower, monitoring is felt to be important for competitive advantage, financial performance and the survival of the franchise because the monitoring results then provide an opportunity to show the attributes and performance of the franchise to the outside world.

Once the monitoring instruments identify a gap, not all systems can easily force adequate performance or the use of standards across units; system 1 and 2 have relatively low possibilities of doing this, and system 3 has some possibility. The franchisor of system 2 argues that their low ability in this regard makes it harder to create competitive advantages and to quickly improve the quality and efficiency in the units, *"There are no*

sanctions when a [franchisee] does not want to do something, then we say 'it's a pity that you have not achieved that goal', but it has no consequences. (…) Learning from business, you can do more with that." Respondents feel that the healthcare culture, in combination with the involvement of professionals, makes it harder to employ such a hard franchisor-franchisee relationship. However, various actors argue that even if there are possibilities to force in the context of less professionalized and complex healthcare services, persuasion is a better choice. As the franchisor of system 3 stated: *"When a franchisee goes beyond what we find acceptable, then you have to be able as a franchisor to have a conversation, to talk about the real purpose of providing care within this formula, so that the franchisee says 'oh yes, I have been so stupid'. If you succeed in that, that is much more valuable than just saying 'this is not what we are doing here' and withdraw his contract."*

Discussion

This paper aimed to explore how franchisors and unit actors perceive the design of the business format to affect the achievement of strategic, organizational, professional and client-related results with franchising, and to identify the reasons for these effects. The study shows that a strong positioning toward customers (clients, insurers, referring providers) helps to achieve positive results. However, whether this positioning is realized as intended—and the positive results thus achieved—is perceived to be influenced by the design of the support and control systems. Differences in design have different perceived effects. In regard to support, the amount, the quality and the type of the support are perceived to influence results. In regard to control, results are perceived to be influenced by the manner in which new actors are selected, the level of standardization and centralized decision-making, the extent of monitoring, and the ability of the franchisor to force the use of standards and adequate performance. We identified various process dynamics that are responsible for these effects. Different support designs are perceived to lead to differences in the level of overhead, resistance, local adaptation, and the extent to which the presentation is uniform, the performance of units is predictable, and innovation and implementation are accelerated. These differences are perceived to subsequently influence results. Similar reasons are perceived to underlie the diverging effects of different control designs. Variations in the level of bureaucracy, ease of knowledge sharing, and system-wide adaptation appear to be additional reasons. The combination of the two dimensions 'level of control' and 'extent of support and its importance and quality' leads to a typology with four ideal types of business formats that vary with regard to the preceding process dynamics, and thus vary in their effects (see Table 4).

Table 4: Typology of support and control in business formats in franchising in healthcare

	Types of business format			
	Extensive business format	**Supporting business format**	**Bureaucratic business format**	**Minimal business format**
Process dynamics	*(high control, much support of high importance or quality)*	*(low control, much support of high importance or quality)*	*(high control, little support of low importance or quality)*	*(low control, little support of low importance or quality)*
Level of overhead (sys)	High	Medium	Medium	Low
Level of bureaucracy (sys/unit)	High	Low	High	Low
Ease of system-wide adaptation (sys)	High	Medium	Medium	Low
Uniform presentation (sys/unit)	High	Medium	Medium	Low
Predictable / guaranteed performance levels (sys/unit)	High	Medium	Medium	Low
Accelerating implementation of practices (unit)	Medium	Medium	Low	Low
Resistance to change (clash autonomy) (unit)	High	Low	High	Low
Ease of local adaptation (unit)	Low	High	Low	High
Ease of knowledge sharing (unit)	High	Medium	Medium	Low

An *extensive business format* has high levels of support of high importance and quality, and units are heavily controlled. When used in the appropriate situation, this format helps to achieve results like efficiency, competitive advantages, and quality of care. It does so by making knowledge sharing easy, reducing the time unit actors spend on identifying appropriate work methods, and steering the unit actors' behavior toward a uniform brand image, predictable performance, and implementation of system-wide changes. It is a suitable format for purchasers that desire geographically dispersed, uniform services and for unit actors that accept losing control and following the guidance of the formula. However, this format can lead to negative effects where professionals desire involvement and autonomy ("not invented by me") and where units must heavily adapt to the needs of their localities. This format can also lead to inefficiencies through the overhead and bureaucracy required. Contractual payments can be relatively high to be reasonable.

A *supporting business format* combines substantial support of high perceived importance and quality with low control. This format is particularly valuable where clients and purchasers need customized care and where professionals seek autonomy

in local implementation and adaptation in their own context, while feeling unburdened by support services. The actual autonomy and ownership feeling are lower when the support services are directed at both care and non-care related activities. It is a less efficient format when many decisions could be made on the system level, rather than requiring participation, and when system-wide adaptation is so important in the healthcare market that the franchisor must exert substantial effort into persuading unit actors. System 2 shares characteristics with this format.

A *bureaucratic business format* is characterized by ample control and little support of low perceived importance or quality. This format can have various negative effects in most types of healthcare services as it gives little room for local adaption and professionals' ideas, as well as causing unit actors to feel unsupported. This format can, however, potentially lead to positive results in environments where standardized, lower cost healthcare services are preferred by clients and purchasers and where customization is not important, but overall seems sub-optimal in healthcare. System 1 used a business format in between the bureaucratic and extensive business format.

A *minimal business format* has low control and low support levels. This combination is suitable to satisfy clients and purchasers who seek customized care and/or when services are complex and professionalized, when professional associations play an important part in developing standards, or when unit actors desire autonomy and an ability to adapt locally. However, the low control and support levels are not very helpful for yielding substantial benefits from the franchise cooperation in regard to using suitable work methods and a uniform brand. Contractual payments should be relatively low in order to be reasonable. The format used by system 3 sits in between the extensive and minimal business format.

As also follows from the discussion above, none of the business format designs seem favorable or unfavorable in all situations. The perceived effects of the same format can diverge across unit actors differing in attitudes, skills and length of stay in the system. Different external contexts (e.g., competitiveness, whether purchasers desire uniformity and predictability), positioning manners, and types of service require different control and support levels, as do franchises that work with existing organizations (fractional model) versus franchises with stand-alone units. Franchisees evaluate the contribution of support to results in relation to the fees they pay, as does the franchisor for the support he can deliver in relation to the fees received. We have mapped all these findings in a new model (Figure 1) depicting how combinations of business format elements are expected to relate to results via multiple intermediating processes and how age, size, attitude, skills, type of franchise, context, and type of service seem to moderate these relationships. This model requires further research.

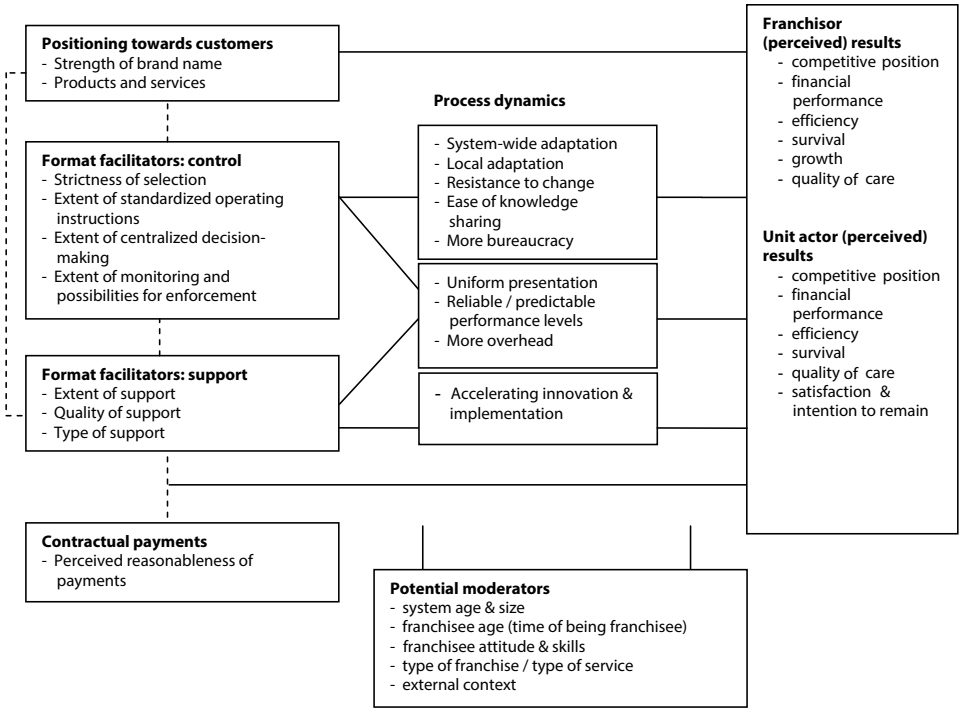

Figure 1: Proposed model of the relationship among the business format, contractual payments and the results achieved within franchises to be tested in future research

Our study shows that the franchise literature originating from other sectors can provide valuable insights to healthcare scholars and practitioners. However, there are also differences that require a specific approach in healthcare. First, strong branding seems predominantly stimulating through the strong position that it provides in relation to stakeholders like insurers and the government (less so by attracting clients). Second, we found that unit actors do not consistently feel extensive support to be stimulating. Some do not want extensive support, as they want to bring in their own ideas and experiment in their localities, rather than risking central support that may not be applicable. Extensive support is sometimes even perceived as an infringement on professional autonomy, and people can feel that their own capacities and visions are not taken seriously. These risks can particularly appear where existing organizations become franchisees because actors receive the support and routines of the franchise in addition to those of their organization. Third, although some standardization can indeed prevent actors from opportunistic activities (Kidwell et al., 2007), an appropriate balance between high and low standardization seems beneficial to gain the advantages of standardization (achieving desired performance, acting as one system, sharing knowledge, deriving

efficiency) on the one hand, and the advantages of freedom (delivering customized care on a local level with autonomy) on the other hand. For similar reasons, our study suggested that a balance between centralized and decentralized decision-making has positive effects for all. When a level of standardization or centralized decision-making is used that is inappropriate to the local situation of units and ideas of professionals, it results in waste because of resistance or threat to leave the system. Finally, we observed that franchises with business formats that are valued by customers and unit actors can still encounter difficulties because of the involvement of multiple external stakeholders (e.g., changing governmental policies, budget cuts).

Limitations and directions for future research

The study also has some limitations that provide directions for future research. First, we lacked suitable data to quantitatively investigate results and to quantitatively support the qualitatively experienced, analyzed and interpreted relationships between results and business format elements. Therefore, we recommend large-scale quantitative tests of the developed model (see figure 1) in a longitudinal design. Ideally, such research includes a baseline qualitative and quantitative study and one or more follow-up quantitative measurements in franchise systems that have planned to change a particular business format design element. Interviews in between the measurements should identify any affecting concurrent developments. Alternatively, a similar design could start with identifying typically low-, medium- and high-scoring franchise systems on a particular business format design element. Second, the study investigated the perceived impact of the business format design on client-related results as perceived by unit actors and franchisors, rather than as perceived by clients themselves. Scholars should investigate the relationship between the business format design and customer-related results (e.g., satisfaction, medical condition, costs) at the level of the customers themselves to really reveal what is the most valuable design to them (clients, insurers, referring providers). Third, the generalizability of the results of this in-depth qualitative study of three Dutch franchises is uncertain. Particularly in for-profit environments and low- and middle income countries, the motives of actors for franchising and thus the perceptions about the most desirable business formats to enhance the chance of success, may differ. Therefore, similar studies in other contexts are required. Finally, although we could draw our conclusions based on significantly diverging perceptions identified by within and between-case comparisons, it is possible that comparison with franchisors and unit actors that 'failed' or ceased franchising would have led to additional and fine-tuned insights in the choices that should not be made to enlarge the chance of success. Therefore, further research should compare the perceptions of operational franchisors and unit actors with failed/ceased ones.

Conclusions

This study suggests that practitioners that use healthcare franchising as a model to achieve positive client-related, professional, strategic and/or organizational results need to carefully design their business format to increase the likelihood of actually achieving positive results. Franchisors seem to be able to stimulate results for all stakeholders if the positioning component comprises products and services that are valued by customers and (potential) unit actors and a strong brand name. They should try to avoid both extensively high and low levels of support and control to units, choosing instead the optimal level that partially diverges across systems, contexts, and unit actors. The processes of system-wide adaptation, local adaptation, knowledge sharing, predictable performance, uniform presentation, accelerated innovation and implementation, bureaucracy, level of overhead, and resistance to change explain why certain levels of support and control are related to results in different situations. It seems important to attune the type and amount of support and the level of control to the type of the service (e.g., desirable level of customization and professionalization), the external context, the franchise type, the unit actors' skills, attitudes and years of working in the system, and the prioritization of goals (e.g., is growth and efficiency prioritized over quality and work satisfaction). Potential purchasers should determine whether the characteristics of the business format fit to their desires. The preceding conclusions are summarized in a typology and model that can be used as a starting point for practitioners and as a basis for future scholarly research. Further research is needed in other contexts like for-profit environments and low- and middle income countries to determine the generalizability of our findings.

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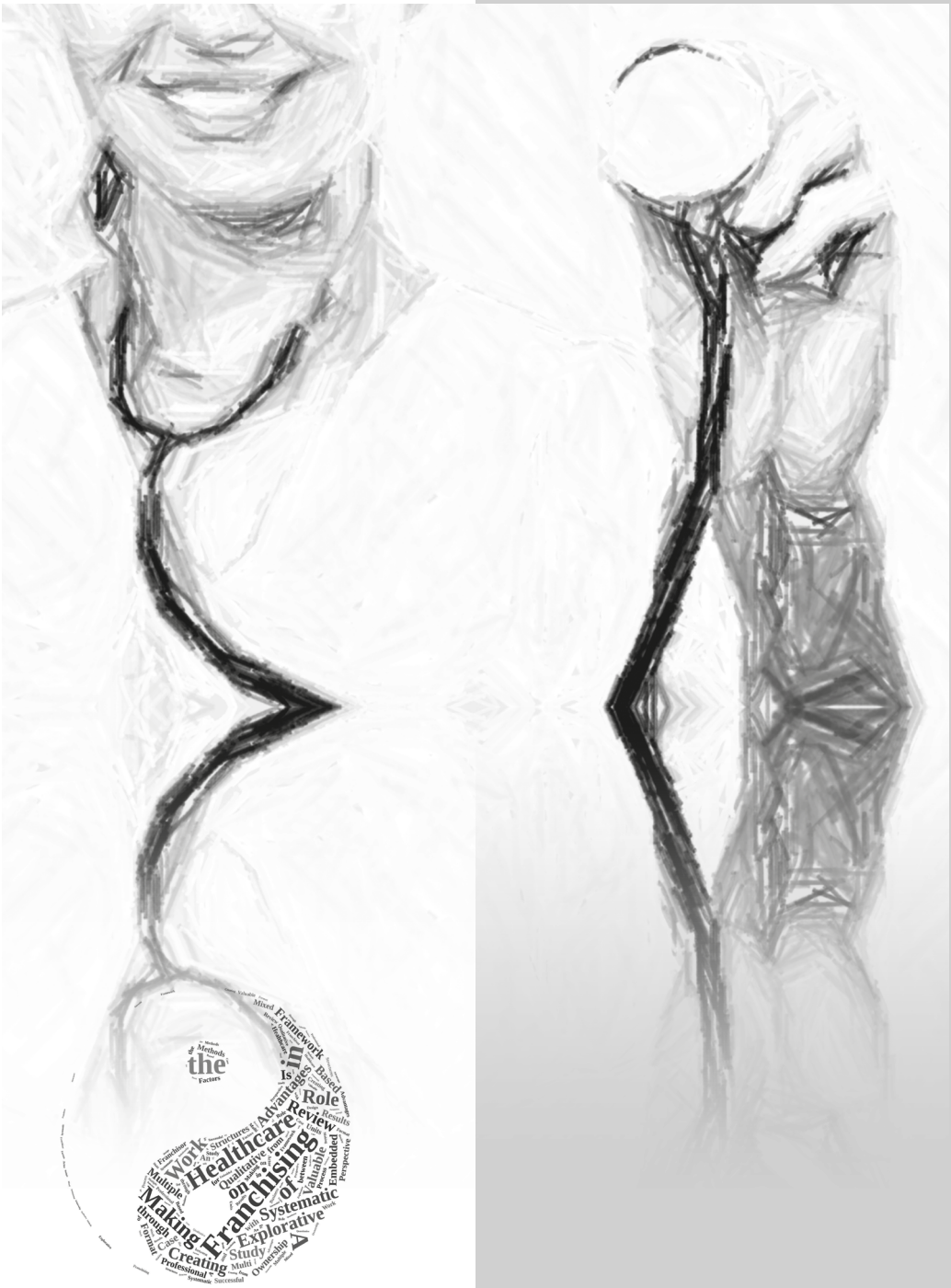
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Chapter 5

Exploring the Role of Ownership Structures in the Results of Professional Healthcare Franchises from a Multi-Actor Perspective

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Abstract

This paper explores how the ownership structure of professional healthcare franchises contributes to the achievement of positive results with franchising for the franchisor, the franchisee, professional service provider and clients. We conducted a comparative embedded case study with three healthcare franchises in the Netherlands using data from 101 interviews, observations and document analyses. We show that different ownership structures at the system-level, i.e., plural form, pure franchise, cooperative franchise, and the unit-level, i.e., stand-alone vs. fractional, active vs. passive, single vs. multi-unit, have different effects as perceived by franchisors, franchisees and professionals. Moreover, we reveal how this variation in experienced effects can be explained by differences in dynamics in regard to management, decision-making, control, steering, support, interests, learning and adaptation. Based on these analyses, we develop new typologies of ownership structures and show how combinations of system-level and unit-level structures can have mutually weakening or strengthening effects.

Introduction

Franchising is increasingly applied as an organizational model in healthcare to overcome the challenges healthcare organizations face today, while it is already a common channel structure in other industries. The healthcare industry is confronted with continuously rising expenditures (Berwick & Hackbarth, 2012; Berry & Bendapudi, 2007), deficiencies and inequalities in the quality of care, and poor diffusion of innovations to improve quality and lower costs (IOM, 2001; Nembhard et al., 2009). Meanwhile, there is an increasing shortage of healthcare professionals, of which a significant percentage is unsatisfied with the work (Davies & Harrison, 2003; Giard, 2010; Gigantesco et al., 2003). To encourage care providers to counter the preceding challenges, various countries have moved their healthcare systems towards more privatization and competition (Cutler, 2002; Schut & Van de Ven, 2005). As a result, increasing attention has been given to organizational models from trade and industry that may provide an effective alternative for current models in healthcare (Hellströmm et al., 2010; Yasin et al., 2002). Franchising is one of them.

Franchising comprises a contractual arrangement between two firms: the franchisor and the franchisee. The franchisee buys the right to market goods or services with the use of the franchisor's business format (Blair & Lafontaine, 2005; Combs et al., 2004). The business format consists of a brand name, support systems, and specification of the products and services that need to be delivered (Falbe & Welsh, 1998; Komoto, 2005). Franchisees deliver health services at locations close to customers, while being supported with tried-and-tested concepts, training, knowledge sharing facilities, and other operational and management support (Christensen & Curtiss, 1977; Hogan et al., 2006; Montagu, 2002). Websites and trade magazines indicate that around 50 franchise systems exist in the USA in various types of care (elderly and home care, eye and hearing care, dental care, paramedical care, medical care, pharmaceutical care)[1]. In the Netherlands, about 30 care franchises exist in, among others, home care, hospital care, mental healthcare, and care for the disabled. Websites report the existence of at least 15 franchises in the UK[2] and in Canada[3].

Those who start operating a franchise channel in healthcare expect it to be a successful model. Two types of structures are used in healthcare franchises of which actors partially have similar expectations. The first type is a unit structure with small-scale independent entrepreneurs, comparable to most franchises in other industries (i.e.,

1 http://www.entrepreneur.com/franchises/healthcare/indexhlth.html, http://www.bison.com/Healthcare_Franchises, http://www.franchisedirect.com/healthcareseniorcarefranchises/15 retrieved 24 May 2013

2 http://www.franchisesales.co.uk/search/care-services-franchise-health-care-franchises, http://www.franchisedirect.co.uk/carefranchises/175, retrieved 24 May 2013

3 http://canada.franchisesales.com/search/health-care-franchise-2 , http://canada.franchisesales.com/search/care-franchise 24 May 2013

a stand-alone model) (Stephenson et al., 2004). This type is often used as an alternative for large bureaucratic healthcare organizations. Actors expect that the combination of local entrepreneurship and support through the business format has the ability to improve the professionals' satisfaction, efficiency and quality of care. This is thought to be achieved by restoring the autonomy of care professionals in care provision while supporting them with effective practices and developed innovations (Hogan et al., 2006; Knott et al., 2008; Montagu, 2002). In addition, healthcare providers expect that the shared positioning with a brand name and clearly defined services may assist in the creation of competitive advantages (Knott et al., 2008; Agha et al., 2007b). The second type is a structure where existing organizations become franchisee for a part of their care services. In this so called fractional model, the franchisee thus owns and offers both franchised and unfranchised products and services (Bishai et al., 2008). The actors who choose this model also expect to improve their competitive position, quality of care, efficiency of care delivery, financial performance and the professionals' work environment. They expect to achieve these results through the proven practices from the business format, the operational support (Christensen & Curtiss, 1977), the shared branding (Agha et al., 2007b), the possibilities for knowledge sharing and development (Agha et al., 2007b; Knott et al., 2008), and the access to innovations originating from the franchisor headquarters and other franchisees (Knott et al., 2008).

However, difficulties may also appear. Franchising requires uniformity to achieve economies of scale and to build a strong brand name. This can reduce the professionals' autonomy and lower their work satisfaction or the quality of care for customized services, particularly when the actual care provision is heavily standardized by the franchisor (Montagu, 2002). Moreover, professionals can misuse their powerful role in care provision to resist the implementation of business format elements that are necessary to reach competitive advantage and efficiency, but which are not in the professionals' interests (Montagu, 2002). Controlling the quality of services provided by professionals may also be difficult for the franchisor as he may lack the specialized knowledge, whereas the system's reputation depends on the quality of services provided (Knott et al, 2008; Montagu, 2002). There is also a risk of a contradiction of interests between the franchisor and the franchisee, such as when franchisors are more profit-oriented than quality-oriented (Pozniak, 2006).

Although increasingly pursued, franchising in healthcare seems to produce varying results. Both positive (e.g., Agha et al., 2007b; Christensen & Curtiss, 1977; Evans et al., 2009; Ngo et al., 2009, 2010) and negative outcomes (e.g., Christensen & Curtiss, 1977; Evans et al., 2009; Shah et al., 2011) have been found for clients, professionals and organizations. Answers regarding what accounts for these differing results become increasingly important as the interest for franchising is growing and the need to find

valuable models in the healthcare sector is urgent. A recent systematic review showed that studies on this issue in healthcare are lacking (Nijmeijer, Fabbricotti & Huijsman, 2014a). However, studies in other industries indicated that the ownership chosen by franchises is an important explanation for the varying results across franchises (e.g., Bordonaba-Juste et al., 2009; Hsu & Jang, 2009; Kaufmann & Dant, 1996; Michael & Combs, 2008; Perrigot et al., 2009; Shane, 1998, 2001; Vazquez, 2009). The ownership structure describes which actor(s) own the units and the business format in the system and who daily operates each of these units. Thus, the ownership structure partly determines the position and roles of the actors in the franchise channel. The question is whether and how these findings will apply to professional healthcare services as well.
In this study we aim to contribute to the knowledge on how franchising can be effectively applied in healthcare. To this end, we explore the views of franchisors, franchisees and professionals regarding the help or hindrance of ownership structures in realizing strategic, organizational, professional and client-related results. We explore their experienced relationship between the achievement of results and their system-level and unit-level ownership structure, as well as their explanations for the perceived relationships.

In addition, this study aims to fill a gap in the literature about franchising – an important and frequently used type of marketing channel (e.g., Young & Merritt, 2013). There is a lack of an integrative empirical insight regarding how combinations of system-level and unit-level structures used in practice influence results for multiple stakeholders. Prior studies focused on the single influence of one type of ownership structure and investigated the perspective of either the franchisor (e.g., Bradach 1995, 1997; Dant & Kaufmann 2003; Shane 1998, 2001) or the franchisee (e.g., Darr et al., 1996; Michael & Combs, 2008). Moreover, the literature lacks empirical explanations for the effects of ownership structures on results. Such insights may help to predict how combinations of ownership structures are likely to work out and which other structural, strategic and behavioral choices should be made in the system to ensure that the desired results are achieved. Prior studies generally used quantitative methods (e.g., Perrigot et al., 2009; Hsu & Jang, 2009; Kaufmann & Dant, 1996; Shane, 1998) and comprised primarily theoretical assumptions about explanations for the effects of ownership structure that were not empirically verified (e.g., Michael & Combs, 2008; Shane, 1998, 2001) (see review of Nijmeijer, Fabbricotti, & Huijsman, 2014b, for an overview). Moreover, ownership structure types such as cooperative franchise structures and fractional ownership have not yet received attention from empirical research. This study takes the first steps in filling these gaps by extending the evidence base with the construction of an integrative model through in-depth qualitative empirical research, showing how (combinations of) ownership structures shape the achievement of results

from the perspective of franchisors, franchisees and professionals and which dynamics are responsible for these effects.

Theoretical background

Scholars from various disciplines have investigated the influence of system-level and unit-level ownership structures on results of franchising in other sectors, employing a diversity of theoretical perspectives. We used these insights to construct a theoretical background to empirically explore the contribution of the ownership structure in professional healthcare franchises and the dynamics that explain this contribution.

The influence of the system-level ownership structure

On the system level, actors must choose who owns the units and the business format: the franchisees, the franchisor or both. This entails a choice between a pure franchise, a plural form or a cooperative franchise structure (see box 1). Prior research has shown that the choices that are made with respect to these ownership structures influence the results achieved.

Box 1: Ownership structure types

System level

- Pure franchise: all units are owned by franchisees. The franchisor owns the business format.
- Plural form: both franchisees and the chain (franchisor) own units. The franchisor owns the business format.
- Cooperative franchise: units are owned by franchisees. The business format is owned by some or all of the franchisees.

Unit level

- Stand-alone versus fractional franchise: owning only one particular franchise versus owning a larger organization than the franchised part only.
- Passive versus active ownership: owner of the franchises has delegated the responsibility for the daily operation of the unit to a unit manager versus daily operation by the owner himself.
- Single-unit versus multi-unit: one versus more units owned by one franchisee

Pure franchise and plural form

Prior studies have used various theoretical perspectives as a basis to investigate the influence of choosing a system with only franchisee-owned units (pure franchise) or a system with both franchisee-owned and franchisor-owned (i.e., company-owned) units (plural form). From a theoretical point of view, the use of franchisees has advantages over using company-owned outlets. Following resource-based theories, franchisees facilitate system-growth to build a strong brand name and reach economies of scale because

they bring financial, informational and managerial resources (Dant & Kaufmann, 2003; Hsu & Jang, 2009; Oxenfeldt & Kelly, 1969). Following risk-sharing theory, this use of franchisees' capital reduces the franchisors' risks (Hsu & Jang, 2009). According to agency theory, using franchisees is advantageous because they have lower incentives to shirk their duties as compared to company-owned managers. As independent entrepreneurs they have more incentives to perform well. This also reduces the monitoring costs required (Brickley & Dark, 1987; Hsu & Jang, 2009; Rubin, 1978). Following organizational learning theory combined with an agency perspective, franchisees also bring the innovations that are required to maintain the system's long-term viability. Through their entrepreneurial incentives, franchisees are primarily focused on explorative learning (innovations) to better adapt to local circumstances (Sorenson & Sørensen, 2001).

However, theories also delineate disadvantages of using only franchisees. From an agency point of view, moral hazard problems can occur in franchisee units, particularly in case of high monitoring costs. To maximize personal benefits the franchisees may be inclined to underinvest and deliver inferior services whilst attracting customers through the franchisor's reputation, harming the entire system (Oxenfeldt & Kelly, 1969; Srinivasan, 2006). Moreover, the income streams derived from the franchisees may be uncertain for the franchisor, as the franchisees' performances are not under the franchisor's control (Bradach, 1997; Srinivasan, 2006). From an organizational learning perspective, the use of only franchisees also undermines the uniformity in the system because the innovation efforts of franchisees reduce the level of standardization. Moreover, knowledge sharing in such systems is difficult as the franchisees' incentives are directed at local learning rather than sharing developed knowledge with other units (Sorenson & Sørensen, 2001). Thus, the use of franchisees only lowers the franchisor's control over the processes, services and profits in the system (Heide 1994; Srinivasan, 2006). Following diversification theory, using only franchisees also implies a less-diversified operation mode, increasing the franchisor's risk (Koh et al. 2009).

Therefore, scholars have theoretically argued and empirically confirmed that a combined use of franchised and company-owned units can deliver the most optimal results in various circumstances because these two types of structures have complementary and synergic dynamics. Studies empirically showed that plural forms can profit from the innovation efforts of their entrepreneurial franchisees while they simultaneously can better control the uniformity and quality of their product through company-owned units (Bradach, 1997; Cliquet, 2000; Dant & Kaufmann, 2003; Sorenson & Sørensen, 2001). Consistent with these advantages, various studies have shown that plural forms predominantly perform better than pure franchises in regard to survival (Bordonaba-Juste et al., 2009), financial performance (Hsu & Jang, 2009; Koh et al., 2009), and efficiency (Perrigot, Cliquet, & PiotLepetit, 2009). However, studies also empirically

showed drawbacks of plural forms. The interests between the two types of units can diverge, different management styles are needed, the risk for conflicts is higher, and franchisees can become anxious (Cliquet, 2000). Indeed, through combining contingency theory with agency and transaction cost theory, Srinivasan (2006) found that only some franchisors financially gain in plural forms. Small chains may even experience weaker financial performance compared to those using a pure franchise structure if they also have high financial liquidity and a lasting advertising strategy. Based on these findings we expect primarily facilitating effects of plural form use in professional healthcare franchises. However, powerful professionals that claim their autonomy (Mintzberg, 1983; Montagu, 2002) may change the dynamics underlying the simultaneous use of company-owned and franchised units, and thus its effects.

Cooperative franchise

In practice, systems show structural variety beyond the frequently investigated pure franchise and plural form that may impact on the results that franchises obtain (Hendrikse & Jiang, 2011). Some systems use a cooperative franchise, which means that the business format is owned by the franchisees instead of a separate independent franchisor. A hierarchical relationship with a powerful franchisor is absent (Hendrikse & Jiang, 2011). The U.S. chain Best Western hotels, Straw Hat Pizza, the Dutch drug store DA, French retail chain Intermarché and Austrian Intersport are some examples of cooperative franchises. It has been hypothesized that this structure may be a valuable structure when system growth has slowed or when the incentives for franchisees to undertake entrepreneurial activities are low due to an imbalance of power (Hendrikse & Jiang, 2011). Through developing an incomplete contracting model, Hendrikse and Jiang (2011) modeled that a cooperative franchise structure regularly is an inefficient model because the franchisor does not invest in this structure due to a lack of power and returns. It can be a competitive structure when "highly specific, non-contractible local assets are most important for the creation of value of the franchise" (Hendrikse & Jiang, 2011, p. 338). Franchise scholars have not yet empirically investigated these theoretically modeled effects of a cooperative franchise structure nor have they empirically confirmed the hypothesized explanations for these effects.

The influence of the unit-level ownership structure

On the unit level, actors must choose between a stand-alone versus a fractional franchise, passive versus active ownership, and multi- versus single-unit ownership (box 1). Prior research has shown that the choices that are made with respect to these ownership structures influence the results achieved.

Stand-alone versus fractional franchise

Franchisees can operate a franchise unit in which they exclusively provide franchise products and services – a so called stand-alone ownership structure (Stephenson et al., 2004) – or they can own and offer also other products and services (Bishai et al. 2008). It has been hypothesized that a fractional structure can lead to suboptimal results because fractional franchisees have less motivation to change their working methods towards the franchise standards if no direct advantages in these standards are perceived or if the franchised services are only a small fraction of the total services offered (Agha et al., 2007a). However, a fractional structure may also facilitate in the initial phase, since the use of an existing infrastructure in fractional franchises implies that no time and resources have to be spent on starting-up a unit (Ngo et al. 2009). Despite these hypotheses, no study has yet empirically examined how the choice of a stand-alone or fractional structure actually facilitates or hampers in achieving the desired results.

Passive versus active ownership

Following an agency perspective, authors have hypothesized that passive ownership of franchised units negatively affects results. It is thought that passive ownership removes the important advantages of franchising over company-owned units in regard to incentives and monitoring. Similar to company-owned managers, the non-owner managers employed by passively owning franchisees have lower incentives to perform well (Michael & Combs, 2008; Shane, 1998). Moreover, through passive ownership an additional layer is introduced that needs to be managed (Shane, 1998). Indeed, Michael and Combs (2008) confirmed that passive ownership is disadvantageous for the survival chances of franchisees. Although Shane (1998) also found a negative effect on the survival chances of franchisors, Vazquez (2009) showed that this effect is likely to be contingent. When the operations manual is not specific and local knowledge is important, this ownership structure appeared to be unwise for franchisors (Vazquez, 2009). However, none of these studies empirically investigated the correctness of the assumption regarding incentives, nor did they provide other explanations for the effect of passive ownership. Because operations manuals in professional healthcare services do not allow extensive specification, local knowledge is often important, and the care service is produced by the interaction between a professional and a client in a local unit, a hindering effect of passive ownership use on results can be expected.

Multi-unit versus single-unit ownership

Following the resource constraint theory, authors have hypothesized that the choice for multi-unit ownership positively influences system growth because it provides access

to human and financial capital (Kaufmann & Kim, 1995; Kaufmann & Dant, 1996). This explanation was empirically confirmed by Bradach (1995) in a case study of fast food chains, revealing that multi-unit franchises can grow easier because the re-use of existing franchisees implies that fewer resources have to be used to finding franchisees for new units. However, from an agency and efficient contracting point of view the effect of multi-unit franchise on the survival chances of the system is assumed to be more equivocal. Multi-unit franchise requires codification of the franchisor's monitoring mechanisms to lead down in the contract with the multi-franchisee, because the multi-unit franchisee takes over the monitoring from the franchisor. This codification is assumed to be problematic for new franchisors as they cannot yet foresee all situations in which franchisees will shirk, enlarging the chance for opportunistic behavior of franchisees once multi-unit franchise contracts are used (Shane, 1998). Indeed, Shane (1998) found that the use of multi-unit ownership lowers the survival chances of new franchisors. However, the effect seems to differ for large franchisors, for which Shane (2001) found a positive survival effect. From an efficient contracting perspective the benefits of multi-unit franchise for this group of franchisors are thought to outweigh the costs and risks of codification. The costs of codification are spread over more units, the multi-unit franchisees can take over the increasingly expensive selection process from their franchisors, and there is less risk for information distortion as compared to the establishment of a hierarchy that is inevitable for large system monitoring (Shane, 2001). Studies have not yet empirically confirmed these assumed explanations for the influence of multi-unit ownership. In his case study, Bradach (1995) found two other explanations for the diverging effects of multi-unit ownership as compared to single-unit ownership. Whilst multi-unit franchisees are a little less locally responsive, they facilitate system-wide adaptation because franchisors have to persuade fewer franchisees to implement changes.

Only a few studies have considered the influence of multi-unit ownership on the results of franchisee units. Reasoning from theories about knowledge transfer, Darr et al. (1995) hypothesized and confirmed that multi-unit franchisees have lower unit costs of production because knowledge transfer occurs more easily between same-owner units, owing to more regular communication, meetings and personal acquaintances. Bates (1998) showed multi-unit ownership to be advantageous for the survival chances of new establishments, hypothetically because they have the advantage of being run by experienced owners.

Methods

Research design

We conducted a multiple embedded case study. Several cases were investigated at several levels of analysis (Yin, 2003). The levels of analysis were the franchisor and the unit level, as research has shown that studying both is necessary to fully understand the processes and outcomes created within franchise systems (Elango & Fried, 1997). A qualitative case study was used as it enabled us to explore in-depth how different ownership structures are perceived to affect the achievement of results in the rarely investigated professional healthcare franchises. It also enabled us to build a theory about the dynamics behind ownership structures that explain *why* and *how* structures have these effects. We investigated multiple cases to confirm findings (replication) and to identify diverging patterns across settings. It thus helped to reach more explanatory power and generalizability (Eisenhardt, 1989; Yin, 2003; Halinen & Törnroos, 2005). Within-case comparisons further enhanced the validity of the results (Yin, 2003). We used the findings from prior studies in other industries to focus attention on particular characteristics and themes, to achieve a deeper analysis of an unexplored phenomenon in healthcare and to extend theory (Yin, 2003; Kauppila, 2010).

Research setting: Professional healthcare franchises in the Netherlands

We conducted our study in the Netherlands, a country with 16.7 million inhabitants and around 22 different healthcare franchises in 2009. Some of these franchises did not survive and various new franchises were started. Anno 2013 there are around 30 franchises, operating in different healthcare sectors: elderly care, home care, mental healthcare, paramedical care, hospital care, youth care, and care for the intellectually disabled. Most of them are not-for-profit organizations. Depending on the sector and service provided, the franchises are reimbursed through the Exceptional Medical Expenses Act (AWBZ) – an act that finances long-term care and uninsurable medical risks -, the health insurance act (Zvw) – comprising health insurance for cure -, or the Social Support Act (WMO) – an act in which municipalities are responsible for the arrangement of support for people with a disability. In both the AWBZ and the WMO, clients have a choice between 'care in kind' or a personal budget that allows them to buy care by themselves (Shäfer et al., 2010). Some franchises require a complementary private payment or use private payments by clients as their only financial resource. The financing based on a personal budget or private payments provides franchises the most flexibility and the least bureaucracy, but franchises also continue to exist in 'care in kind' and health insurance. Particularly existing providers become franchisee or set up a franchise in these last two acts, as it is difficult for new providers on the market to get access to reimbursement, especially in the AWBZ.

We theoretically sampled our cases as is recommended for a multiple case study approach (Patton, 1990). First, we selected cases that vary in their ownership structure to be able to investigate the effect of different ownership structures, to uncover the dynamics behind the different structures, and to reason through these dynamics how combinations of structures affect results. We selected the cases in such a manner that we covered every ownership structure type at least one time. Second, we selected cases that differed in healthcare sector (different financing, regulations) and types of services provided by different professionals, because scholars have theoretically assumed that these differences may play a role in franchise design in healthcare and in the achieved results (see e.g., Montagu, 2002). We only used cases that had operated for at least three years and where the people involved were willing to share their sensitive insights (Clarkin, 2008; Eisenhardt, 1989). The selected cases operate in the mental health care (system 1), the hospital eye-care (system 2) and the care for the intellectually disabled (system 3) (table 1).

Table 1: Ownership structures of case study systems

Case Study System	System-level structure			Unit-level structure					
	Pure, plural or cooperative			*Multi or single-unit*		*Passive or active*		*Fractional or stand-alone*	
	Pure	Plural	Cooperative	Multi	Single	Passive	Active	Fractional	Stand-alone
1			X	X		X		X	
2		X			X	X		X	
3	X*	X*			X		X		X

* Only recently changed into plural form. Has been a pure franchise for a long time.

Franchise system 1

Franchise system 1 was initiated in 2004 by four mental healthcare organizations to gain a stronger market position. It was established in response to the introduction of market competition by the Dutch government. The franchise offers specialized ambulatory care to adults. The initiators became both shareholder and franchisee of the franchise and developed a separate body that would function as the franchisor. The franchise was developed as a *fractional franchise* with *passive ownership*: existing organizations would become franchisee and would redesign a part of their care delivery using the business format, whereby employed managers would conduct the daily operation of the units. Care professionals provide care as an employee, serve as employed manager, or serve in both roles; they do not own a unit by themselves. Because additional franchisees were not found and the franchisor director position did not have any real power, the separate franchisor director position was removed. The system-level ownership structure of this system is thus a *cooperative franchise*. Each of the franchisees owns *multiple units*. The

system has 28 units, with unit sizes between 10 and 100 FTE employees. The provided care is reimbursed through the health insurance act (Zvw). The units operate under a business format with a shared access system, standardized protocols, care pathways, marketing, intranet, outcome measurement and knowledge-sharing meetings.

Franchise system 2

Franchise system 2 was founded by a specialized ophthalmology hospital in 2003 with the take-over of an ophthalmology department of a general hospital to gain a stronger position through the provision of high-quality, efficient care in an increasingly competitive market. After obtaining two additional ophthalmology departments in other hospitals, the specialized hospital began franchising in 2007, leading to a *plural form* system. A private liability company of the specialized hospital is the franchisor, and general hospitals are the franchisees. It is a *fractional franchise* with *passive ownership*: only the ophthalmology departments of hospitals are franchised and a manager and a professional from the department conduct the daily operations of the unit. Professionals do not own a franchise by themselves; they work either in a partnership that is independent from the hospital (ophthalmologists) or as an employee (e.g., optometrists). The franchisor provides a business format with a brand name, operations manual, intranet, marketing and advisory support. There are also opportunities to share knowledge with other units. The franchise is aimed at improving the quality and efficiency of care and the work satisfaction of professionals in the ophthalmology department (e.g., through task shifting and optimization of care pathways), and at gaining a stronger position in the market and towards insurers. The provided care is reimbursed through the health insurance act (Zvw). The unit sizes vary between 10 to 23 FTE workers, including independent ophthalmologists working in a partnership. The system has 11 franchised and 3 company-owned units.

Franchise system 3

System 3 was founded in 2003 by a father who was highly dissatisfied with the quality of regular care that was available to his intellectually disabled son. The father wanted a place where disabled individuals could live as normal a life as possible, with ample opportunities to engage in pleasant activities and receive love and attention. To achieve these goals, he developed a franchise in which two care professionals own and operate a small-scale, full-time living facility, i.e., *stand-alone* units that the franchisees *actively own*. Each franchisee owns *one unit*. The founder assumed that this structure would lead to highly committed professionals with the autonomy to provide care to their own standard. Each franchisee hires two to five FTE employees to assist in providing care. The franchisor provides a business format, including an operations manual, initial

training, facilitation of the care building and a loan, an administration system, quality measurement, advisory support and the brand name. In 2010, the *pure franchise* system changed to a *plural form* system by adding some company-owned units to the franchise system. The provided care is reimbursed through personal budgets of clients via the AWBZ or the WMO. The system contains 99 franchisees and 8 company-owned units.

Data sources

Data were collected by semi-structured interviews, observations, and strategic and operational archival documents (see table 2).

These methods were used complementarily and allowed to improve validity through data triangulation (Eisenhardt, 1989; Yin, 2003). Interviews were deemed appropriate for gathering rich data about the dynamics underlying the effect of ownership structures, as we could ask for experiences and feelings (Patton, 1990). A total of 101 face-to-face interviews with 91 respondents (37 professionals, 55 franchisee representatives, 24 franchisor representatives) were conducted between 2009 and 2012 by the primary author (table 2). Some respondents were interviewed more than once to obtain additional information and to monitor developments. In order to limit bias and to acquire a representative overview (Eisenhardt & Gaebner, 2007) we selected franchisor representatives with different functions and units with a varying age, region and ownership structure. Moreover, within each unit respondents with different functions were interviewed. A predetermined topic-list was used for the interviews to increase the reliability and validity of the study. Every interview focused on the following topics: 1) experienced results of franchising, 2) perceived contribution of every system-level and unit-level ownership structure used in the system in achieving the desired results (i.e., facilitating and hindering effects), and - if relevant - the reason for choosing a particular structure (particularly for franchisors), 3) dynamics that result from these structures that explain the perceived effect of ownership structure, 4) other aspects that can lead to differing results despite using the same ownership structure. Every topic was covered in each interview with ample room for new topics and detailed reflections brought in by the respondent. The interviews lasted from 30 minutes to over 2 hours, with an average of 1.5 hours. They were recorded and transcribed verbatim by the interviewer. Documents were used to prepare the interviews in the cases and to complete and triangulate the findings from interviews. Observations of meetings and units were used to stimulate new lines of inquiry, to triangulate, and to provide additional insights by observing the interactions between actors within particular ownership structures (e.g., observing how decision-making evolves in the cooperative structure in system 1). During the observations and document analyses the same topic-list was used as in the interviews to ensure consistency.

Table 2: Sources of data

Case study system	No. of interviews						Archival documents		Observations	
	Franchisor	*Franchisee*	*Company-owned unit*	*Professionals in unit*	*Customer*	*Total number**	*Number*	*Examples*	*Number*	*Examples*
1	4	27 (of 4 different franchisees)	n.a.	13	2	32	50+	Patient forum on internet, business plan, internal memo, minutes, media articles, operation manual, franchise contract	4	Care program council meeting, care program council conference, board meeting
2	15	20 (of 3 different franchisee units)	13 (of 2 different units)	11	1 (6 very short interviews)	49	50+	Annual report, minutes, media articles, internal memo, intranet, operation manual, franchise contract	8	Network days, franchisee-franchisor meeting, franchisor team meeting
3	5	8 (of 8 different franchisee units)	1	13	2	20	22	Annual report, media articles, intranet, operation manual, franchise contract, quality and complaints annual report	4	Franchise council meeting, site visits with presence of clients

*total is lower than the sum of the columns, as some count double (e.g., some professionals are also franchisee).

Data analysis

We did not translate the data into English until writing this paper in order to avoid loss of nuances and possible misinterpretations of the data. We began the analysis process by reading the interview transcripts and documents several times while applying codes to the data. We manually applied codes within Atlas.ti, a qualitative analysis software package. We attached memos to preserve initial analyzing thoughts. The structures as described in the theoretical background were used as a basis for coding. As is recommended for case studies by various authors (e.g, Eisenhardt & Graebner, 2007; Miles & Huberman, 1994; Dul & Hak, 2008) we then used cross-case and within-case comparison techniques to further conduct the analysis for each of the codes. During this analysis process we applied new codes to the data to refine the analysis. We started within searching for consistent and distinct patterns within our cases regarding the (perceived) effect of an ownership structure on different types of results by different actors (franchisor, franchisee and professional) and the explanations for these effects. The consequent analysis was written down in a case report per case that was member-checked with representatives of the case to verify and complement the analysis. We then searched for consistent and distinct patterns between our cases. We constructed matrices where we scored the perceived influence of a structure on the achievement of a particular result type with + (facilitating effect), - (negative/hindering effect) or 0 (no perceived effect). In determining the score, the focus was on shared agreements and disagreements; as a result, a diverging perception of one out of all respondents did not receive attention in the final analysis. When some of the respondents from the same actor-group observed a positive effect while others perceived a negative effect or when all of the respondents reported both positive and negative effects, a +/- sign was mapped. We compared the contrasting ownership types to enrich and confirm the analysis. Whenever possible we selected interview citations that were representative of the perceptions of some respondents or that clearly illustrate a conclusion. Where concise, illustrative citations were absent for a conclusion, we summarized the conclusion in text without illustrating it with a citation. To verify and complement the analysis, the results of the between-case comparisons were member-checked in a meeting with representatives of all of the cases.

Results

We first describe how the franchisors, franchisees and professionals perceive their system-level ownership structure to affect the achievement of positive results with franchising. Then we analyze which dynamics explain these perceived effects. Subsequently, we do the same for the unit-level structures.

The system-level ownership structure: perceived influences on results

The system-level ownership structure is perceived to affect results. Franchisors, franchisees and professionals differ in their perceptions. Franchisors feel that a system structure with both franchised and company-owned units, i.e., a plural form, is the most advantageous ownership structure that positively contributes to all types of results of importance to them (growth, efficiency, financial performance, competitive position of the system, survival, quality of care for clients). Franchisees are less positive. They perceive primarily zero or sometimes even negative effects of the use of a plural form on their competitive position, the efficiency of care, the quality of care for their clients, and their own work satisfaction. Franchisees are the most positive about a pure franchise structure, with positive perceived influences on all results except survival (where they see zero effect). They have mixed feelings about the influence of a cooperative structure. Professionals are also the most positive about the influence of a pure franchise structure on the results that they find the most important (quality of care for their clients, efficient care provision, their own work satisfaction); their perceptions on the other structures are neutral or mixed (see table 3).

The analysis reveals that these perceived differences in effects are related to two structural characteristics of these system-level ownership structures. First, whether there is an independent central franchisor agency that owns and controls the business format. In a pure franchise and plural form, such an agency is present; in a cooperative franchise, it is absent: the franchisees together form a board that has the decision-making power. Second, whether company-owned units are present or not (plural form versus pure or cooperative franchises).

The presence or absence of an independent central franchisor agency that owns and controls the business format

Actors in our study perceive that the presence of an agency stimulate franchisee satisfaction as well as system- and unit-level financial performance, efficiency, competitive advantage and quality of care. They feel that the absence of an agency tends to have a hindering effect on the achievement of these results. The analysis reveals that this difference in effects can be explained by differences in management, interests, decision-making, system-wide adaptation, learning (development) and control.

Table 3: Perceived influence of ownership structures on the achievement of results

Ownership structure		Competitive advantage		Financial performance & efficiency		Survival		Growth		Quality of care		Work satis-faction	
System level ownership structure	Cooperative franchise system 1	FE: PROF:	0/- 0	FE: PROF:	+/- 0	FE: PROF:	0 0	FE: PROF:	+ 0	FE: PROF:	+/0 +/0	FE: PROF:	+/0
	Plural form system 2	FO: FE: PROF:	+ 0 0	FO: FE: PROF:	+ 0 0	FO: FE: PROF:	+ 0 0	FO: FE: PROF:	+ 0 0	FO: FE: PROF:	+ 0 0/+	FE: PROF:	0 0
	Plural form system 3	FO: FE: PROF:	+ 0/- 0	FO: FE: PROF:	+ 0/- +/-	FO: FE: PROF:	+ 0 0/+	FO: FE: PROF:	+ + 0	FO: FE: PROF:	+ 0/- 0/-	FE: PROF:	0 +/-
	Pure franchise system 3	FO: FE: PROF:	+/0 +/0 0	FO: FE: PROF:	+/- + 0	FO: FE: PROF:	0/- 0 0	FO: FE: PROF:	+ + 0	FO: FE: PROF:	+ + +	FE: PROF:	+ +
Unit level structure: fractional and stand-alone	Fractional system 1	FE: PROF:	+/- +/-	FE: PROF:	+/- 0	FE: PROF:	+ +/0	FE: PROF:	+ 0	FE: PROF:	+/- +/-	FE: PROF:	0/- 0/-
	Fractional system 2	FO: FE: PROF:	+/- +/- +/-	FO: FE: PROF:	- +/- +/0/-	FO: FE: PROF:	+ +/0 +/0	FO: FE: PROF:	+/- 0 0	FO: FE: PROF:	0/- +/- +/-	FE: PROF:	+/-
	Stand-alone system 3	FO: FE: PROF:	+ + 0	FO: FE: PROF:	+ + +	FO: FE: PROF:	0 0/- 0	FO: FE: PROF:	+ 0 0	FO: FE: PROF:	+ + +	FE: PROF:	+/- +/-
Unit level structure: passive and active ownership	Passive ownership system 1 and 2	FO: FE: PROF:	0/- 0 0	FO: FE: PROF:	0/- 0/- 0/-	FO: FE: PROF:	0 0 0	FO: FE: PROF:	0 0 0	FO: FE: PROF:	0/- 0/- 0/-	FE: PROF:	0 0
	Active ownership system 3	FO: FE: PROF:	+ + +	FO: FE: PROF:	+ + +	FO: FE: PROF:	0 0 0	FO: FE: PROF:	0 0 0	FO: FE: PROF:	+ + +	FE: PROF:	+/- +/-
Unit level structure: multi-unit ownership	Single-unit system 2	FO: FE: PROF:	0 0 0	FO: FE: PROF:	0 0 0	FO: FE: PROF:	0 0 0	FO: FE: PROF:	0 0 0	FO: FE: PROF:	0 0 0	FE: PROF:	0 0
	Single-unit system 3	FO: FE: PROF:	+ + 0	FO: FE: PROF:	+/0 +/0 0	FO: FE: PROF:	0 0 0	FO: FE: PROF:	+/0 0 0	FO: FE: PROF:	+ + +	FE: PROF:	+ +
	Multi-unit system 1	FE: PROF:	+/- 0/-	FE: PROF:	+/- +/-	FE: PROF:	+ 0	FE: PROF:	+ 0	FE: PROF:	+/- +/-	FE: PROF:	0 0/-

+ = perceived as facilitating to achieve this result type, - = perceived as hampering to achieve this result type, 0 = no (perceived) effect on the achievement of this result type
FO=franchisor representatives, FE=franchisee representatives, PROF=professionals working in a unit (either as franchisee or as employee or in a partnership)

Without an independent central agency there is a lack of a coordinating and organizing mechanism for the entire system to achieve all the intended aims (i.e., no managing force). Instead, franchisees try to manage the system by themselves, often with a focus

on their own interests, leading to suboptimal results. The process of decision-making about changes and improvements appears to be another reason for the predominantly hindering effect of agency absence. Basically, the absence of an agency could stimulate system- and unit-level efficiency, quality and satisfaction, because realistic and feasible decisions for units are more likely and decisions can be made instantly. As a franchisee puts it, *"With a separate agency you create your own administrative busyness. Then you are busy with persuading the agency of why you would not do a particular thing, and that agency had to bring all the parties together and try to reach consensus. Now we have to reach that consensus by ourselves and can directly do that during our discussion, we can directly put our discussion into action."* Franchisees argue that this *"decision-making in consultation instead of being dictated from the agency above"* also enlarges that chance for commitment and satisfaction with decisions by professionals, because *"the professionals more have the feeling that it is something from their own."* However, in practice decision-making is often felt to be more inefficient by franchisees, as *"We have to negotiate about everything, you cannot make a fast decision for everybody."* No one can make a breakthrough when interests conflict and consensus is not reached. This situation regularly results in slower change and improvement in the system. Therefore, multiple franchisees, managers and professionals feel that their franchise cooperation leads to less competitive advantage, efficiency and quality improvement than would be possible, lowering their satisfaction with the franchise. The same applies to the regularly slower, less efficient and suboptimal system-wide adaptation processes that result from the absence of an agency that can steer on adaptation of all units whilst accounting for the common interests.

The presence or absence of an agency that supports in the development of knowledge, improvements and innovations in the system appears to be a fifth reason for diverging effects. Without an agency the franchisees themselves must learn and invest in development. This can slow improvement and innovation in the franchise network because the franchisees have less time to do that than an agency and are inclined to prioritize the own above the common interests. The latter also implies that they do not want to freely share all the things they have developed that might be beneficial for the entire system. They say that *"We have developed this, we do not want to share that for free, we want to have something back, we have invested in it."* Negotiations and *"complex discussions only about money"* sometimes distract from improving results across all the units.

A lack of control in absence of an agency is the final explanation for diverging effects. While a central agency can control the implementation of the business format to warrant quality and uniformity, people from the system without an agency told that *"We do not have a referee person who is [not a franchisee] and who could say: 'we have agreed to do this*

in the operation manual. You could not do this, but then I have to remove that brand name from your building because that is the task I got." They feel that this situation harms results because some uniformity is important for a strong brand name and for delivering the services as expected by clients. As a franchisee puts it, *"It's not good when there are too many degrees of freedom in the formula, too low levels of fulfilling the standards, you have to be quite strict on that. Because you work with one shared brand."* Respondents do however mention that forced implementation can stride with the autonomy professionals and managers in healthcare are used to, leading to less satisfaction. With an agency, the autonomy depends on how heavily the agency controls the business format. In none of the cases this has led to a conflict yet.

Presence or absence of company-owned units

Other differences in the effects of system-level structures stem from the presence or absence of company-owned units. Effects diverge because the presence or absence of such units is related to differences in management, control, steering, system-wide adaptation, interests and development on the system-level, and local adaptation, interests, decision-making and management on the unit-level.

The franchisor organization is responsible for the management of the company-owned units and has the ultimate decision-making responsibility. Although primarily having advantages, the franchisors feel that this responsibility also has some disadvantages. It makes the management of company-owned units more time consuming and costly than franchisee units, for example in regard to personnel. *"With our company-owned units we got all the HRM problems of those units (...) It took a lot of time to deal with all these issues. "* (system 2). The franchisor also runs larger financial risks by investing own resources in company-owned units. However, the franchisors argue that these disadvantages are regularly outweighed by the better abilities and information that it provides them to manage the entire system, making the use of company-owned units advantageous overall. First, the franchisor earns the revenues of the company-owned units, which are regularly larger than the fees received from franchisees *("We make a little more profit on a company-owned unit")*. Second, the franchisors use this financial advantage to develop and improve their system for both themselves and their franchisees. Third, the franchisor spreads risks by earning both the company-owned units' revenues and the franchisees' fees. Fourth, with company-owned units franchisors have their own safety net for solving problems, *"At one location, the franchisees suddenly dropped out and we had to take over that immediately. And then we observed that we actually did not have an organization to do that quickly and easily."* Fifth, franchisors can sample substantial information in their own units instead of being dependent on the possibly colored information provided by their autonomous franchisees. Franchisors argue that this helps them to better manage their franchisees.

Franchisors feel that this 'objective' information sampling in company-owned units also provides them with other advantages that help to better warrant quality, competitive advantage, survival and efficiency. First, it allows better control of the business format; an advantage that was particularly noticed by the franchisor that had only franchised units in the past *"We provide the formula, so we must take care that it stays that particular formula, that the ranges of the formula stay the ranges, that people do not surpass those ranges too much. Before we had far less substantive and financial information to do [that], the company-owned units have provided that."* Second, they feel that they are better able to steer the franchise system in the direction that they deem the most positive overall with a focus on system interests instead of risking a focus on franchisee interests only. Third, a franchisor argues that they have learned a lot from operating own units because *"We can think better about new opportunities to improve our quality to be able to continue with leading the way in the sector, because we now better know what happens on the shop floor."* The franchisors feel that this information advantage – combined with the possibilities to experiment with changes in the own units (instead of being dependent on cooperation of franchisees) – help them to anticipate better on the opportunities and threats that units face and to keep franchisees satisfied with the formula because the daily operations of the units educate them as to the type of support needed by franchisees.

Franchisors feel that company-owned units also stimulate positive results of the entire system because these units can be used as a credible show-case to persuade the autonomous franchisees. This facilitates system-wide adaptation. *"We started the implementation of a quality system in company-owned units. We could show a smooth working system to our franchisees. That really worked."* This situation basically also facilitates control. In the own units franchisors can better steer and control compliance with prescriptions from the operations manual, such as regular quality evaluation with customers. By subsequently using these units as a show-case of importance to the franchisees, uniform implementation and good performance levels are stimulated. Yet it appears that professionals that claim their autonomy and ideas – such as physicians – can prevent the franchisor from having more control and steering in company-owned units than in franchised units, thereby loosing most of the advantages of company-owned units.

However, the franchisees and professionals have other, less positive, views on the effects of the presence of company-owned units. They do not see the advantages that franchisors see, but some even saw disadvantages. This finding is not surprising given the fact that franchisees in franchise systems always strive for autonomy whilst franchisors seek control and steering (Kidwell et al. 2007). First, the franchisees and professionals in our cases feel that the franchisor organization at times prevails the own interests above the interests of the unit professionals and customers in managing and deciding about

the company-owned units, threatening the quality of care and reputation of the system. As a franchisee of system 3 puts it, *"All responsibilities are delegated to the manager of all company-owned units, the actual boss of those units. And that person is not a care professional, has no sense of care, and determines whether personnel can be attracted for a particular unit or not. I heard once that she only gave permission for an uncertified worker; a certified one would be too expensive. It is again a manager that works from the interest of an organization and not from the interest of the resident. That is dangerous".* Initially, franchisees in system 3 were afraid that the quality and reputation of their system would also be harmed by the fewer incentives that company-owned professionals would have as non-owners to perform well. But they do not see this happen in practice, possibly due to the type of service (care) and the intrinsic motivation of the professionals. Second, they feel that the professionals in company-owned units have less autonomy to locally adapt to the customers' needs, particularly in system 3. They argue that this lowers their satisfaction and care quality, particularly because the interests can diverge. As a professional of system 3 said, *"We do not get permission to build a shed for our residents to tinker freely and make a mess whereas it would be a lot nicer for our residents and our employees to have that. Now we always have to clean up and only have this table. It is frustrating that we cannot do what we like to do. When we were franchisees, the shed was already there for a long time."* Third, company-owned units are confronted with slower decision-making because permission is needed from the franchisor organization, lowering the efficiency and agility on the unit level.

Despite the perceived disadvantages of company-owned units, the possibility to work in a company-owned unit also has some advantages for professionals and managers. First, they like the opportunity to be involved in learning and developing together with the franchisor organization. As a respondent from system 3 describes, *"New things are tested in our company-owned part of our system first, and some professionals deliberately choose to be more involved in those developments by becoming a company-owned manager instead of a franchisee."* Second, they like the easier access to the knowledge of the franchisor organization. Third, some of them like to have less risk and responsibility compared to what they would have as a franchisee.

The unit-level ownership structure: Perceived influences on results

Stand-alone versus fractional franchise

Fractional units are part of a parent organization whereas stand-alone units are independent. Although two of our cases consciously choose a fractional structure as they wanted to improve their existing organizations by franchising, such a structure appears to have various hampering effects on the actual achievement of the desired results. A stand-alone structure is felt to be more helpful to positive results (table 3).

The diverging effects of a stand-alone and fractional unit structure are first due to differences in freedom in managing, steering, controlling and deciding about one's unit and in whose interests are put first. In contrast to the regular situation in many large, traditional care organizations, professionals in stand-alone franchise units can autonomously manage, steer, control and make decisions with a focus on the unit's interests, creating a very agile unit. They are no longer dependent on management layers and other departments; the organizational structure is flat. This situation is felt to stimulate quality and efficiency of care and makes many of them satisfied with their work. As a professional puts it, *"We can directly change something in the care when we think that is necessary, you can directly change it. And that's very pleasant because we can directly see the result of our change. We therefore are able to keep the quality very high, we are continuously busy with improving, adapting, improving. That's why we are continuously satisfied by our work, that you can see, hey, we've done it!"* Nevertheless, the large autonomy cannot satisfy all professionals. Some ultimately prefer to be told what to do and stop being a stand-alone franchisee.

A fractional franchise unit in contrast is dependent upon multiple stakeholders in the parent organization for its decision-making. Consequently, decision-making is often as slow and complex as in the original parent organization, hampering an actual quick improvement by the franchise cooperation. As a professional of system 2 describes, *"We have made a business plan for that change, but then the physicians have to agree with it and deliberate about it, now it is at the executive manager and the financial manager, and the operating room manager also has to think about it because they maybe lose patients. So it takes so much time."* This slow improvement at times leads to dissatisfaction and frustration. This situation is worsened by the regular heavier focus on the interests of the parent then on the individual unit. The parent uses the franchise as long as it advantageous for the performance of the organization. But the implementation of business format elements that could elevate the unit results are impeded if they put the interests of other departments at risk or if they conflict with policies in the parent organization. In every unit there is thus only partial steering and control on the local business format implementation. This situation results in less reliable performance levels and less uniformity across units, making it harder to create competitive advantages with a strong brand name towards insurers, referring providers and clients. As a franchisee of system 2 puts it, *"You want to guarantee that when I arrive at a [franchise] location, I should get the same service, namely, the same access, the same quality of care…It cannot be that you come to one place….this is what we guarantee; this is what we deliver"*. Moreover, some professionals and managers feel tensioned because they have to deal with the sometimes contrasting requirements of two organizations: *"I have plans and guidelines that I have to follow from my parent organizations, and I have guidelines of the franchise*

organization (…). So I have to meet the requirements of both. I find that difficult and complex sometimes" (professional system 1).

The diverging effects of stand-alone and fractional ownership are also due to differences in adaptation and learning (development). Most stand-alone professionals are highly satisfied as they have ample room to locally adapt their care to the needs and wishes of their customers and themselves. In a fractional structure the local adaptation of the franchised unit regularly is more restricted. In contrast to stand-alone franchisees, actors in the fractional structure also have an ambivalent commitment to joint learning in the system. The parent companies, at times, retain the time investment in joint learning in the franchise by preferring their own production targets, and some professionals and unit managers are more committed to the parent than to the franchise organization. The units therefore sometimes profit less from the efficiency and innovation that could results from knowledge sharing and development in the franchise cooperation. Some actors therefore conclude, like a franchisee of system 1, that *"I think that we should really deliberate about what the advantages are of working under a large umbrella of the parent or whether to create more of our own character within the franchise organization to work more efficiently and more cheaply within that organization, and make use of the potential of innovation."*

Differences in support and service provision are a final reason for diverging effects. Owing to these differences, some organizations and professionals still prefer a fractional structure. In a fractional structure, the units have double support: support from their parent and support from the franchise system. The fractional units are therefore felt to be less prone to failure and bankruptcy. Moreover, it is felt that the use of the brand name strength and size of both the parent and the franchise brings an additional competitive advantage to the fractional unit. Multiple professionals also feel more unburdened from secondary tasks because of the double support, like a professional of system 2, *"Going commercially with the partnership outside the hospital was thought to be scary. Because then you miss the whole structure of the hospital. When you are going to do it by yourself you have to take up much more management tasks, become a real entrepreneur. And most of the ophthalmologists just want to be ophthalmologist, doing patient care."* Respondents from the fractional systems also feel that the quality of service is likely to be higher for those customers that need both franchised and non-franchised care, because continuity of care is more easily arranged when both types of care are part of the same organization.

Active versus passive ownership

An active owner is a professional that both owns the unit and conducts the daily operations and management, whereas a passive owner has delegated this responsibility

to a manager and/or professionals. All actors perceive active ownership as advantageous to achieve positive results and passive ownership as disadvantageous or not affecting results (table 3).

The respondents firstly attribute the different effects to differences in management, decision-making, steering and control. Active owner professionals can autonomously manage, steer and make decisions, and have full control over the implementation of the business format and improvements in their unit; the organizational structure is flat. They can directly make changes and improvements in their care delivery rather than deliberating about it with management layers. As a client from system 3 illustrates, *"When we are not satisfied or want a change in the care provision, we know that we have to announce that to [the franchisee], the communication is direct; also when they want to announce something they directly do that. That is fantastic. Before, when my child lived in a large organization, we sometimes said something to an employee and nothing happened."* This situation is felt to facilitate the delivery of efficient, high quality care and satisfies many professionals with their work. In passively owned units in contrast, the professionals and unit managers are for major issues often ultimately dependent on the owner for approval, and the owner cannot steer the entire behavior of the unit. As the franchisor of system 2 argues, *"Sometimes the [owner] agrees with what we want to do but the professionals do not want it. And sometimes it is the other way around, that the [owner] does not want because they for example have to cut costs."* There is thus only partial mutual control over the business format implementation and what happens in the unit. They feel that this situation reduces uniformity and efficiency levels across the entire system.

Secondly, the diverging effects are attributed to differences in interests and learning. The respondents find that active ownership stimulates quality and efficiency of care. As active owners, professionals are focused on fulfilling their own and their customers' interests. They have incentives to continuously learn and experiment to further improve performance and to provide customized continuous care. As the franchisor of system 3 puts it, *"You really see that people who previously worked as an employee in a large organization develop themselves enormously once they become an entrepreneur. The ownership is the most important, that you are responsible for your residents and that the success or failure of the unit heavily depends on your own energy, time investment, enthusiasm. That feeling really brings about another type of energy in people." (franchisor system 3)* Many active professionals are also satisfied with their close involvement and the high quality of care they can provide. However, some become dissatisfied because they find that their continuous involvement asserts too heavy an impact on their work-life balance. In the passively owned units, the individual motivation and willingness of the professionals and managers determine whether the focus is on the interests of the

customers and the unit. Unless their individual motivation and willingness is strong, their focus as non-owners is more on their personal interests and the interests that the owner directs them to follow. When the professionals or managers see benefits in business format elements, they are enthusiastic to implement them. But they are not if they are prone to hold on to their own working methods, as an example in system 2 clearly shows, *"We were talking about control by phone after surgery; it is in our business format and experiences in other hospitals show that it is positive for both the hospital and patients. But then we are talking about it and then they are again discussing about it, unsure, unwilling. So it took a long time to implement it."* The actors feel that this likely lower commitment and the lower control levels also lead to less uniformity in business format implementation, making it harder to build a strong brand name for the entire system.

Multi-unit versus single-unit franchise

Every franchisee in system 1 owns multiple units, while the franchisees in the two other systems each own one unit. The actors in system 2 do not see much of an effect of their single-unit structure because their fractional structure eliminates some single-unit characteristics such as autonomous decision-making. The other systems show that both structures have advantages and disadvantages in achieving results (see table 3).

Multi-unit franchise is felt to facilitate growth, survival and competitive advantage when new franchisees are scarce because unit expansion occurs through the existing franchisees. Multi-unit franchise also stimulates efficiency and financial performance through reducing the search costs for suitable new franchisees and reaching economies of scale for franchisees to earn back their investments. Opinions differ in regard to whether multi-units facilitate quality and efficiency improvement through knowledge sharing. Some see that there are economies of scale as *"I observe that sharing knowledge and tuning ideas is easier with units belonging to our own organization. It is more difficult to do so with the units of other [owners]. They have different manners."* Others do not experience easier knowledge sharing between units of the same franchisee than of different franchisees, particularly not between units that are located at distance from each other.

Multi-unit franchising is also thought to have hindering effects as compared to a single-unit structure. Decision-making in units in the multi-unit structure sometimes occurs more slowly because permission of the multi-unit management must be sought. This management layer makes a multi-unit structure more costly in its daily operations and restricts local learning and adaptation in the unit, reducing the possibilities to improve quality of care in the own localities. However, the extent to which the possibilities for local decision-making, learning and adaptation are actually restricted

depends on how much freedom the multi-unit franchisee gives to the individual unit and the freedom in the business format. Professionals of system 1 feel that the management layer also partially removes the attractiveness of franchising because *"There is less room for entrepreneurship of the unit manager. And a franchise is actually particularly a nice organizational form when there are local franchisees everywhere who can safely choose entrepreneurship in healthcare. And that is not what you see in this organization now."* Finally, using multi-unit franchise makes it harder to control uniform business implementation in the early years of existence because every franchisee implements the not yet fully developed business format in its own way. As a respondent describes, *"There has been an explosion of growth of new units of [franchisees], suddenly all these new units were there, and all were thinking about the best way to build their unit and were developing new ideas. You can imagine that there was hardly any control about all these things whereas the brand name suddenly appeared everywhere."*

Conclusion and discussion

The role of ownership structures in achieving results

This paper showed that the ownership structure used by professional healthcare franchises is perceived to affect the achievement of positive results with franchising for franchisors, franchisees, professionals and clients. Moreover, it revealed that differences in management, control, steering, interests, support, adaptation, learning/development and decision-making processes are the underlying dynamics that can explain why different system-level and unit-level ownership structures have different perceived effects. On the system level, the combination of the two dimensions 'with or without an independent central agency' and 'with or without company-owned units' leads to four ideal types of system-level ownership configurations that vary in regard to the preceding dynamics and thus in their effects (see figure 1).

A *hierarchical franchise* has (many) company-owned units and a central franchisor agency. From the franchisor's perspective, this structure is the most facilitating to achieve all types of results – a finding that is consistent with most findings on the plural form in other industries (e.g., Bradach, 1997; Perrigot et al., 2009). For the franchisors, this structure combines the strengths of both franchised and company-owned units: 1) the steering, control, learning capacities, and quick decision-making of the company-owned units that can also be used to better manage and support franchisees, and 2) the motivation, resources, local learning and adaptation capacities of the franchisees. The strengths of 1) may be more difficult to realize when professionals claim their autonomy, reducing the facilitating effects of the combination of the two structures. However, the franchisees and professionals appear to be less enthusiastic about the

effects of this structure, or are indifferent. The franchisees and professionals do not necessarily experience the advantages of the presence of company-owned units that the franchisor sees for them (better support, innovations, system-wide adaptations) and feel that a larger focus on system interests can harm both reputation and quality. The structure may lead to dissatisfaction and lower quality and efficiency levels, because professionals in company-owned units may have less autonomy to locally adapt to their customers' needs and the units are less agile because they need approval from the central agency. Franchisees and professionals therefore see a *shared power franchise* – with only franchisee units – as the most facilitating structure to achieve the results they desire, due to the combination of support and cooperation on the one hand and autonomy in managing and operating their own unit on the other. The franchisors, in contrast, are less enthusiastic about this structure. They feel that their dependence on information from franchisees and their diminished steering abilities hamper achieving a strong competitive position, their survival chance, and an efficient operation.

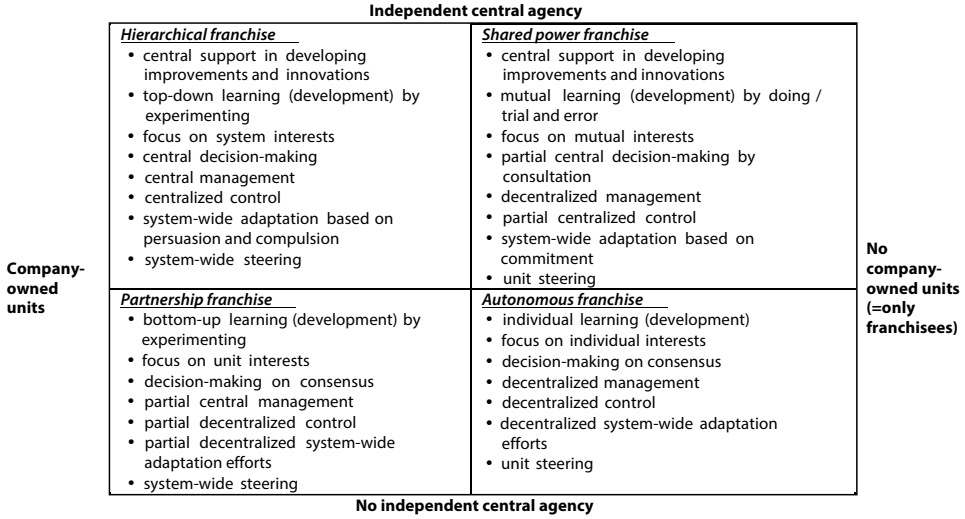

Figure 1: Typology of system-level ownership structures in franchising

In an *autonomous* and a *partnership franchise*, the franchisees together form a board to manage and steer the entire system: an independent central franchisor agency with allocated power is absent. In an autonomous franchise, the franchisees are unified through working together under the same business format but in the daily operations they operate particularly independent from each other with a focus on their own interests. Similar to what was modeled by Hendrikse and Jiang (2011), this structure does not seem particularly efficient. System-wide decisions, adaptations and control are

only achieved when all or most franchisees agree. These characteristics imply a high risk of conflict: actors strive for the fulfillment of their own interests and ultimately, nobody can force a decision. This structure provides franchisees and professionals with autonomy and involvement, but also with less support in secondary tasks. All these characteristics increase the difficulty of achieving competitive and efficiency advantages with the franchise. In a partnership franchise, the franchisees are slightly more connected because they also own some units together. This shared governance responsibility leads to more system-wide steering and management, facilitating slightly more efficiency than an autonomous franchise structure. The quality levels in company-owned units may be more at risk than in an autonomous franchise. The focus is more on the solid performance of the entire unit instead of on the interests of the individual professional who owns the unit and his customers. Similar to an autonomous franchise, the risk for conflicts is high.

Table 4: Dynamics of unit-level ownership structures

	Stand-alone vs fractional		**Active vs passive**		**Single-unit vs multi-unit**	
	Stand-alone	***Fractional***	***Active***	***Passive***	***Single-unit***	***Multi-unit***
Management unit	Autonomous	Plural	Autonomous	Delegated	Singular	'Division'
Decision-making unit	Autonomous	Dependent	Autonomous	Dependent	Autonomous	Dependent
Steering unit	Autonomous	Shared / plural	Autonomous	Shared / plural	Autonomous	Central
Control implementation	Full	Partial	Full	Partial		
Interests	Unit	Parental organization	Unit	Personal and owner		
Local adaptation	Autonomous	Restricted	Based on incentives or intrinsic motivation	Based on command or intrinsic motivation	Autonomous	Restricted
Learning (development) and knowledge sharing in system	Based on full commitment	Based on ambivalent commitment			Loose connections between units	Stronger connections same-owner units in neighborhood
Support	Central	Central and parent				

The combination of the system-level configurations with different unit-level structures can change the actual effects. This study shows that every unit-level structure has its own dynamics (see table 4) that facilitate the achievement of particular results and make it more difficult to achieve others. A stand-alone, active and single-unit structure facilitates the achievement of a high work satisfaction of professionals

and a high quality of care through providing franchisee-professionals with ample autonomy to locally learn, adapt, decide and steer. In passive, fractional and multi-unit ownership, the professionals are at times still dictated by non-professionals, restraining them from behaving how they would like. Moreover, as was hypothesized (Agha et al., 2007a; Michael & Combs, 2008; Shane, 1998), the lack of ownership incentives and the presence of both franchised and unfranchised services sometimes also hamper the change of working methods and the commitment to both unit and system success. However, as some existing organizations consciously choose to join a franchise with their organization, these ownership structures are inevitable. Some professionals also ultimately prefer passive and fractional ownership because of their lower responsibility and higher support levels. Moreover, as in many professional organizations (Nam et al., 2010; Hinings, Brown, & Greenwood, 1991), in all franchise structures, the professionals regularly have a powerful impact on whether changes are being implemented, particularly those professionals in partnerships. The autonomous, direct decision-making and singular management in stand-alone, active and single-unit franchises stimulate an efficient care delivery, although economies of scale in knowledge sharing seem easier to achieve in a multi-unit franchise – a finding similar to the uncovered effect of Darr et al. (1995). To facilitate growth, the multi-unit franchise structure is suitable, which is consistent with what could be expected from findings in other industries (e.g., Kaufmann & Kim, 1995). This structure seems particularly helpful when new franchisees are scarce.

The combination of the characteristics of a unit-level and a system-level structure can strengthen or make it more difficult to achieve particular results. The dynamics that make a hierarchical franchise a stimulating structure from the system's perspective – central control, decision-making and management, system-wide steering and system-wide adaptation – are weakened in combination with a fractional unit structure. That is, the plural management, steering and control, the dependent decision-making, the focus on the parental interests and the ambivalent commitment to system learning and adaptation that characterize the fractional structure make it hard for the franchisor to actually exert the central and system-wide influence. With passive ownership partially having the same underlying dynamics as a fractional structure, the same kind of argumentation applies. However, fractional and passive unit ownership also does not appear to be the preferred combination with other system-level structures if one wants to achieve positive results with franchising. That is, the preceding characteristics make decision-making by consultation, decision-making by consensus, system-wide adaptation based on commitment, and partial (de)central control even more complex and prolonged, thereby making it more difficult to achieve competitive, survival, financial and quality advantages. In contrast, the achievement of the results that are

facilitated by the different system-level structures is at least not to be hampered and even be stimulated by combining it with stand-alone, active and single-unit structures. The autonomy in unit management, decision-making, steering and local adaptation and the full control over ones unit in these structures keep the way clear for central and system-wide influence (as in hierarchical and shared power franchise) as well as (partially) decentralized and cooperative dynamics of system-level structures (as in shared power, partnership and autonomous franchise).

However, we found indications that hampering effects of ownership structure do not necessarily have to lead to negative results in practice because various other factors also play a role in the ultimate results. These other factors can neutralize or compensate the hampering effects in practice. Thus, systems with an autonomous franchise structure or passive ownership can still deliver high quality care and realize rapid improvement ability when the professionals and franchisees are highly committed to the system or their own unit, even though the structure in itself does not facilitate these qualities. Likewise, the lower control levels in an autonomous franchise can stimulate the work satisfaction of the franchisees and the professionals that have a desire for ample autonomy, but such work satisfaction is also possible to achieve in hierarchical and shared power franchises if the central agency gives the franchisees and professionals sufficient autonomy within the business format. Similarly, facilitating effects of particular ownership structures do not necessarily translate in a contribution to positive results in practice in healthcare services. Autonomous and powerful professionals at times prevent the franchisor from having significant control, system-wide adaptation and learning opportunities, reducing the actual stimulating effects of a hierarchical (plural form) franchise.

We have mapped all these findings in a new model (see figure 2), depicting how combinations of system-level and unit-level ownership structures are expected to relate to results via multiple intermediating system-level and unit-level processes, and how attitudes, skills, business format control and type of service seem to moderate these relationships. As our study focused on the effect of ownership structure on results, the study primarily suggested a unilateral effect. There may however be bilateral dynamics. For example, one of our cases changed the system-level ownership structure towards a structure with both franchised and company-owned units, because they noticed that the achievement of some results was hampered by the absence of particular processes within a shared power franchise, such as top-down learning by experimenting and central management. Further research should confirm the existence of unilateral, bilateral, moderating and mediating effects.

Study contributions

This study made two major contributions. This paper is the first to provide an in-depth structured insight in how one of the major design factors in a franchise – ownership structure – can help or hamper in realizing the potential of franchising in healthcare for multiple actors. This contribution of our paper is noteworthy, given the increasing use of franchising in response to multiple challenges in healthcare, the significance of the sector, and the lack of evidence to support evidence-based operation to realize the potential.

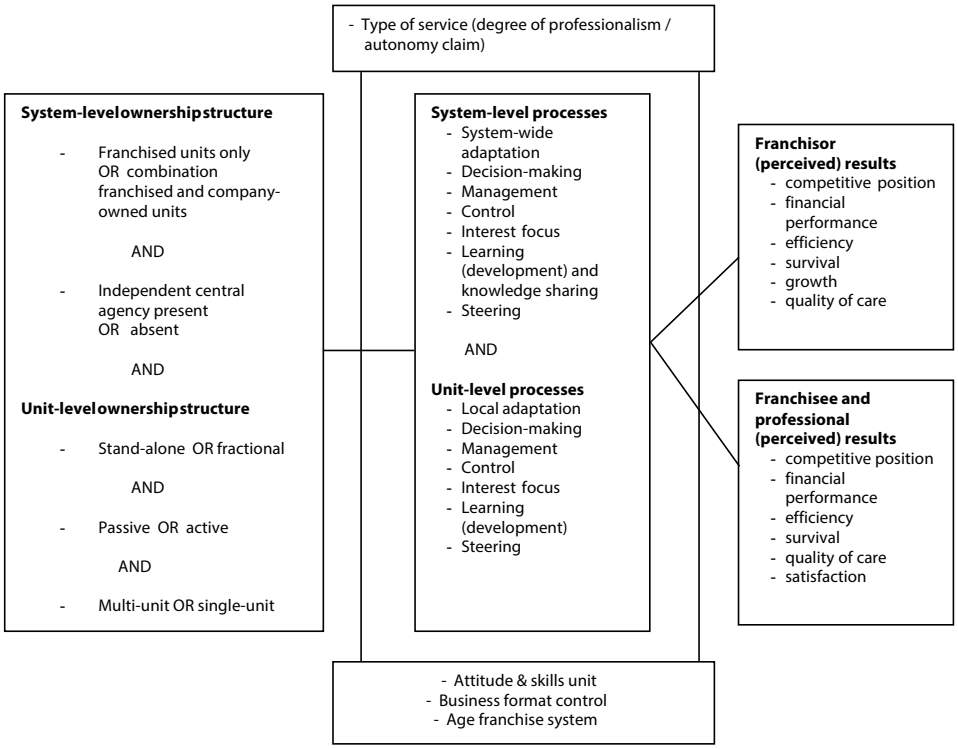

Figure 2: Proposed model for the relationship between ownership structures and results to be tested in future research

Second, this study contributes to franchise research in a broader sense. This study is the first to empirically uncover the dynamics underlying the effects of all system-level and unit-level ownership structures on results for franchisors, franchisees and professionals. Through this we are able to show that the results of every single structure will in practice be partly dependent on the structures that are concurrently used and

we can show how combinations of structures on both the system and the unit level are likely to work out in practice for all parties. This provides a more realistic picture as compared to most of the existing research that quantitatively considers only one structure for either franchisor or franchisee, providing better decision-making support to practitioners. Additionally, these uncovered dynamics help to determine what other choices should be made within the franchise system – for example in regard to the type of support provided, control instruments, selection choices – to compensate for flaws in the ownership structure in order to ensure that the desired results are achieved. The typologies and model developed in this study can be used as a basis for future research. Our study also provides empirical insight in the functioning of two not yet empirically investigated ownership structures: cooperative and fractional franchise structures.

Directions for future research

Because these new insights were retrieved from an in-depth study of three cases in healthcare, further research is required to confirm and extend these insights. First, we recommend large-scale quantitative tests of the developed model (see figure 2) both within and outside the professional healthcare sector, incorporating multiple combinations of system- and unit-structures, intermediating processes, moderating variables and result types from multiple actor perspectives. Second, such research should also provide further insight in whether and how the comparative value of different (combinations of) ownership structures changes over time. Research in other industries showed that the value of particular single structures changes over time (see e.g., Shane, 1998, 2001, for single vs. multi-unit ownership, and e.g., Kosava & Lafontaine, 2010 for plural forms). Third, further research should also resolve the limited focus of our study on ownership structure only. Although this focus was required to study the role of ownership structure in-depth, research has shown that the ultimate results of franchising are dependent on the compatibility and cohesion with many other structural and behavioral aspects (see e.g., Nijmeijer et al. 2014b for an overview). Fourth, science and practice could benefit from further investigations of how franchisees experience the plural form. This study signaled a discrepancy between the franchisees not seeing any value from this structure and the franchisors assuming advantages for the franchisees in terms of receiving better support and a show-case for tried-and-tested improvement. The only prior study from the franchisee perspective confirmed some of these advantages in retail and service industries (Perrigot & Herrbach, 2012).

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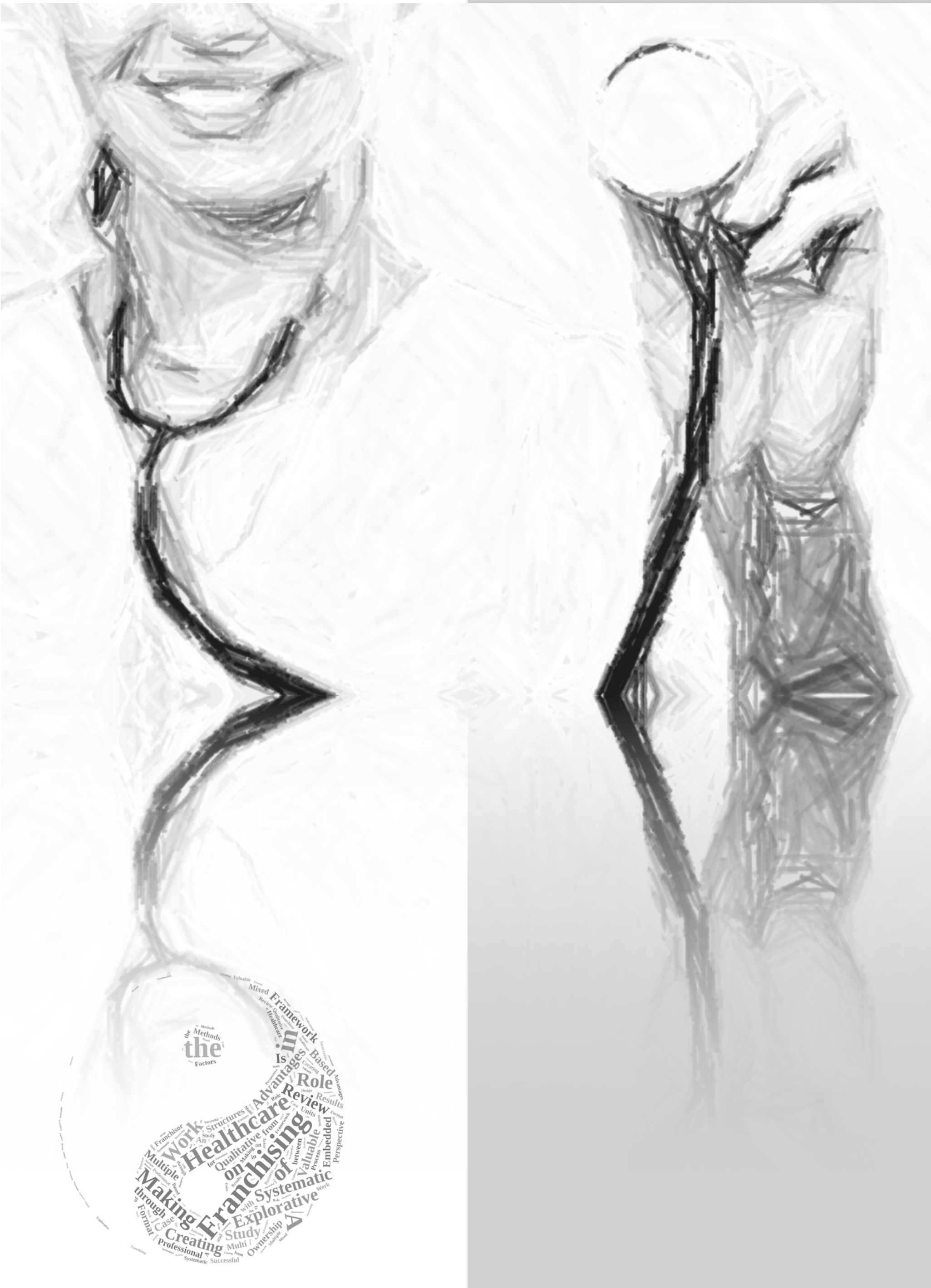

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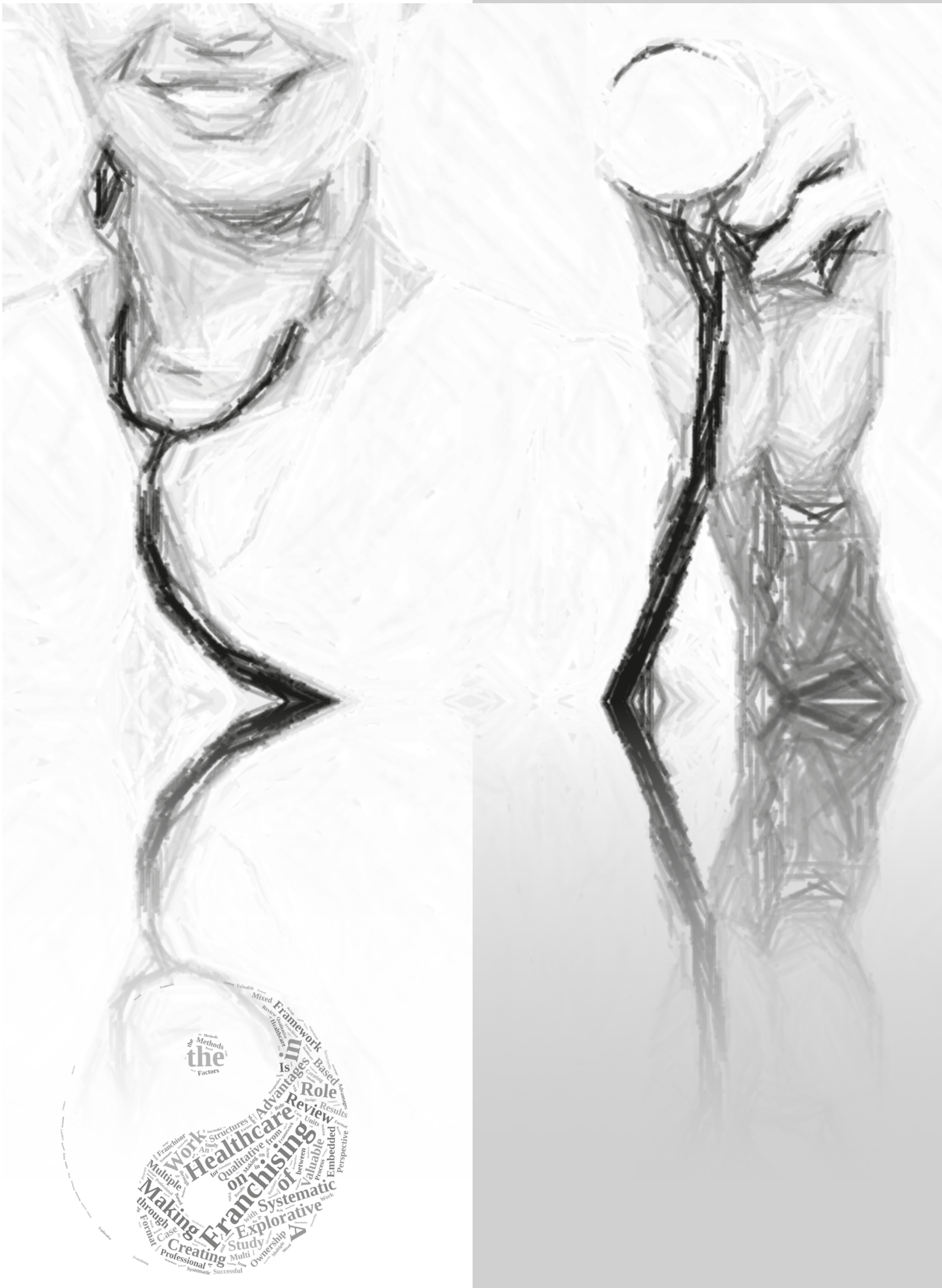
Chapter 6

Creating Advantages with Franchising in Healthcare: An Explorative Mixed Methods Study on the Role of the Relationship between the Franchisor and Units

This chapter was submitted as:
Nijmeijer, K.J., Fabbricotti, I.N., & Huijsman, R. Creating Advantages with Franchising in Healthcare: An Explorative Mixed Methods Study on the Role of the Relationship between the Franchisor and Units.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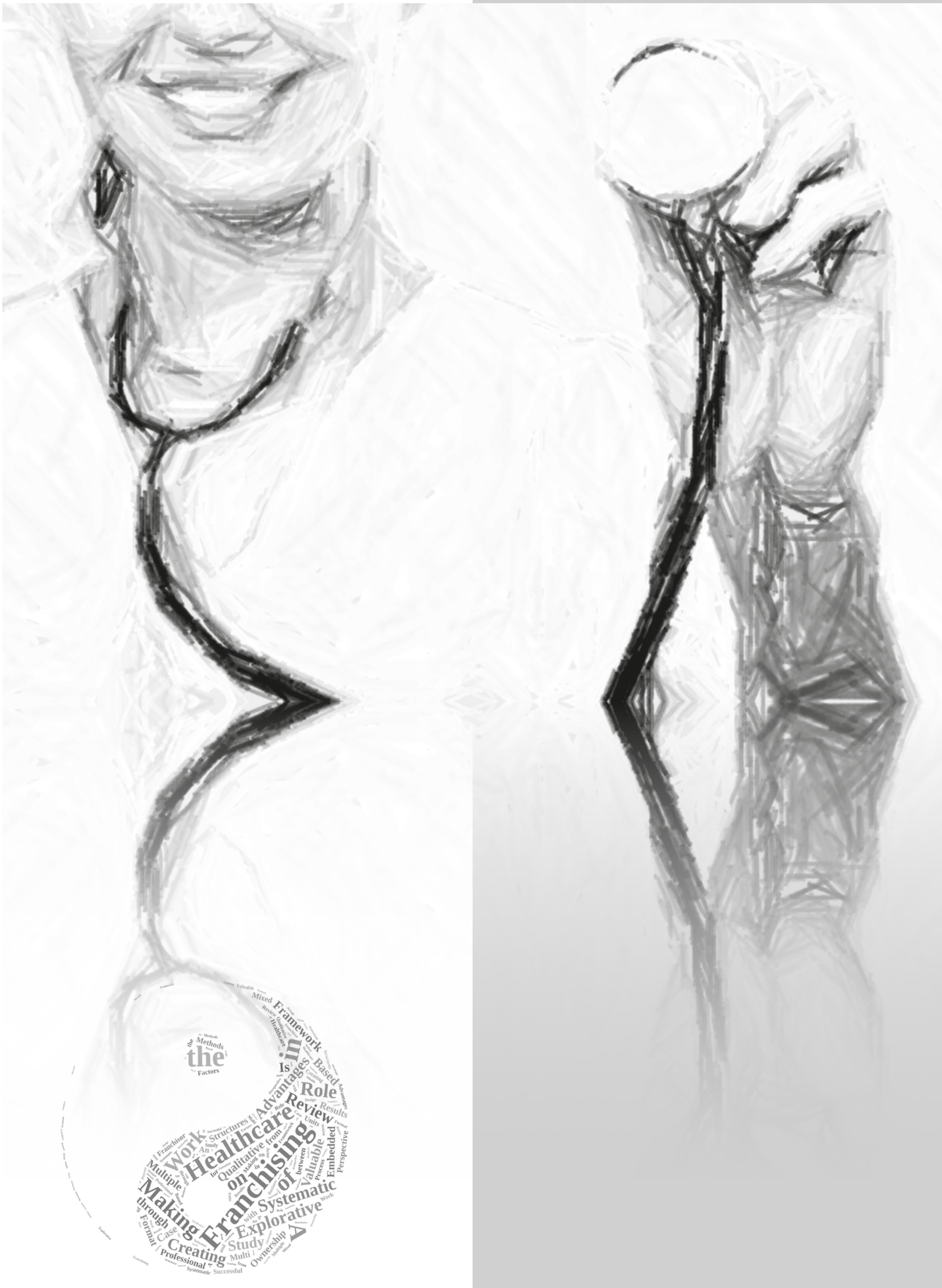
Chapter 7

Making Franchising in Healthcare Work: A Quantitative Exploration of Design and Process Factors for Successful Franchising

This chapter was submitted as:
Nijmeijer, K.J., Huijsman, R., & Fabbricotti, I.N. Making Franchising in Healthcare Work: A Quantitative Exploration of Design and Process Factors for Successful Franchising.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Chapter 8

General Discussion

Introduction

The aim of this thesis was to explore how one can make the theoretically promising franchise model for healthcare work. The overall question was: "*How are the structural design and process dynamics of healthcare franchises related to achieving positive strategic, organizational, professional and client-related results?"* In the following sections, answers are provided on the research question, the strengths and weaknesses of the methodology are considered, and the main findings are discussed. The discussion concludes with implications and recommendations for research and practice.

Conclusion: No blue print for making franchising in healthcare work

The main conclusion of this thesis is that there is not one unequivocal manner to make franchising in healthcare work. Which structural design elements and process dynamics are related to achieving positive results with franchising, and how, depends on whether one looks from the perspective of the franchisor or the unit actors, the desirable types of results, and the contexts and combinations in which the design elements and process dynamics are used. We elaborate on this conclusion below.

Choices in structural design and process dynamics

On an aggregated level, the theoretical and qualitative studies indicated that the actual strategic, organizational, professional and client-related results achieved in healthcare franchises are dependent on how franchisors and unit actors design their business format and ownership structures, the relative height of contractual payments, the attitudes and skills needed, the cohesiveness in which the franchisor and unit actors relate to each other, and the type of franchise model used. The quantitative study confirmed that these aspects are related to the overall results experienced by unit actors. A partially contradictory picture emerged from the perspective of the franchisor. The overall quantitative results perceived by franchisors were related only to the level of relational cohesion between the franchisor and unit actors and the design of the business format (see table 1).

Table 1: Overview of the choices in structural design and process dynamics related to overall results

Design element or process dynamic	Description	Results franchisor perspective		Results unit actor perspective	
		Qual	Quant	Qual	Quant
Business format					
Strength of positioning toward customers	Extent to which the presentation and collection of attributes of the healthcare services are perceived to be unique and attractive and presence of well-known brand.	+	+	+	+
Appropriate support in regard to type, amount, quality	Amount, quality and type of support (e.g., training, marketing) that suitably and sufficiently assist franchisees and unit managers in starting-up and operating their unit.	+	+	+	+
Level of control non-care activities	Extent to which the behavior and performance of units is controlled in regard to non-care related activities (through selection, decision-making, standardization, monitoring).	+ or -	+	+ or -	+
Level of centralized decision-making about care	Extent to which decisions about care provision in the units are made centrally (centralization of decision-making rights).	+ or -	0	+ or -	-
Level of standardization of care	Extent to which content and manner of care provision by unit actors is controlled by standardized operating instructions.	+ or -	0	+ or -	+
Ownership structure					
Non-cooperative vs cooperative system	Business format is owned by an independent central franchisor agency versus by some or all of the franchisees.	+	0	+	+
Plural form vs pure franchise system	Units are owned by both the franchisor and the franchisees, versus units are owned by franchisees.	+	0	0 or -	+
Active vs passive unit ownership	Franchisee-owner does the daily operations of the unit himself versus franchisee-owner has delegated the responsibility for the daily operation to an employed manager.	+	0	+	+
Single vs multi-unit ownership	Franchisee owns one versus more units.	+ or -	0	+ or -	+
Contractual payments					
Reasonable height of contractual payments	Extent to which the payments are reasonable relative to what franchisees receive in return in regard to branding, support, development and system management.	+	Not	+	+
Attitudes and skills					
Adequate attitudes and skills of franchisor	Extent to which attitudes and skills of the franchisor are adequate to successfully manage and operate the system.	+	0	+	+
Adequate attitudes and skills of unit actors	Extent to which attitudes and skills of the franchisees and unit managers are adequate to successfully manage and operate their unit(s).	+	0	+	+

+ = positive relationship; - = negative relationship; 0 = no or neutral relationship
Qual = qualitative study, Quant = quantitative study

Table 1: Overview of the choices in structural design and process dynamics related to overall results (continued)

Design element or process dynamic	Description	Results franchisor perspective		Results unit actor perspective	
		Qual	Quant	Qual	Quant
Relational cohesion					
Level of task cohesion	Extent to which franchisor and units closely cooperate as partners with attuned tasks, roles, respect and attention to each other's needs, share knowledge, communicate, and are mutually involved in improving and innovating.	+	+	+	+
Level of social cohesion	Extent to which the franchisor and the units trust each other, are mutually committed to making the entire system and individual unit(s) successful, are not focused on individual interests (opportunistic behavior) and have low conflict levels.	+	+	+	+
Type of franchise					
Stand-alone vs fractional type of franchise	Units exclusively provide franchised products and services versus units offer both franchised and non-franchised services (i.e., franchised services are part of a larger organization).	+	0	+	+

+ = positive relationship; - = negative relationship; 0 = no or neutral relationship
Qual = qualitative study, Quant = quantitative study

More specific, the thesis indicates that both the franchisor and the unit actors experience more positive results when the level of task cohesion and social cohesion among them is larger and when the business format includes a stronger positioning toward customers and appropriate support services. The role of the level of control in the business format in shaping overall results differs for different control elements and from the franchisor and unit actor perspective. Actors in both groups quantitatively experienced better overall results when they perceived more extensive control of non-care activities. Whereas unit actors also experienced better overall results when they felt more standardization of care activities and more decentralized decision-making about care, the designs of these control elements seem to matter less from the perspective of franchisors. This conclusion partially contradicts the qualitative study which indicated that control of care and non-care activities has both positive and negative effects from the perspective of both the franchisors and unit actors.

The mixed methods design also produced contradictory results regarding the role of ownership, attitudes and skills, and type of franchise in making franchising work from the franchisor perspective. The theoretical and qualitative findings indicated that franchisors would benefit from employing a plural form, non-cooperative system structure and stimulating active ownership by franchisees of one or more units. By contrast, the quantitative findings suggested that franchisor's experienced overall

results do not differ across ownership choices. Also the use of a stand-alone type of franchise and appropriate attitudes and skills were unexpectedly not quantitatively related to franchisor's experienced overall results. From the unit actor perspective by contrast, the ownership structures, attitudes and skills, and stand-alone type of franchise were positively related to overall results of franchising, albeit the positive relationship with a plural form was somewhat unexpected. Also a reasonable level of contractual payments to the franchisor was of importance to them.

Despite the presence of all these aggregated, overall relationships with results, the thesis also indicates that one actually should dig deeper than these overall relationships to really understand what makes franchising work for whom in which situation. We elaborate on that conclusion in the next sections.

Conclusion

At an aggregated level, unit actors experience more positive overall results of franchising in healthcare when:

- the business format includes a strong positioning, appropriate support, control of non-care activities, standardization of care, and decentralized decision-making about care;
- a non-cooperative, plural form system structure is used and franchisees actively own a single unit;
- the contractual payments are reasonable relative to what is received in return;
- the attitudes and skills of franchisors and unit actors are adequate to fulfill their role;
- the level of relational cohesion is higher;
- a stand-alone type of franchise is used.

At an aggregated level, franchisors experience more positive overall results of franchising in healthcare when:

- the business format includes a strong positioning toward customers, appropriate support, and control of non-care activities;
- the level of relational cohesion is higher.

The findings between the methods in the mixed methods design are partially contradictory in regard to the role of ownership, attitudes and skills, and type of franchise from the franchisor perspective.

Pivotal role of process dynamics

The business format, ownership structures, relational cohesion, type of franchise, contractual payments, and attitudes and skills are perceived to relate to results of franchising because each of these aspects produces various process dynamics. As a consequence of these process dynamics, the presence and direction of the relationships with results regularly differ for different types of results. The process dynamics that are produced by support and control in the business format, relational cohesion, ownership

structures, and franchise type are partially overlapping, diverging and contrasting to each other.

This thesis for example showed that more support and control in the business format basically can help promoting competitive advantage, survival and quality of care through steering the behavior of unit actors toward desirable performance levels and a uniform presentation. However, these designs can also hinder the quality of care, efficiency and work satisfaction by reducing the chance that business format practices are feasible and valuable to local units, by stimulating resistance of professionals, and by reducing their ownership and autonomy feeling. By contrast, through more task and social cohesion one enlarges the chance of feasible and valuable practices in the franchise and retains the opportunities for professionals to incorporate their own ideas. More control and social cohesion facilitate efficient knowledge sharing, but at the same time reduce (short-term) efficiency on the system-level through the larger overhead levels required. Task cohesion, a plural form, non-cooperative system-level ownership, support and control help stimulating the quality of care, work satisfaction, efficiency, competitive advantage and survival by accelerating innovation and implementation (no reinvention of the wheel) and by reducing the resources unit actors have to spend on choosing and applying appropriate work methods. However, support, control and plural form ownership can also negatively affect these result types by restricting the ability of unit actors to adapt to the local customers' needs and create an efficient fit with local practices. Such local adaptation and efficient local management and decision-making are stimulated by choosing a stand-alone franchise type, active and single-unit ownership. Whether the process dynamics underlying the system-level ownership structures in healthcare (steering, management, decision-making, control, interests) really play a role in results from the franchisor perspective is uncertain as quantitative relationships between ownership and overall results were absent.

The positioning, contractual payments, and attitudes and skills lead to a different type of process dynamics than the preceding ones, thus having a different function in making franchising in healthcare work. The positioning toward customers is essential because it determines whether customers and (potential) unit actors find the formula attractive and because it motivates actors to work hard on its achievement and maintenance. All the other process dynamics and structural design elements in the franchise system need to contribute to realizing the desired positioning. As systems differ in how they want to position themselves (e.g., highly customized care in a hospitable climate vs. a predictable care trajectory for clients within a fixed interval of time), so do the process dynamics and structural designs required. Through their own appropriate attitudes and skills, unit actors are able to suitably apply, complement and locally adapt the business format and make optimal use of the ideas of their peers and franchisor. Franchisors with appropriate attitudes and skills are able to fulfill their roles in regard to business format

development and adaptation, behavioral steering and cooperation with unit actors in a manner that suits their particular franchise sytem. Which attitudes and skills exactly are appropriate depends on the process dynamics one wants to generate. A level of contractual payments that is reasonable from the franchisee perspective ensures that the franchisor has sufficient resources for the desirable level of support, control, and innovation development in the system while the costs of care and franchise membership are acceptable.

Conclusion

- Different choices in regard to the design of support and control in the business format, relational cohesion, ownership structures and franchise type are related to results of franchising because they produce a variety of partially overlapping, diverging and contrasting process dynamics.
- These process dynamics include: local adaptation, management and decision-making; accelerated innovation and implementation of practices that are feasible and valuable to units; efficiently choosing and using care and non-care practices; synergy realization; facilitation of knowledge sharing; uniform presentation; system-wide adaptation; steering toward predictable performances; resistance to change; more bureaucracy; greater overhead levels.
- Dependent on the types of results one wants to achieve and the desired positioning toward customers, different process dynamics are desirable, and thus different choices in regard to support and control, relational cohesion, ownership and franchise type.
- At least from the perspective of unit actors, appropriate attitudes and skills and reasonable contractual payments make franchising work further because they help to really obtain potential benefits from the franchise cooperation.

Importance of situational fit

As also follows from the preceding conclusion section, this thesis indicates that making franchising work requires situational fit. Given their interdependencies, all of the choices that are made in regard to the design of the business format, ownership structure, relational cohesion, attitudes and skills, type of franchise, and contractual payments need to fit to each other. Moreover, considering the overlapping, diverging and contrasting process dynamics underlying these choices and the consequent different relationships with different types of results, different combinations of structural design elements and process dynamics are optimal in different situations. The optimal combination seems to depend on how the franchise wants to position itself toward customers, which results one wants to achieve for whom, the type of healthcare service and healthcare professional, how the external context looks like (e.g., purchasing policies of insurers), and the age and size of the franchise. The thesis for example showed that franchisors and unit actors that aimed to improve the quality and efficiency of care with franchising felt that they primarily benefited from back-office support to reduce the amount

of resources spend in non-care related work and from accelerated innovation and implementation. A franchise design supporting ample local adaptation was thought to be pivotal for complex healthcare services requiring substantial customization to deliver high-quality care. A uniform presentation and predictability were thought to be more important for a competitive position toward purchasers of care in case of more standardizable services.

The thesis also indicated that it partially differs across unit actors within the same franchise system how situational fit is to be achieved. Unit actors with different attitudes and skills, performances, and length of stay in the system have partially different needs and desires in regard to the type and extent of support, control, height of contractual payments, ownership, and 'composition' of relational cohesion (e.g., not all unit actors feel the need to share knowledge themselves and to be actually involved in developing innovations). These internal differences in situational fit imply that it is hard, if not impossible, to produce entirely optimal situational fit for all actors in one franchise system.

Given the importance of situational fit, one obtains only one piece of the puzzle of how to make franchising in healthcare work through studying aggregated, quantitative relationships with overall results.

Conclusion

Making franchising in healthcare work requires situational fit. That is, the most appropriate combination of process dynamics and structural design elements depends on the desired positioning of the franchise towards customers, the desirable results, external context/ market, type of healthcare service/professional, age and size. In combining process dynamics and structural design elements, one needs to account for their interdependencies, including their partially overlapping, diverging and contrasting effects. The configuration in which situational fit is achieved partially differs across unit actors within the same system. Producing entirely optimal situational fit for all actors and for all result types in one system seems impossible.

Start of a new typology of franchise organizations in healthcare

Through abstracting out the conclusions of the thesis, roughly three ideal-types of franchise configurations can be distinguished that seem suitable to make franchising work in different situations: a *soft/loosely coupled franchise,* a *back-office franchise,* and a *full care franchise* (see table 2). Relational cohesion is important and functional in all three configurations of healthcare franchises. Ownership and type of franchise are not included in the typology. The process dynamics they produce can strengthen or weaken the effects of the three ideal-types. These three configurations of franchise organizations are a rough starting point; they require further research and development.

In a *soft/loosely coupled franchise* the franchisor and unit actors work relatively independent from each other. They particularly work together in developing and sharing improvements and innovations, using the same brand and core attributes in providing services. The level of support and control are relatively low. Relational cohesion is a major uniting factor between actors that also facilitates developing and improving together. Unit actors are entrepreneurial, independent, and willing to cooperate with peers. Contractual payments are low as the input from the franchisor is relatively small. This type of franchise is particularly suitable to deliver high-quality care and stimulate work satisfaction when healthcare services are relatively complex, professionalized and customized, and when uniformity and predictability of the process of healthcare delivery is less important to customers. This type is also suitable to efficiently innovate to continuously adapt to changing markets and client desires. Clearly demonstrating and communicating the core attributes and performances of the services to customers must help establishing the brand name in absence of other uniformities.

A *back-office franchise* is primarily directed to unburdening healthcare providers and generating economies of scale in non-care activities like administration and ICT. Consequently, the level of control and support are high for non-care activities and low for care-related activities. Relational cohesion is important to obtain synergy from the franchise cooperation and to ensure local fit of the franchised practices. Unit actors must be entrepreneurial and independent in care provision, willing to cooperate with peers, and accept steering and loosing control in non-care activities. This franchise type is primarily suitable to stimulate the quality of care, efficiency of care, and work satisfaction when many administrative and organizational tasks can be arranged centrally or in cooperation; professionals have more time left to provide care and economies of scale are obtained. Similar to the soft/loosely coupled franchise, this type is suitable for relatively complex, professionalized services or services requiring customization and when uniformity and predictability of the care process is less important.

A *full care franchise* is focused on the entire organization and process of care delivery. Consequently, the level of support and control are high, as is the level of contractual payments. Relational cohesion must prevent resistance of professionals and ensure local fit of the franchised practices. Unit actors must accept steering and losing control and must be willing to follow the guidance of the formula. This franchise type is primarily suitable to stimulate the efficiency and competitive position when many tasks and activities of local providers can be arranged centrally or in cooperation, when quick adaptation to nation-wide changes is important, and when uniformity and predictability are important to purchasers and clients. This type is also beneficial for the quality and efficiency of care when the care services require less customization and are relatively easy to standardize and replicate, and when professional bodies play an important part in developing care standards that can be complemented in the franchise.

Table 2: Situational fit of three ideal types of healthcare franchises

	Soft/loosely coupled franchise	Back-office franchise	Full care franchise
Pivotal characteristics			
Focus	Accelerated improvement and innovation, using same brand and core values	Unburdening healthcare providers and yielding economies of scale in non-care activities	Optimal performance through focus on entire organization and process of care delivery
Role of relational cohesion	Facilitating and uniting factor	Facilitating factor, ensuring local fit	Preventing resistance, ensuring local fit
Support level	Low	Low care activities; high non-care activities (e.g., administration, ICT)	High
Control level	Low	Low care activities; high non-care activities	High
Attitudes and skills needed from unit actors	Entrepreneurial, independence, willing to cooperate and involve with peers	Acceptance of steering and losing control in non-care activities, entrepreneurial and independence in care, willing to cooperate and involve with peers	Acceptance of steering and losing control; follow guidance of formula
Contractual payments	Low	Medium	High
When suitable and valuable			
Process characteristics	Individual development and innovation expensive, time-consuming, difficult	Many administrative and organizational tasks that can be arranged centrally or in cooperation	Many care and non-care related tasks and activities of providers can be arranged/ determined centrally or in cooperation
Type of service / professional, type of positioning	Relatively complex, relatively professionalized, requiring customization	Relatively complex, relatively professionalized, requiring customization	Less complex, less customization, relatively easy to standardize and replicate; or services in which professional associations play an important part in developing care standards
External context / positioning	Changing markets or client needs; uniformity and predictability in process of healthcare delivery less important for positioning toward purchasers (insurers, regional care offices, government, clients) and clients	Cost pressures; uniformity and predictability of process of healthcare delivery less important for positioning toward purchasers (insurers, regional care offices, government, clients) and clients	Medium changing markets or client needs, requiring quick nation-wide adaptation; uniformity and predictability in healthcare services are important for positioning toward purchasers (insurers, governmental offices, clients) and clients
Pivotal types of results	Quality, efficiency of innovation, work satisfaction	Quality, efficiency of care, work satisfaction	Efficiency, competitive position, quality (if used in appropriate situation)

Methodological considerations

This thesis provides a comprehensive initial evidence base regarding the structural design elements and process dynamics related to success in franchising. It does so through using a mixed methods design that sequentially integrated systematic literature reviews, a qualitative multiple embedded case study and a quantitative cross-sectional survey, with inclusion of the perspectives of franchisors and unit actors. The literature reviews gave theoretical grounding for the empirical studies. The qualitative multiple embedded case study in three healthcare franchises in different sectors was instrumental in refining, complementing and adapting the theoretical background to the empirical situation of Dutch healthcare franchises. It also helped gaining an in-depth understanding of the reasons underlying the identified relationships and developing a survey instrument appropriate for this situation. Through the quantitative study in nineteen healthcare franchises from five different sectors, we were able to triangulate findings and obtain quantifiable insights from a larger population of healthcare franchises. Nevertheless, this thesis also has several methodological limitations that are considered below.

Formulating conclusions with inconsistencies between methods in mixed methods design

The mixed methods design with systematic reviews, a qualitative study and a quantitative study was instrumental in producing the theoretically grounded in-depth and broad findings in this thesis, but also makes it hard to formulate clear conclusions about which main structural design elements and process dynamics are related to results. Particularly from the perspective of franchisors, various inconsistencies were found between the theoretical and qualitative findings on the one hand, and the quantitative findings on the other hand. These inconsistencies evoke the question whether the truth is more reliably reflected by extensive qualitative data sampling in three franchise systems or by 41 quantitatively surveyed franchisor representatives from nineteen franchise systems. We ultimately gave more weight to the statistical quantitative findings in formulating conclusions about the overall relationships with results given the sequential order of our methods, while acknowledging the contradictions with the theoretical and qualitative findings.

Causal inferences: Conducting explorative research in real-life settings

Although all the empirically investigated relationships in this thesis were theoretically grounded, the conclusions need to be interpreted with caution because the research design does not permit making causal inferences. Thus, it remains uncertain whether the design elements and dynamics really affect results or are only related. It is hard to

develop causal inferences for complex organizational arrangements in real-life settings like franchising, in which many aspects relate to results. We lacked a suitable basis to employ the strongest research designs that are possible in such complex settings, because this was the first study that has comprehensively investigated this topic in healthcare.

Use of perceptions from one data source in the quantitative study

Perceptual self-reported quantitative measures were used for design elements and dynamics as well as for results, all obtained from the same respondent. For some result types, particularly the quality of care, we had no choice because objective quality indicators that can be compared across healthcare sectors are lacking. Perceptual self-reported measures have shown to be a valid and effective substitute (Hart & Banbury, 1994; Inma & Debowski, 2006). However, it would have been beneficial for the validity to triangulate with available objective measures from other data sources like annual reports (e.g., solvability for financial performance). Using objective result measures would also have resolved the potential problem of common method variance (Conway & Lance, 2010), although we have no indications that this has biased our results (see chapter 7).

Role of the researcher in the qualitative study

The data sampling and analysis in the qualitative study were primarily conducted by one researcher. Although theory was used as a framework, it is possible that other researchers would have interpreted and clustered the structural design elements and process dynamics partially different (Yin, 2003). The interpretations were checked for correctness, clarity and consistency through member checks by case reports, presentations and advisory boards, and through the involvement of a research team in judging and fine-tuning the analyses. Interview quotes in the case reports and articles permit readers to evaluate the interpretative elements in the analyses. A part of the qualitative findings could be triangulated by the quantitative study. Nevertheless, the validity of the findings would have been strengthened by systematically checking, complementing and refining the analyses through a Delphi-study or concept mapping study with case representatives (or other experts), resulting in a validated framework of success factors of franchising in healthcare (Plochg & Van Zwieten, 2007; Swanborn, 2002). The closer involvement of the researcher in one of the cases made it challenging to keep distance for the sake of objectivity, but also provided unique possibilities to follow developments over time and continuously sharpen and reflect on interpretations. The theoretical framework, comparison with the other cases, the research team and advisory boards helped maintain objectivity.

Investigating heterogeneous franchise systems in different healthcare sectors

Investigating franchises in different healthcare sectors is beneficial for the generalizability but increased the difficulty of comparison. The heterogeneity in healthcare services provided and professionals involved now and then made it hard to distinguish between perceptions that were the consequence of this heterogeneity and that were shaped by differences in structural designs and process dynamics. Our within-case analyses helped making clearer distinctions.

The heterogeneity in franchise systems also made it complicated to distinguish clear actor groups at the unit level. Initially, the focus was only on franchisees. Soon it became clear that a broader focus was required to obtain a comprehensive understanding of how franchising works. Franchisees, unit managers and professionals were included; professionals often had a franchisee or unit manager role as well. Depending on the topic of analysis and convergence of perceptions, these roles were aggregated or separated. Distinguishing similar roles across cases was complicated: while a franchisee in one system was an independent entrepreneurial professional at a small-scale facility, a franchisee in another system constituted an organization with professionals and managers operating a unit. This heterogeneity alone at times led to a difference in perspective and perception. We partially resolved this issue in the quantitative analysis by including a 'type of franchise' control variable. Nevertheless, it is likely that we have lost some nuance in our analyses through our distinctions and aggregation of all types of unit actors across systems in one 'unit actor' group.

Provisional framework of what makes franchising in healthcare work

In all, the insights of what makes franchising in healthcare work are provisional and need further development. First, it remains partially unknown whether the designs and dynamics are related to all types of results or to only some because a single overall measure of results was used in the quantitative study. Thus, the thesis does not provide quantitative large-scale insight in which choices should be made to achieve a particular type of result (e.g., quality of care). Moreover, it does not reveal potential trade-offs between results, such as between maximization of profits and the provision of high quality care (Pozniak, 2006). Second, we have not quantitatively investigated if the process dynamics indeed mediate the relationships with results for both the franchisors and the unit actors, and how strong. Third, only operational franchise systems with at least one franchisee were included. Comparison with franchisors that failed to contract at least one franchisee and with franchisors and unit actors that have quit franchising may would have led to additional or fine-tuned insights. Fourth, the small number of franchisors included in the quantitative study due to the relatively young healthcare

franchise industry prevented subgroup analyses for different types of healthcare (e.g., mental healthcare vs. home care). The qualitative study indicated that different types of healthcare may require different designs and levels of relational cohesion as they differ in the level of professionalization and customization. The small sample also hindered quantitative investigation of the conclusion of situational fit. Finally, although the inclusion of multiple different healthcare sectors strengthens the generalizability of our findings, actual generalizability to other countries need to be established.

Discussion of the findings

Five themes can be extracted from the findings in this thesis that merit further discussion.

The need to adapt insights from business to make franchising in healthcare work

This thesis shows that the franchise literature originating from business can provide useful insights regarding how to make franchising in healthcare work. The clusters of structural design elements and process dynamics related to results are largely similar. However, their role and detailing regularly differ from business as a consequence of the combination of imperfect market mechanisms, the pivotal role of healthcare professionals, and the delivery of personal, intimate services that require at least some customization (Berry & Bendapudi, 2007). Thus, although the insights from business can be used as a basis, adaptation and complementation is required to make franchising in healthcare work. This conclusion is consistent with studies in healthcare that investigated other methods and organizational forms originating from business, like the time out procedure and crew resource management from aviation (De Korne et al., 2010), lean and six sigma (Proudlove et al., 2008), total quality management and business process reengineering (Yasin et al., 2002). We elaborate on this conclusion below.

We noticed that the role of various structural design elements and process dynamics differed from business or needed complementation. Contrary to business (Minguela-Rata et al., 2009, 2010), a greater amount of support was not consistently considered more appropriate in healthcare. Through more moderate support levels, unit actors retained opportunities to incorporate their own professional ideas and meet the specific needs of local clients in need for care. Also in regard to control, both the franchisors and unit actors argued that unit actors need sufficient space, particularly in providing care in complex and customized services. Possibly even more than in business (Clarkin & Rosa, 2005), it seems important in healthcare to provide unit actors with opportunities to provide input and be involved in developing innovations and standards to ensure that they feel ownership and fit and that they accept rather than resist their implementation.

The ultimate absence of a quantitative relationship with a plural form from the franchisor perspective may be explained by the involvement of healthcare professionals that reduce the control and steering advantages of company-owned units. It is also possible that altruistic motivations and strong professional norms (Andersen, 2009) resulted in fewer performance differences between unit managers and franchisees than in business. Even though business insights also indicated that contractual payments need to be reasonable from the franchisee perspective (Dubost et al., 2008), the social-ethical character of healthcare makes reasonable payments even more important. This thesis also showed that strong branding regularly is not a sufficient condition in various healthcare sectors to increase client volumes; production limits and purchasing policies hinder significant shifting of volumes across providers. Together with the non-profit character of multiple franchises, this implies that franchises in healthcare regularly strive toward other types of results than those in business, asking for different structural designs and process dynamics.

Various authors have also argued that copying the franchise model from business to healthcare can lead to problems that hinder success. Montagu (2002) argued that implementation of potentially beneficial business format elements can be hindered by professionals that misuse their powerful role to refuse implementation. This thesis shows that professionals indeed sometimes resist implementation, particularly when they feel that it is imposed too heavily and does not benefit their practice. Also the fractional type of franchise that is regularly used in the healthcare sector can hinder uniform implementation across units. Moreover, authors have warned that the use of a franchise model similar to business can threat the quality of care and work satisfaction of professionals because the uniformity required for branding and economies of scale restricts autonomy (Montagu, 2002). Following this thesis, in case of situational fit such a threat does not necessarily exist; the design and operation of the franchise must fit to the type of service/sector. Finally, authors have argued that successful franchise application could be hindered because controlling the quality of services provided by professionals may be difficult for the franchisor as he lacks the specialized knowledge, whereas the system's reputation depends on the quality of services provided (Knott et al., 2008; Montagu, 2002). In this thesis, this issue was not directly brought to the front and framed as unique to franchising. In the entire healthcare sector, actors are considering and struggling how quality can be measured.

Different from business sectors, franchise systems in healthcare also have to deal with a regulated sector with complex rules and reimbursement systems, political-ethical issues, clients that use but regularly not pay a service, and, dependent on the sector, a strong position of professional scientific bodies. This environment frequently does not stimulate, or even hinder, entrepreneurial or deviating activities. Financing is based on predefined activities; deviating activities are not (financially) stimulated

(Phillips & Garman, 2006). At least in the Netherlands, superiorly performing healthcare organizations with large demands for their services are regularly not rewarded; some organizations even bear financial losses because they are doing well. The content and application of laws and regulations restrict the possibilities to implement alternative work methods that do not entirely fit (Phillips & Garman, 2006; Timmermans et al., 2008). Ambiguities and uncertainties in changing governmental policies and regulations also negatively affect the development and growth of new organizational models. Historically, most providers and individuals in healthcare also do not feel taking entrepreneurial risks. As financing, policies and cultures differ across sectors (Timmermans et al., 2008), so does the entrepreneurial climate for franchise models.

The use of business insights to make franchising in healthcare work, and vice versa, also requires further research. The broad focus of this thesis has resulted in an initial overview. To really understand the differences and similarities one needs to investigate the role of individual design elements and process dynamics in-depth, with attention to the role of the external environment in business sectors with and without similar characteristics (e.g., compare highly professionalized medical services with professionalized advocacy franchise).

Franchising from the customer perspective

This thesis does not provide insight in what the customers of franchise systems, i.e., clients and other purchasers (health insurers, regional care offices, local governments), actually value in franchise systems. The thesis only includes the perceptions of franchisors and unit actors about what makes franchising work for customers. However, ultimately the clients and purchasers should value healthcare franchises to make this organizational form work on the long term. Surprisingly then, also in other industries it is hardly known what it is that customers value about franchise systems and how franchises thus should be designed and operated to be successful (Dant, 2008). Consistent with the assumptions of authors in the literature about healthcare franchising, the franchisors and unit actors in our studies felt that their clients value franchising because they receive high quality care in their own localities through the combination of care provision in decentralized units and centrally arranged support, quality monitoring and standardization of best practices (Knott et al., 2008; Montagu, 2002). However, they perceived that clients only benefit from these characteristics if the franchise is designed and operated in a way that suits the type of healthcare services and the clients' needs. The same applies to the potential ability for clients to easily identify the care through branding, transparency and uniformity in the franchise (Pozniak, 2006). Some franchisors and unit actors argued that the purchasers would benefit from the same characteristics as the clients in need for care.

Suitability of franchising for healthcare professionals

An important question is whether healthcare professionals should desire to work in a franchise. This thesis shows that the answer on this question depends on the franchise system and professionals themselves. As long as the franchise design and dynamics fit to the type of healthcare services and the professionals' needs and desires, a franchise can indeed provide a pleasant work environment in which professionals can focus on the provision of high-quality care in a supportive work environment with ample opportunities for knowledge exchange with peers, while earning a good income (Hogan et al., 2006; Knott et al., 2008; Pozniak, 2006). However, in case of a misfit a franchise can be a bad experience; the warnings for undesirable reductions of autonomy, impossibilities to develop an own identity, and hindrances to implement own ideas and products and services that fit best with the needs and wants of clients (Montagu, 2002; Knott et al., 2008) then become reality.

Potential contrasts between the franchisor and the unit actors

Many franchise studies assume that franchisors and franchisees have conflicting interests. While franchisors seek control, franchisees always strive for autonomy (Kidwell et al., 2007). And while franchisors strive for high sales, franchisees benefit from higher unit-profits (Castrogiovanni & Justis, 1998). Overall, this thesis shows that franchisors and unit actors in healthcare indeed sometimes have different perceptions or pursued interests, of which some inevitably inherent to their differences in roles. However, this thesis also shows that diverging perceptions and interests can be partially prevented by ensuring situational fit. Franchisors indeed struggled with the issue of control versus autonomy, as hypothesized by for example Kidwell et al. (2007), but also recognized that, depending on the type of service provided, healthcare providers need a particular autonomy in their care provision to appropriately help their clients. Diverging perceptions and interests can also be partially prevented by greater task cohesion in the form of communication and mutual involvement in developing new standards. This finding is consistent with a subset of franchise studies (e.g., Clarkin & Rosa, 2005; Falbe & Dandridge, 1992) that argued that successful franchise relationships are based on co-creation and entrepreneurial innovation of both the franchisors and franchisees, rather than by hierarchical steering, management and enforcement by the franchisor.

Situational fit: Not one best practice to make franchising work

The conclusion that situational fit is required to make franchising in healthcare work is consistent with a subset of the franchise literature. Primarily the last decade, authors have shown that individual design and process choices can have different effects in different combinations (e.g., Barthelemy, 2008; Gillis & Combs, 2009). Acknowledging

the heterogeneity among franchise systems, authors have also tried to distinguish homogeneous groups based on age, size and pricing strategies (Carney & Gedajlovic, 1991; Castrogiovanni et al., 1995) and to develop configurations of franchise organizations including structural, strategic and process-related features (Castrogiovanni & Justis, 1998). Using Mintzberg's typology of organizations, Castrogiovanni & Justis (1998) reasoned that franchise organizations use one of two hybrid forms: carbon-copy or confederation franchise. The first form shares similarities with the 'full care franchise' distinguished in this thesis, while the latter shares similarities with a 'soft/loosely coupled franchise'. The conclusion also fits in the 'configuration' and 'systems' view in general organization theory (Castrogiovanni & Justis, 1998; Mintzberg, 1983).

Implications and recommendations for research

Various implications and recommendations for further research can be formulated that will extend the theory and evidence base and help to provide better decision-support to franchise practitioners.

More confidence in causal inferences through stronger research designs

Although it is hard to really ascertain causality in complex organizational settings, scholars could employ stronger research designs through using our findings as a starting point. Such research should employ a longitudinal design and focus on the influence of particular design elements or dynamics instead of the entire model. Ideally, it includes a baseline qualitative and quantitative study and one or more follow-up quantitative measurements in a small number of franchise systems that have planned to change the element(s) or dynamic(s) of interest. Interviews with key stakeholders between measurements should identify any concurrent developments that might also affect results. Alternatively, a similar design would begin with the identification of a few typically low, medium and high scoring franchise systems on the element(s) or dynamic(s) of interest in a large sample of systems.

Investigate multiple types of results from different data sources in one study

As a complement to the overall quantitative results measure used in this thesis, research should include valid separate measures for different types of results. To strengthen the validity of such research each type of result preferably is measured by data from at least two data sources; one perceptual measure and one objective measure from for example public databases or annual reports. Separately measuring different types of results will provide quantitative insights in potential trade-offs between different types

of results when a particular design or process dynamic is used. Generating such insights would better support practitioners in determining how to design and operate their franchise to reach their prioritized goals (e.g., improve quality, obtain optimal financial performance). To obtain valuable insights such research should preferably include care-specific, patient-related outcomes like accessibility and medical outcomes if research is conducted within one sector.

More in-depth investigation of situational fit within franchise systems

Quantitative or mixed methods investigation of the conclusion of situational fit would be a valuable extension to this thesis. Given the breadth and exploratory nature of the research in this thesis, more in-depth and confirmatory insights are needed to really provide reliable decision-making support to practitioners. Franchise practitioners can better decide how to design and operate their system and units when they understand why and how different choices are related. Such research should provide quantitative confirmation and more in-depth insight in whether and how the design elements, process dynamics, and types of healthcare services/sectors moderate and mediate each other, as illuminated in this research.

Employ a multi-actor / multi-stakeholder approach

This thesis has shown the value of including the perspective of more than one actor in the same study. Investigating multiple perspectives helps practice determining which particular choices are beneficial for different stakeholders and for which choices interests diverge. As a direct complement to this thesis, it is important to investigate which elements make franchising work from the client perspective. Are their (experienced) results primarily related to the positioning of the formula, to the attitudes and skills of the unit actor(s), to the level of standardization and centralized decision-making, to the unit-level ownership structure? The role of attitudes and skills can be investigated through within-system comparisons between units; the role of the structural design elements only through quantitative cross-system comparisons or through investigating perceptions of clients that have switched care providers. Similar suggestions apply to adding the perspectives of insurers, regional care offices, local governments and referring providers.

Investigate 'failed' franchisors and franchisees

Investigating 'failed' and ceased franchisors and unit actors will help to confirm and extend the insights in the choices that should not be made to enlarge the chance of success. A comparison of such failed franchisors and unit actors with operational ones will also help obtain more insights in the role of the external context: did 'failed' ones

operate in more hindering external contexts, or were they less able to cope with such a context than their successful counterparts?

International comparisons with attention to the role of the external context

A cross-national study will be a valuable extension. It permits investigating whether different (combinations of) designs, relationships and behaviors are required in different external contexts, given the differences in healthcare systems, rules, legislation and cultures across countries. Such a study also helps determining the actual generalizability of our findings to other countries and the role of the external context itself in the success of franchising. Moreover, through cross-national data sampling a larger number of healthcare franchises can be included. This larger sample size will permit performing subgroup analyses to identify if different types of healthcare services and functions on the unit level (franchisee, professional, unit manager) require different configurations to make franchising work. A larger sample size also permits obtaining a more in-depth insight in situational fit through investigating mediating and moderating relationships, as described above.

Implications and recommendations for practice

Implications and recommendations for organizations and professionals using franchising

Franchisors and unit actors embarking on franchising in healthcare must realize that there is not one best practice to make it work; situational fit is key. When developing a new franchise system, it seems wise for franchisors to first determine how the system wants to position itself toward customers and which results are desired for different stakeholders, while accounting to the type of healthcare service, healthcare market and type of healthcare professionals. Then they can determine which process dynamics are required. Subsequently, the desirable combination of franchise design elements, level of relational cohesion, contractual payments, and attitudes and skills can be established. For unit actors that want to join a franchise it seems wise to obtain reliable information about the system, including its functioning in daily practice (e.g., what is the actual involvement of unit actors in development), and determine whether it fits with their personal desires, their skills and the results they want to achieve. Franchisors and unit actors in existing franchise systems should regularly reflect whether there still is situational fit, and adapt accordingly. In all cases, successful franchising in healthcare requires a certain level of task and social cohesion. In particular, franchisors must involve healthcare professionals to develop (care) standards and share ideas, as this will reduce the resistance and ensures a valuable fit with localities.

Particularly when franchise configurations similar to the *soft/loosely coupled* and *back office* ideal-types are used (see table 2), franchisors and unit actors must work on demonstrating their quality and costs with indicators of relevance to clients and other payers/purchasers. They must also ensure that the care services across units are delivered according to the core characteristics defined in the positioning component of the business format (e.g., hospitality) and must clearly communicate and demonstrate this to customers. Because the uniformity of care provision basically is lower in these two franchise ideal-types, the establishment of a strong brand-quality or –cost link depends on the experiences of clients in their actual service encounter and on the demonstrable quality and costs.

In designing and operating their system, franchisors and unit actors must also take the possibilities and restrictions of national and regional rules, regulations and policies into account. Not all support types and knowledge sharing activities are allowed under competition law. Examples are benchmarking up-to-date information and shared bids on healthcare procurements with units that operate on the same market[1]. National contracting of local healthcare providers is hindered by both the financing system (e.g., requirement to contract with each regional care office in the AWBZ) and competition law, reducing one of the potential values of franchise cooperation. Franchisors must also consider the existing roles and activities of the scientific and professional bodies in their healthcare sector when designing their franchise system. Dependent on the sector, these bodies play a minor or major role in the development of standards and policies and in providing knowledge sharing facilities. Some anecdotal evidence from our studies suggests that a major role of these bodies can reduce the value of franchising in regard to facilitating knowledge sharing and innovation development, and can interfere with developing and uniquely profiling the franchise system based on (care) standards. Standards and conservative ideas of these bodies can also slow or hinder the implementation of particular innovative or adapted work methods. On the other hand, such existing care standards can be used as a solid basis for franchise development.

Implications and recommendations for health insurers, regional care offices, and (local) governments

Society increasingly asks for small-scale, decentralized healthcare facilities and home care to keep healthcare affordable in the long term and to provide those in need with high-quality care. For more complex care a trend toward concentration and spread of care is stimulated by the Dutch government and scientific, professional bodies. Franchising basically is a suitable organizational model to support these societal trends.

1 See 'Richtsnoeren voor de zorgsector, maart 2010, ACM.

It combines large-scale knowledge sharing, innovation development and economies of scale in the back-office with local care provision by professionals. It could also provide possibilities for purchasing nation-widely available healthcare with predictable quality and costs. However, competition law, the financing system, and continuously changing and ambiguous policies hamper further growth and flourishing of healthcare franchising and similar types of organization. Governments and politics should work on more stability and long-term vision because many entrepreneurs will not dare to take risks in instable, continuously changing quasi-regulated markets. Moreover, together with banks, insurers and regional care offices, they should work on a more supportive entrepreneurial climate in healthcare by rewarding innovative, entrepreneurial activities and by providing space and financing for new, promising entrants on the healthcare market. Pay for performance models and personal budgets basically provide health insurers, regional care offices and local governments with possibilities to stimulate new promising organizational forms like franchising, but actual use of these possibilities by these purchasers is required. Nevertheless, this thesis also warns these parties that not every franchise system is to be trusted in fulfilling its promises; judging its situational fit and value is essential.

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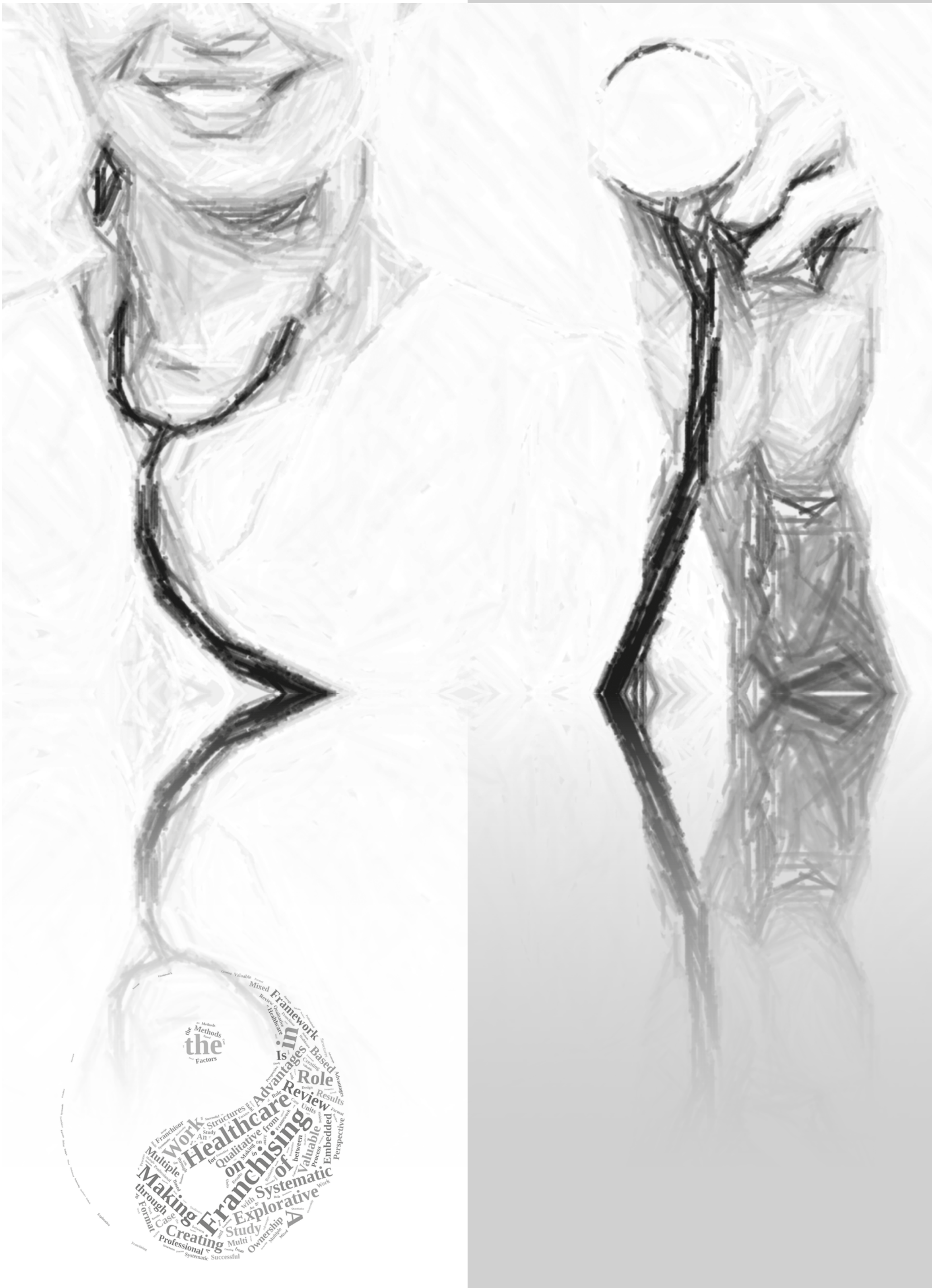
Franchising
Healthcare
Framework
Making
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Explorative
Creating
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Summary

Introduction and methods

Business format franchising is increasingly being used as a form of inter-organizational cooperation in healthcare. It is a promising model to efficiently deliver high quality care, provide professionals with a supportive work environment, and achieve positive strategic and organizational results. However, evidence is lacking concerning how these healthcare franchises should be designed and operated to actualize success. Therefore, this thesis aimed to explore the following research question: *"How are the structural design and process dynamics of healthcare franchises related to achieving positive strategic, organizational, professional and client-related results?"*

Because of the lack of research in healthcare regarding this topic, an exploratory sequential mixed methods study was conducted with three sequential steps. First, a theoretical framework was built around this question through conducting two systematic literature reviews; one of findings within healthcare and one of findings from other industries. Second, qualitative and mixed methods studies were used to refine, adapt, and complement the framework from other industries for healthcare on the basis of three cases in three different healthcare sectors. Third, a cross-sectional survey was developed to quantitatively investigate the framework for healthcare based on data from nineteen healthcare franchises in five different healthcare sectors. Data were sampled from both the franchisor and actors operating units to obtain a comprehensive understanding of how healthcare franchises can be designed and operated successfully.

Phase 1: Development of a theoretical framework through systematic reviews

Chapter 2 and 3 present the two systematic literature reviews that were used as a theoretical foundation for the empirical studies. The review presented in ***Chapter 2*** aimed to identify the available empirical evidence regarding the *results of franchising in healthcare* for organizations, clients and professionals. The review included 15 articles. It reveals that the body of empirical knowledge is quite undeveloped. The evidence available so far shows that franchising has the potential to be valuable to healthcare practices, but that the actual results achieved vary within and across franchise systems. The available studies hardly provide insights into what factors produce those variable results.

Therefore, ***Chapter 3*** comprises a systematic review that aimed to collect all the empirical evidence from all industries on the *structural design and process-related factors* that make franchising work and to integrate this evidence in a framework. Through analyzing 126 articles, five major factor clusters with multiple sub-factors were identified that are related to the results of franchising: the ownership structure that is

chosen for the system and the units, the design of the business format, the design of the contract, the behavior of the franchisor and the franchisee and their interaction, and the age and size of the system and the units. The review also suggests that franchisors and franchisees should consider the compatibility and cohesion of these different aspects if they are to achieve optimal results, rather than assuming that all individual aspects have a universal similar effect.

The findings from chapter 2 and 3 were used as a theoretical framework and to generate the topic list for the qualitative research.

Phase 2: Adaptation and in-depth exploration of a framework of success factors of franchising in healthcare through qualitative and mixed methods studies

The studies described in the next three chapters of the thesis aimed to provide an in-depth insight in how franchise organizations in healthcare are structurally designed and operated, and how these designs and process dynamics are perceived to promote or hamper achieving positive results. Moreover, the studies aimed to understand the underlying reasons for their importance to really grasp how healthcare franchises work and how effective choices can be made by franchise practitioners.

The study described in ***Chapter 4*** focused on the role of the *business format*. A qualitative comparative embedded case study was conducted with three healthcare franchises providing mental healthcare, hospital eye-care, and care for the intellectually disabled. Data were collected through 96 in-depth semi-structured interviews with franchisors and unit actors, observations and document analyses. The study reveals that the positioning toward customers, the type, quality and amount of support, and the level of control with regard to the selection of new participants, standardization, centralized decision-making, monitoring, and possibilities to force, are the elements that are perceived to be related to results for all parties. It is suggested that both extensively high and low levels of support and control to units should be avoided. A moderate level of support and control seems to stimulate results because system-wide changes, local adaptation, knowledge sharing, solid performance levels, accelerated innovation and implementation, and a uniform brand presentation are easily achieved, while the level of bureaucracy, overhead and resistance to change are relatively low. However, what the appropriate, moderate level of support and control exactly is seems to partially diverge for different franchise systems and unit actors. It seems important to tune the level of support and control to the desired positioning and the type of service (e.g., desirable level of customization), the ownership structure, the unit actor's skills, attitudes and

experience, and to which goals are prioritized. It also seems important that the level of *contractual payments* is adapted to what is provided per the business format because franchisees must experience the payments as relatively fair. The conclusions are summarized in a typology of four types of business format and in a model that can be used by practitioners and scholars.

Chapter 5 focuses on the role of the *ownership structure*. The research design and methods used are similar to chapter 4. The study shows that different system-level and unit-level ownership structures have different effects as perceived by franchisors and unit actors. The analyses reveal that the variation in perceived effects can be explained by differences in regard to management, decision-making, control, steering, support, interests, learning and adaptation. Based on the analyses, new typologies of ownership structures are presented and it is shown how combinations of system-level and unit-level structures can have mutually weakening or strengthening effects. The study also provides indications that hampering or facilitating effects of ownership structures do not necessarily have to lead to negative or positive results in practice. The individual motivation and willingness of unit actors, the level of control in the business format, the degree of professionalism and claimed autonomy, and the age of the franchise system are other factors that may neutralize or compensate the facilitating or hampering effects in practice.

Chapter 6 seeks to understand the role of the *relationship between the franchisor and the units* through an explorative sequential mixed methods study. The mixed methods study comprised a qualitative comparative embedded case study in three healthcare franchises, similar to chapter 4 and 5, and a sequential quantitative cross-sectional survey of nineteen Dutch healthcare franchises from five different sectors. The study suggests that it is important for successful healthcare franchising to have communicatively open and cooperative relationships in which professional franchisees and unit managers feel to have the opportunity to contribute ideas and articulate their needs to the franchisor. Moreover, it seems important that there is ample trust and commitment between the franchisor and the unit actors. Relationships with these characteristics are helpful because they allow the realization of synergy and local fit, alleviate professional resistance to implementation, and prevent reinventing the wheel in developing improvements, innovations and valuable practices. This helps to ensure satisfaction in the units, survival from either the franchisor or unit perspective and, for most of these characteristics, quality of care in the franchise. Selective characteristics were also related to growth from the franchisor perspective and competitive position and efficiency of care and innovation from the unit actor perspective.

All together, the chapters 4, 5 and 6 indicate which structural and behavioral decisions may have to be made in healthcare franchises to ensure that the desired results are achieved. The integration and aggregation of these findings resulted in a preliminary adapted framework depicting the success factors of healthcare franchising.

Phase 3: Quantitative exploration of the framework of success factors of franchising in healthcare through a nation-wide cross-sectional survey

The study in ***Chapter 7*** aimed to quantitatively explore the preliminary adapted framework for healthcare franchises. A nation-wide cross-sectional survey was conducted with nineteen healthcare franchises providing mental healthcare, hospital care, care for the intellectually disabled and youth care, paramedical care, and elderly and home care. Data of 41 franchisors (93% response rate) and 349 unit actors (67% response rate) were analyzed. Contrary to expectations from the findings in phase 1 and 2, from the franchisor perspective only relational cohesion and a business format characterized by a strong positioning, appropriate support services and more control of non-care activities were related to results. From the perspective of unit actors in contrast, results are related to the business format elements and relational cohesion also found for franchisors, as well as to appropriate attitudes and skills, reasonable contractual payments, ownership structures, type of franchise, and system age.

Discussion and conclusion

The main conclusion of this thesis is that there is no blue print to make franchising in healthcare work; it requires situational fit. Multiple choices in regard to the design of support and control in the business format, level of relational cohesion, and, at least for unit actors, ownership structures and franchise type, are related to different types of results because they produce a variety of overlapping, diverging and contrasting process dynamics. At least from the perspective of unit actors, appropriate attitudes and skills and reasonable contractual payments make franchising work further because they help to really obtain potential benefits from the franchise cooperation. The most appropriate combination of process dynamics and structural design elements to make franchising in healthcare work depends on the desired positioning toward customers, desired results, external context/market, type of healthcare service/ professional, age and size. Producing entirely optimal situational fit for all actors and for all result types in one system seems impossible. Through abstracting out these conclusions roughly three ideal-types of franchise configurations can be distinguished that seem suitable to make franchising in healthcare work in different situations: a *soft/loosely coupled franchise*, a *back-office franchise*, and a *full care franchise*.

The conclusions need to be interpreted with consideration of several methodological limitations. These limitations relate among others to the impossibility to make causal inferences, the use of one overall results measure in the quantitative study, the use of perceptions from one data source, and the investigation of heterogeneous franchise systems.

Considering the findings in the thesis we discuss that the insights from business need to be adapted and complemented for valuable use in the healthcare sector. Moreover, reflections are provided on the suitability of franchising for professionals and customers, and on potential contrasts between the franchisor and unit actors.

The thesis concludes with formulating implications and recommendations for organizations and professionals embarking on franchising in healthcare, as well as for health insurers, regional care offices and (local) governmental organizations.

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Samenvatting

Introductie en methoden

Franchising wordt in toenemende mate gebruikt als vorm van interorganisationele samenwerking in de zorg. Het is een veelbelovend model om efficiënte zorg van hoge kwaliteit te leveren, zorgverleners een prettige ondersteunende werkomgeving te bieden en goede strategische en organisatorische resultaten te behalen. Er is echter nauwelijks wetenschappelijk bewijs omtrent hoe deze franchiseorganisaties in de zorg zouden moeten worden vormgegeven en hoe actoren daarbinnen zouden moeten handelen om daadwerkelijk succesvol te zijn. Daarom wordt in dit proefschrift de volgende onderzoeksvraag geëxploreerd: *"Hoe zijn de structurele vormgeving en procesdynamieken van franchise organisaties in de zorg gerelateerd aan het behalen van positieve strategische, organisatorische, professionele en cliëntgerelateerde resultaten?"*

Vanwege het gebrek aan wetenschappelijk bewijs is een exploratieve sequentiële mixed methods studie uitgevoerd waarin drie volgtijdelijke stappen zijn gecombineerd. Allereerst is een theoretisch raamwerk ontwikkeld door het uitvoeren van twee systematische literatuurstudies; een met bevindingen binnen de zorg en een met bevindingen uit alle sectoren. Vervolgens is het raamwerk verfijnd, aangevuld en aangepast voor de zorgsector middels kwalitatief en mixed methods onderzoek in drie cases uit drie verschillende zorgsectoren. Tenslotte is een cross-sectionele survey ontwikkeld om het raamwerk voor de zorg kwantitatief te exploreren op basis van data van negentien franchiseorganisaties in vijf verschillende zorgsectoren. In het gehele onderzoek zijn data verzameld bij zowel de franchisegever als de vestigingen (locaties) om een veelomvattend beeld te krijgen van de wijze waarop franchise in de zorg succesvol kan worden toegepast.

Fase 1: Ontwikkeling van een theoretisch raamwerk middels systematisch literatuuronderzoek

Hoofdstuk 2 en 3 omvatten de twee systematische literatuuronderzoeken die zijn uitgevoerd om een theoretisch raamwerk te ontwikkelen voor het empirische onderzoek in de zorg. Het literatuuronderzoek in ***hoofdstuk 2*** had tot doel om het aanwezige empirische bewijs omtrent de *resultaten van franchise in de zorg* voor organisaties, cliënten en zorgverleners in kaart te brengen. Het onderzoek met 15 geïncludeerde artikelen laat zien dat de wetenschap omtrent dit onderwerp nog onderontwikkeld is. Op basis van de aanwezige studies wordt geconcludeerd dat franchising potentieel waardevol is voor de zorg, maar dat de daadwerkelijk behaalde resultaten variëren tussen en binnen franchise systemen. De studies geven nauwelijks inzicht in de redenen die mogelijk ten grondslag liggen aan deze wisselende resultaten.

Daarom was het systematische literatuuronderzoek in ***hoofdstuk 3*** erop gericht om op basis van empirisch bewijs uit alle sectoren een raamwerk te ontwikkelen van alle

structuur en proces keuzes die franchise werkend maken. Het raamwerk is ontwikkeld op basis van 126 artikelen en bevat vijf hoofdclusters van factoren met diverse subfactoren die gerelateerd zijn aan resultaten van franchising: de eigendomsstructuur die wordt gebruikt op het niveau van het gehele systeem en de vestigingen, de vormgeving van het business format (formule), de vormgeving van het contract, het gedrag van de franchisegever en de franchisenemer en hun onderlinge interactie en de leeftijd en grootte van het systeem en de vestigingen. De resultaten van het literatuuronderzoek suggereren tevens dat het belangrijk is dat de franchisegever en franchisenemers oog hebben voor de compatibiliteit en samenhang tussen deze verschillende factoren, in plaats van te veronderstellen dat factoren in alle situaties hetzelfde effect hebben.

De bevindingen uit hoofdstuk 2 en 3 zijn gebruikt om een theoretisch raamwerk en een topiclijst te ontwikkelen voor het onderzoek in de zorg.

Fase 2: Aanpassing en diepgaande exploratie van een raamwerk van succes factoren van franchise in de zorg middels kwalitatief en mixed methods onderzoek

De studies in de volgende drie hoofdstukken van het proefschrift beogen diepgaand inzicht te geven in hoe franchiseorganisaties in de zorg zijn vormgegeven, hoe actoren daarbinnen handelen en hoe deze structurele vormgeving en procesdynamieken het behalen van positieve resultaten met franchise in de zorg bevorderen of belemmeren. Daarnaast beogen de studies inzicht te geven in de achterliggende redenen voor het belang van deze vormgeving en procesdynamieken om goed te doorgronden hoe franchiseorganisaties in de zorg werken en zouden kunnen werken.

In ***hoofdstuk 4*** staat de rol van het *business format* (i.e., de formule) centraal. Om de rol van het business format te bestuderen is een kwalitatieve vergelijkende ingebedde case studie uitgevoerd met drie franchiseorganisaties in de GGZ, gehandicaptenzorg en ziekenhuiszorg (oogzorg). Hierbij zijn data verzameld middels 96 diepgaande semi-gestructureerde interviews met franchisegevers en actoren binnen vestigingen, observaties en analyses van documenten. De studie laat zien dat de positionering naar klanten, het type, de kwaliteit en de hoeveelheid ondersteuning en de mate van control (beheersing) wat betreft selectie van nieuwelingen, standaardisatie, centrale besluitvorming, mogelijkheden tot afdwingen en monitoring een (gepercipieerde) rol spelen in de resultaten die worden behaald voor alle stakeholders. De bevindingen suggereren dat men zowel extreem veel als extreem weinig ondersteuning en control van vestigingen zou moeten vermijden. Een matige hoeveelheid ondersteuning en control lijkt resultaten te stimuleren omdat enerzijds systeembrede aanpassingen, lokale

aanpassingen, kennisdeling, goede prestatie niveaus, snelle innovatie en implementatie en een uniforme brand presentatie kunnen worden bereikt, terwijl anderzijds de mate van overhead, bureaucratie en weerstand van actoren binnen vestigingen (professionals, franchisenemers, vestigingsmanagers) binnen de perken blijft. Wat precies een passende hoeveelheid ondersteuning en control is lijkt gedeeltelijk te verschillen voor verschillende franchise systemen en actoren. Het lijkt belangrijk om de hoeveelheid ondersteuning en control af te stemmen op de gewenste positionering en het type zorg (bv. mate waarin maatwerk gewenst is), de eigendomsstructuur, de vaardigheden, attitudes en ervaring van actoren binnen vestigingen en de doelen die geprioriteerd worden. Ook is het belangrijk dat de hoogte van de contractuele betalingen aangepast worden aan wat de franchisegever qua business format aan de franchisenemer geeft, omdat franchisenemers de betalingen als relatief rechtvaardig moeten ervaren. Deze conclusies worden samengebracht in een nieuwe typologie van vier typen business format en in een model dat kan worden gebruikt door wetenschappers en de praktijk.

Hoofdstuk 5 richt zich op de rol van de *eigendomsstructuur*. Hiertoe zijn eenzelfde onderzoeksdesign en methodologie gebruikt als in hoofdstuk 4. De studie laat zien dat verschillende eigendomsstructuren op systeemniveau en vestigingsniveau in de perceptie van franchisegevers en actoren binnen vestigingen verschillende effecten hebben. De analyses geven aan dat deze variatie in ervaren effecten verklaard kan worden door verschillen in onderliggende dynamieken tussen eigendomsstructuren wat betreft management, besluitvorming, control, sturing, ondersteuning, belangen, leren en aanpassen. Op basis van de analyses worden nieuwe typologieën van eigendomsstructuren ontwikkeld en wordt zichtbaar gemaakt hoe combinaties van structuren op systeemniveau en vestigingsniveau wederzijds verzwakkende of versterkende effecten kunnen hebben. De studie suggereert ook dat de bevorderende of belemmerende effecten van eigendomsstructuren in de praktijk niet per se tot negatieve of positieve resultaten hoeven te leiden. De individuele motivatie en bereidwilligheid van actoren binnen de vestigingen, de mate van control in het business format, de mate waarin zorgverleners hun autonomie claimen en nodig hebben en de leeftijd van het franchise systeem zijn andere factoren die de bevorderende en belemmerende effecten in de praktijk mogelijk kunnen neutraliseren of compenseren.

Hoofdstuk 6 heeft tot doel inzicht te geven in de rol van de relatie tussen de franchisegever en de vestigingen. Hiertoe is een exploratieve sequentiële mixed methods studie uitgevoerd. De mixed methods studie bestond uit een kwalitatief vergelijkend ingebed case studie onderzoek in drie franchiseorganisaties, gelijk aan de methodologie hoofdstuk 4 en 5, gevolgd door een kwantitatieve cross-sectionele survey van negentien

franchiseorganisaties in vijf verschillende zorgsectoren. De studie suggereert dat het voor het succes van franchise in de zorg belangrijk is om open te communiceren en een coöperatieve relatie te hebben waarin professionele franchisenemers en vestigingsmanagers gevoelsmatig de mogelijkheid hebben hun ideeën in te brengen en hun behoeften kenbaar te maken aan de franchisegever. Daarnaast lijken vertrouwen en commitment van belang. Franchise relaties die deze kenmerken bezitten zijn waardevol omdat zij het mogelijk maken synergie in de samenwerkingsrelatie en lokale fit te bewerkstelligen. Ook verkleinen ze de kans op weerstand tegen implementatie en wordt vermeden dat verbeteringen, innovaties en waardevolle praktijken overal in het franchise systeem opnieuw worden uitgevonden. Middels deze onderliggende dynamieken helpen deze relatiekenmerken om tevredenheid onder actoren binnen vestigingen te creëren, continuïteit voor franchisegevers en/of actoren binnen vestigingen te realiseren en, voor de meeste kenmerken, een goede kwaliteit van zorg te garanderen. Enkele kenmerken zijn ook gerelateerd aan groei vanuit het perspectief van de franchisegever, alsmede aan competitief voordeel en efficiency van zorg en innovatie vanuit het perspectief van actoren binnen vestigingen.

Gezamenlijk laten hoofdstuk 4, 5 en 6 zien welke vormgeving en handelingswijzen mogelijk gebruikt moeten worden binnen franchiseorganisaties in de zorg om te zorgen dat de gewenste resultaten worden behaald. De integratie en aggregatie van deze bevindingen mondt uit in een voorlopig aangepast raamwerk van succesfactoren van franchise in de zorg.

Fase 3: Kwantitatieve exploratie van het raamwerk van succes factoren van franchising in de zorg middels een nationale cross-sectionele vragenlijst

De studie in ***hoofdstuk 7*** beoogt om het voorlopig aangepaste raamwerk voor de zorg kwantitatief te exploreren. Hiertoe is een cross-sectionele survey uitgevoerd onder negentien operationele franchiseorganisaties in de 1e en 2e lijns GGZ, ziekenhuiszorg, gehandicaptenzorg en jeugdzorg, paramedische zorg en ouderen- en thuiszorg. Uiteindelijk zijn data van 41 franchisegevers (93% respons) en 349 actoren binnen vestigingen (67% respons) geanalyseerd. In tegenstelling tot wat was verwacht op basis van de bevindingen in fase 1 en 2, laat de studie zien dat vanuit het perspectief van de franchisegever alleen relationele cohesie en een sterke positionering, adequate ondersteuning en meer control van niet-zorg activiteiten in het business format gerelateerd zijn aan resultaten. Daarentegen zijn de resultaten die vanuit het perspectief van actoren binnen vestigingen worden behaald aan vele factoren gerelateerd. De door hen ervaren resultaten zijn, net als voor de franchisegever, gerelateerd aan het business format en relationele cohesie. Daarnaast spelen ook attitudes en vaardigheden,

rechtvaardige contractuele betalingen, eigendomsstructuren, het type franchise en de leeftijd van het franchise systeem een rol.

Discussie en conclusie

Op basis van alle bevindingen wordt geconcludeerd dat er geen blauwdruk is om franchise in de zorg succesvol toe te passen; het vereist situationele fit. Diverse keuzes omtrent de ondersteuning en control in het business format en de mate van relationele cohesie zijn gerelateerd aan het behalen van verschillende typen resultaten omdat zij leiden tot een diversiteit aan overlappende, uiteenlopende en tegengestelde procesdynamieken. Dit geldt ook voor keuzes omtrent eigendomsstructuren en type franchise, in ieder geval vanuit het perspectief van actoren binnen vestigingen. Geschikte attitudes en vaardigheden en redelijke contractuele betalingen dragen in ieder geval vanuit het perspectief van actoren binnen vestigingen verder bij aan het behalen van positieve resultaten omdat zij helpen om potentiële voordelen van samenwerking binnen een franchise uit te nutten. De meest geschikte combinatie van procesdynamieken en structurele vormgevingselementen om franchise succesvol toe te passen hangt af van de gewenste positionering richting klanten, de gewenste resultaten, de externe context/markt, het type zorg/professional, leeftijd en grootte. Het lijkt onmogelijk om algeheel optimale situationele fit voor alle actoren en voor alle typen resultaten in één franchisesysteem te realiseren. Door de conclusies te abstraheren worden eerste ruwe schetsen van drie ideaaltypen van franchiseconfiguraties gemaakt die geschikt lijken om franchise in de zorg werkend te maken in verschillende situaties: een *loosely coupled franchise*, een *back-office franchise* en een *full care franchise*.

Bij het interpreteren van de conclusies moet rekening worden gehouden met enkele methodologische beperkingen van het onderzoek. Deze zijn onder meer gelegen in het niet kunnen vaststellen van oorzakelijke verbanden, het onderzoeken van heterogene franchiseorganisaties en het gebruik van één overall resultaat maat en percepties vanuit één databron in het kwantitatieve onderzoek.

In het licht van de bevindingen in dit proefschrift wordt bediscussieerd dat inzichten uit het bedrijfsleven aangepast en aangevuld moeten worden om bruikbaar te zijn voor de zorg. Tevens wordt gereflecteerd op de geschiktheid van franchise voor professionals en klanten, evenals op eventuele tegenstellingen tussen franchisegever en actoren binnen vestigingen. Het proefschrift besluit met implicaties en aanbevelingen voor zorgaanbieders en zorgverleners die al franchisen of dit willen gaan doen, alsmede voor zorgverzekeraars en (lokale) overheidsorganen.


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Dankwoord

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Het wetenschappelijke franchisebos werd een stukje overzichtelijker en aangenamer door Evelien Croonen, UD bij de RUG. Evelien, wat was het fijn om af en toe met jou te kunnen sparren over franchisevraagstukken, definities, literatuur en wat dan ook meer. Ook bedankt voor je introductie van mij bij verschillende collega-wetenschappers tijdens mijn eerste congres van de International Society of Franchising in Boston en de gezellige daaropvolgende trips naar Fort Lauderdale en Zhuhai, China.

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Mijn meer praktische werk en samenwerking met collega's in Het Oogziekenhuis Rotterdam zijn onmisbaar geweest in het volhouden van mijn promotietraject. René Baljon en alle Oogzorgnetwerk collega's: bedankt voor jullie medewerking aan mijn onderzoek, jullie gastvrijheid en het bieden van mogelijkheden om mijn kennis praktische toepassing en waarde te geven. Ilse en Jolanda, onze trip naar China voor het OOGbus project was enorm vermoeiend, maar onvergetelijk en zinvol. Het is super de kennis uit mijn onderzoek samen met jullie te kunnen benutten. Dames van het stafbureau, bedankt voor de gezellige en fijne werkplek op de vele maandagen in Het Oogziekenhuis. Els, wat is het fijn en inspirerend met jou samen te werken. René Z., Ron en Christine, bedankt voor jullie samenwerking en vertrouwen. Ook alle andere collega's: bedankt voor de fijne en inspirerende werkomgeving.

Dit proefschrift had niet tot stand kunnen komen zonder de medewerking van heel veel zorgformules en hun respondenten in het kwalitatieve en kwantitatieve onderzoek. Iedereen die heeft meegewerkt: ontzettend bedankt voor jullie openheid, tijd en vertrouwen in mij als onderzoeker om jullie ervaringen, kennis en documenten mee te delen. Ik hoop dat mijn bevindingen een goede basis vormen om met franchise(-achtige) principes de zorg beter en efficiënter te maken.

Alle zorgorganisaties en adviseurs die mij in de loop der tijd hebben uitgenodigd om over franchise in de zorg van gedachten te wisselen: bedankt voor de interessante discussies, prikkelingen die mijn gedachten hielpen aanscherpen en het geven van het gevoel dat mijn onderzoek van waarde is voor de praktijk.

Mijn vriendinnen wil ik bedanken voor alle gezellige momenten, ontspanning, interesse en begrip voor mijn afwezigheid soms. Charlotte en Marjon, alsmede Marjolein, Tirza en Toke: door jullie heb ik me vanaf moment één thuis gevoeld in Rotterdam. Bedankt voor alles. Mijn jaarclubgenootjes van Dez Amados, wat is het super dat we nog steeds leuke dingen samen doen. Onze lustrumreis naar Dubai zorgde voor een goede break en was een reis om nooit te vergeten. Mijn GW-studievriendinnen uit Maastricht, bedankt voor de gezellige etentjes en uitjes. Dat we dat nog maar lang mogen voortzetten. Alle oud-ZoMa dames: het is altijd weer leuk jullie te spreken. Ik heb nooit spijt gehad van mijn keuze bij de ZoMa vooral schakel-studenten op te zoeken. Last but not least, Irene. Al vanaf de brugklas zijn we vriendinnen. Hoewel we na de middelbare school alleen maar ver van elkaar vandaan hebben gewoond, voelt het altijd weer vertrouwd. Ik ben dan ook heel blij dat jij tijdens de grote spannende dag als paranimf naast mij staat.

Pap en mam, jullie hebben me altijd gestimuleerd om het beste uit mezelf te halen qua opleiding en ontwikkeling. Dank ook voor jullie nooit aflatende interesse in hoe het met mijn proefschrift ging, ook al vond ik dat soms heel irritant en beantwoordde ik dat met een 'ander onderwerp'. Nienke en Petra, wat is het fijn om jullie als zus en schoonzus te hebben. Nienke, super bedankt dat je als 'supportende' zus als paranimf naast me staat. Mijn schoonouders Nel en Cas, bedankt dat ik me bij jullie altijd welkom voel. Ook andere familieleden, bedankt voor jullie interesse en steun.

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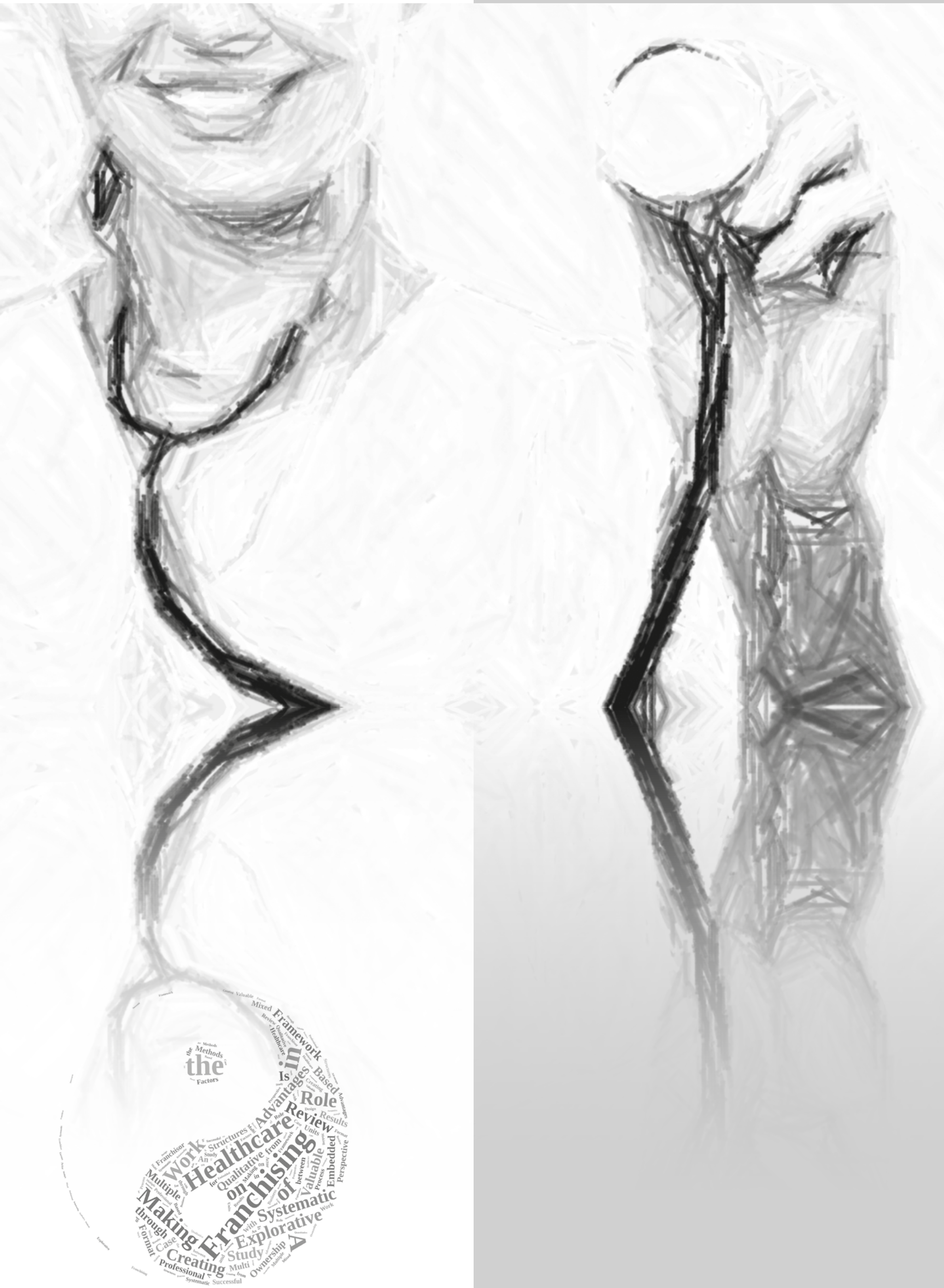
- Karlijn



Franchising
Healthcare
Making
Systematic
Explorative
Framework
Review
Role
Advantages
Qualitative
Creating
Work
Study
Ownership
Multiple
Valuable
Embedded
Perspective
the
Methods
Factors
Professional
Case
through
Format
Mixed
Results
Structures
Based
Successful

Curriculum Vitae

PhD Portfolio

Name:	Karlijn Nijmeijer
Department:	Institute of Health Policy and Management
PhD period at iBMG:	2009 – 2013
Promotor:	Prof.dr. Robbert Huijsman MBA
Co-promotor:	dr. Isabelle Fabbricotti

Courses and workshops

Theme workshop patient perspective, iBMG	2009
Academic writing in English	2010
Ready in four years	2010
Qualitative interviewing, Kwalon	2010
Workshops project management and networking, PhD career day, EPAR	2010
Workshop successful presenting, NWO	2010
Qualitative research (interviewing, focus groups, analyzing, writing), Kwalon and iBMG	2011
Evidence-based management, expertise centre healthcare logistics, iBMG	2011
Personal Effectiveness, ICM opleidingen en trainingen	2012
Mindmapping, Mindmap Nederland	2012
iBMG PhD career event	2013
Media training Eva Kuit, jBMG	2013

Attended seminars and conferences

Symposium improving chronic care	2009
Research colloquia HSMO	2009-2012
Conference 'Customer relations in healthcare. The return of healthcare marketing in cure and care'	2010
25th Annual International Society of Franchising Conference, Boston, USA	2011
Lustrum symposium iBMG, March 2012	2012
26th Annual International Society of Franchising Conference, Fort Lauderdale, USA	2012
Lustrum symposium iBMG, October 2012	2012
27th Annual International Society of Franchising Conference, Zhuhai, China	2013
Conference 'Elderly care 2040. A future-proof elderly care through research and practice!'	2013
Opportunities in healthcare by franchising – meeting ING and Nederlandse Franchise Vereniging (NFV)	2013

Presentations and participation in meetings

Presentation 'Franchising in healthcare: design, application and value creation', BZO research colloquium	2009
Presentation 'Making franchising work: a framework based on a systematic review', HSMO research colloquium	2011
Presentation 'Exploring franchising in healthcare', research seminar Faculty of Economics and Business, Rijksuniversiteit Groningen	2011
Presentation 'Is Franchising in healthcare valuable? A systematic review', HSMO research colloquium	2011
Paper presentation 'Is franchising in healthcare valuable? A systematic review', 26th Annual International Society of Franchising Conference, Fort Lauderdale, USA	2012
Paper presentation 'Exploring the role of ownership structures in the results of professional healthcare franchises from a multi-actor perspective', Zhuhai, China *(awarded with the International Society of Franchising Best PhD Student Paper Award)*	2013
Presentation 'Is franchising in healthcare successful?', Come in and look around, expert meeting, Customer Factory Franchise Consultants	2013
Presentation 'Effectively designing and managing of franchise organizations in healthcare: what should you do?', Flevum – Rotterdam Eye Hospital meeting about franchise in healthcare	2013
Presentations about effectively designing and managing healthcare franchises for a variety of healthcare franchises	2012-2013
Participation in various brainstorm meetings and round table meetings of existing and potential franchise organizations	2012-2014

Reviewer and chair

Reviewer of papers for the International Society of Franchising Conferences	2012-2013
Chairing a paper presentation session, International Society of Franchising Conference	2013
Reviewer for the International Journal of Management Reviews	2013-2014

Organizing meetings and participation in working groups

Working group jBMG; PhD portfolio, IOBO, overviews of courses and workshops	2009-2010
Co-Organizing meeting '10 year Eye Care Network', Eye Care Network in cooperation with Flevum	2011
Organizing meeting 'Franchise in Healthcare', in cooperation with Flevum	2013

Teaching activities

Co-evaluating bachelor theses (BMG)	2010-2011
Co-evaluating master thesis (ZoMa)	2010
Co-evaluating master thesis (HEPL)	2011
Workgroups traineeship 'working in healthcare'	2010
Workgroup kwaliteitskunde, schakel	2010
Lecture 'franchising', course healthcare marketing (ZoMa)	2011
Lecture 'research into franchising as a form of cooperation in the healthcare sector', course strategy and innovation (ZoMa)	2012

Additional activities

Business consultant and researcher The Rotterdam Eye Hospital	2008-now

About the author

Karlijn Nijmeijer was born at 30 March 1985 in Meppel. In 2003 she graduated from secondary school at Dingstede in Meppel. In 2006 she graduated Cum Laude as a bachelor in Health Sciences at Maastricht University. During her Bachelor she participated in the Honours Program of the Faculty of Health Sciences. She received the Catharina Pijls Aanmoedigingsprijs for her Bachelor thesis about the role of protocols in the care needs assessment by the Centrum Indicatiestelling Zorg (CIZ). In 2007, she graduated Cum Laude as a Master in Public Health, specialisation Health Policy, Economics and Management, at Maastricht University. In 2008, she finished a Master in Healthcare Management at the institute of Health Policy and Management (iBMG). During this master, she worked three days a week as a management trainee in the Rotterdam Eye Hospital.

In September 2008 she started working as a scientific researcher at the iBMG and the Rotterdam Eye Hospital. Initially she conducted a research focused on the value of networks in eye care. This project was conducted within the Eye Care Network. In 2009 the focus of her research switched to the subject of her PhD thesis. In March 2013 she received the International Society of Franchising Best PhD Student Paper Award during the 27th International Society of Franchising Conference in Zhuhai, China. She acted as a reviewer of papers for conferences and journals, and was involved in a few teaching activities at iBMG. She also acted as a speaker and expert in healthcare franchising in various meetings and brainstorm sessions in Dutch healthcare franchises and consultancy organizations. Karlijn combined her research with part-time consultancy work in the Rotterdam Eye Hospital. She was involved in various strategic, quality-oriented, and franchise-related activities. From January 2014 on Karlijn expanded her work as a business consultant in the Rotterdam Eye Hospital. Besides, Karlijn continues her work on franchising in healthcare as a consultant/practice-oriented researcher.