

15.232 Business Model Innovation: Global Health in Frontier Markets, Fall 2013

SughaVazhvu Team Learning Memo

Healthcare provision even in the developed world is a complex, controversial endeavor. In developing world countries, this complexity remains, but with the added difficulty of severe capital, personnel, and educational constraints. It is interesting, then, that some of the most interesting and creative solutions for the provision of healthcare come from the most resource-poor environments.

From a certain perspective, this is appropriate: because of these constraints, efficiency and creativity are the only techniques available. There is an added sense of urgency as a consequence of largely unavailable healthcare - many interventions are not a question of quality of life but rather of preservation. Devi Shetty's efforts at Narayana Health provide further evidence that there is fat to trim from almost any effort - one simply needs to look at it from the right angle. Where there is sufficient need, cardiac surgeons can improve their efficiency. If it comes down to life or death, patient's families can act as nurses, and removing amenities like costly hospital food or air conditioning can bring costs to startling lows - less than 10% the cost of a comparable surgery in America - while maintaining performance at key safety and outcome statistics. It was quite impressive to learn the degree to which an operation can be pared down and optimized.

An unfortunate consequence of these situations is that interventions and governing authorities can often take a short-sighted approach. It was concerning to learn the difficulties that organizations like Riders for Health have had in expanding. Riders for Health has continually demonstrated lower costs compared to competitors and impressive statistics regarding their ability to improve efficiency and number of patients reached, but ministries of health have seemed unwilling to expand funding and scale fleet size. Perhaps this relates to how the expenditures relate to health? When paying for antibiotics or vaccinations, the outcomes are easily understood and direct: a patient who receives antibiotics is generally cured and a vaccinated patient never gets sick in the first place. These outcomes are familiar and may easily be assigned a fair cost. Convincing ministries of health of the value of improving infrastructure seems much more difficult. The effects of improving mobility are so far removed from health outcomes that however efficiently Riders for Health operates, it is difficult to pinpoint which lives are saved and what costs are reduced. How can organizations that indirectly influence health in important ways convince stakeholders of their importance? What are fair metrics that are both concrete and convincing? Most importantly, how do they form a sustainable business model that both makes money and fulfills their mission?

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Even when fair metrics for the evaluation of business models have been established, implementing these metrics is not always straightforward. Data collection can be challenging and costly in low income or rural settings, especially when communication is an obstacle. It was interesting to learn the importance of conducting baseline studies to produce a set of 'control' data. Avahan was innovative in its application of business thinking to health-care and its strong focus on data collection and transparency. However, their failure to conduct baseline studies made it challenging to evaluate the efficacy of their interventions and their overall performance. This shortcoming is particularly significant in a setting such as India, where the huge population 'denominator' makes it extremely challenging to put coverage outcomes in perspective.

Looking back, we found several points in common among promising companies that we learned throughout the class. Those companies which succeeded in delivering healthcare to low-income patients in rural areas or at least in pilot markets are offering i) very cheap (locally affordable), ii) standardized services or products iii) with simple but decent technologies and operations. The biggest challenge is obviously located in iv) the lack of sustainable funding models, which is caused by economic vulnerability of the patients who need the healthcare service the most. To realize sound business cycles where healthcare providers gain sufficient income for their services, holistic approaches are required; not only providing poor patients with affordable healthcare service, but also offering them opportunities to have employments for making money. In that sense, collaborations and alignments among multi-stakeholders are inevitable for going forward.

Last, the question of 'how good is good enough health care?' has been a recurring controversial question in the course of our analyses. In settings where little or no healthcare at all is available, is 'something' always better than 'nothing'? The number of physicians/medical personnel, the availability of medications, and the accessibility of medical technologies are obvious limiting factors in the delivery of healthcare in rural settings.

The innovative healthcare business models we have learned about in this course share one common goal: to deliver healthcare services and products to the poor who are in desperate need but are severely constrained financially. The initial success of some ventures is encouraging but their impacts are quite limited unless they could scale up quickly. However, growth requires significant funding which turns out to be a tremendous challenge to overcome. Organic growth is extremely slow, particularly for non-profit organizations. But money in the open market never comes free. Organizations who receive investment in the capital market are inevitably burdened by the required return demanded by those investors. As a result, the business model has to accommodate these "for-profit" mandates and the organizations are forced to deviate from their original missions.

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