Journal of Business Research xxx (2015) xxx–xxx

Contents lists available at ScienceDirect

Journal of Business Research

Scaling private health care for the base of the pyramid: Expanding versus broadening service offerings in developing nations☆

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ARTICLE INFO

Article history:
Received 1 March 2015
Received in revised form 1 June 2015
Accepted 1 June 2015
Available online xxxx

Keywords:
Base of the pyramid
Developing countries
Decision
Enterprise
Healthcare
Sustainability

ABSTRACT

Sistema Ser is a private health care organization that originated in the volunteer work of its founder and director, Dr. Jorge Gronda, who, over the course of 15 years, established structures that turned his personal initiative into a sustainable enterprise. At the time of the case, Dr. Gronda is considering how to lead his organization into its next important development step, further scaling SSer's social impact. The case's core issue is whether or not Dr. Gronda should maintain SSer's current service portfolio but geographically expand the organization in order to reach a large number of remote BOP communities with primary health services, or if SSer should broaden its range of services to cover additional medical procedures offered in San Salvador.

1. Introduction

Early one morning in September 2013, Dr. Jorge Gronda, an Argentine gynecologist, was on his way to the Puna, a highland region in Jujuy, one of Argentina's most northern and poorest provinces (see Appendix A). As he traveled, Dr. Gronda remembered volunteering in this remote area, far from the province's capital, San Salvador de Jujuy, and from any reasonable access to health care services. The work had inspired him to gradually establish a private health care system for this base of the pyramid (BOP) market, providing services to poor communities that an ineffective public system had failed to supply. He called his organization "Sistema Ser" (SSer), a network comprised of CEGIN (a private enterprise and medical center belonging to Dr. Gronda and his family, offering preventive and primary gynecological services); a number of independent, affiliated private health care providers; and Fundación Ser (a foundation that coordinates the affiliation of further providers and the promotion of the SSer network). SSer offered a variety of high-quality, low-cost primary health care services—low-complexity treatments that address some 80% of the most common diseases—for people otherwise excluded from the health care system.

Dr. Gronda crossed the pass at an altitude of more than 4000 m and took the familiar, dusty road through the salt desert. In an hour, he would reach Abra Pampa, a town of 9425 inhabitants, many with indigenous roots. There, he would meet with Rosario Quispe, a long-standing friend and local entrepreneur. She had introduced Dr. Gronda to this region 20 years before and was now eager to discuss with him a difficult decision that he was facing. Should he extend the current activities of his organization—which operated predominantly in San Salvador, the capital of Jujuy—to the Puna? Or should he use the new private hospital he had recently started managing to extend SSer's range of services delivered in San Salvador? When Dr. Gronda had spoken with Rosario about the issue some months before, she had shared her concern: "Sistema Ser works well in San Salvador. But here, in the Puna, SSer reaches maybe 5% of the women. The other 95% are still left without care."

Dr. Gronda and Rosario agreed that extending SSer's health services to the Puna would generate at least two challenges. First, in order to establish a permanent practice in Abra Pampa, SSer would need to find physicians who were willing to work in this remote region on a

☆ At the time this case was finalized, the founders of Sistema Ser were about renaming their organization into "Umana". Acknowledgment: The authors thank the Centro de Intercambio de Conocimiento (CIC, VIVA TRUST: http://ciconocimientos.org) for supporting this research; the Central American Healthcare Initiative (CAHI: http://www.ca-hi.org) for providing a central discussion platform; Arch Woodside for comments on an earlier draft of this case; three anonymous reviewers for their helpful feedback; and, in particular, Jorge Gronda, Irene Gonzales, Simon Gronda (SSer), and Rosario Quispe for their time, great support and insights into their unique organization and local context.

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http://dx.doi.org/10.1016/j.jbusres.2015.07.044

permanent basis. Dr. Gronda knew of five young Jujuyian physicians who he thought he might be able to motivate to do the job. They were very connected to the region and would soon return from their training in Cuba. Still, Dr. Gronda and Rosario knew that if working in the Puna did not pay off financially for the physicians, they would not stay. They were aware that paying physicians to work in the highlands would be expensive. SSer would need to offer a minimum monthly salary of 15,000 Argentinian Pesos (ARS; approximately US $2500 in 2013). This would, in turn, require the poor consumers in the Puna to pay higher prices for health services than the patients in San Salvador de Jujuy were paying. Second, the Puna was an expansive region with a low population density. Hence, providing health services in the Puna would also present logistical challenges. Even if SSer could position physicians in Abra Pampa, patients would still need to travel long distances, spending several hours on the sparse bus routes that connect the small villages to the town.

Rather than scale health services to the Puna, recent developments had revealed an alternative way to increase SSer's impact. A few months earlier, Dr. Gronda had become president of a newly built private hospital in San Salvador. The hospital provided SSer the opportunity to broaden the scope of services it delivered in San Salvador, particularly for BOP patients—meaning that it could go beyond primary health services to include more-complex treatments, otherwise known as secondary health care.

In any case, scaling SSer's services seemed very important. Just the day before, headlines in Jujuy had reported the resignation of 300 local physicians from the public health care system. "It's obvious," thought Dr. Gronda, "physicians want to send a message. The state of the public health care system is no longer bearable. Physicians can hardly earn a living, and the majority of the population still doesn't have access to timely, quality care. I need to respond to this crisis of the Argentine public health care system by increasing the social impact of my organization. At the moment, I can see options, but which one should I choose?"

2. Health care needs of BOP populations

Health care in Argentina is delivered by both private and public providers (see Appendix B) or, as Dr. Gronda describes it, "One system for the rich and another for the poor." People who purchase private insurance and those covered by the public social insurance sector ("obra social") may access the services of public or private facilities, contracted by their insurance company, which then refunds the respective provider. All individuals who work in the formal (private or public) economy, as well as their families, are covered by public social insurance. Only a minority of people, however, can afford private insurance. In 2006, this number was estimated to be 3.3 million people—just eight percent of the population of Argentina (Belló & Becerril-Montekio, 2011).

Thus, a large percentage of the population depends on public health care services that offer treatments free of charge. But the public system is fragmented and characterized by an inefficient use of resources, high variations in the quality of care, a lack of adequate infrastructure, and low salaries (OPS, 2011). As Dr. Gronda explains, low salaries have led to yet another problem: in the public domain, a physician earns roughly US $800 a month, while a private-practice physician can earn US $2000 to $10,000, depending on the type of services offered and other factors. Therefore, many physicians spend considerable time working in private practices.

Because physicians prefer to work in the private sector, they are less available for patients in the public system. Together with an increasing number of people going to hospitals for health care services, patients often spend hours waiting to be seen (there is no appointment system to see physicians), sometimes even overnight. Even the simplest surgeries have significant waiting times. For example, patients can wait a month to have gallstones removed and often twice that for more-complex procedures.

BOP populations reside primarily on the outskirts of the capital and the rural regions of Jujuy, such as the Puna. At the time of the study, there were only three hospitals and not a single ambulance over a distance of almost 1000 km. In 2011, a new public hospital with 46 beds, Nuestra Señora del Rosario, opened in Abra Pampa, the second largest town in the area. However, the level and quality of its services were perceived to be low. Patients reported the loss of important test results or infected wounds that stayed open for weeks.

In addition to the issues with the public health care system in general, the BOP population faced several particular challenges. Rosario explained: "Nearly 95% of the population here [in the Puna] lack health coverage. Only the approximately 300 men in the mines and their families have an obra social [public insurance]." But apart from these few men with formal jobs in the mines, most people worked in the informal sector. Therefore, they had no access to public social insurance, and paying out of pocket for private services was too expensive.

Another of Rosario's concerns was that approximately 90% of specialty services, such as gynecology, were provided in the province's capital, San Salvador de Jujuy. But, she explained, "San Salvador is more than 220 km away from here, Abra Pampa. The distance, the travel time is immense [up to nine hours by bus]. Then, where do you to spend the night, where do you eat? … No, no, this is not possible." Seeing a physician could take anywhere from two days to a week—with a negative economic (loss of earnings) and social (leaving family/children alone at home) impact. The latter was particularly important, as families had up to ten children.

Not only was it difficult to receive specialty services in the Puna, but there was also an insufficient delivery of preventive health care in this region. And, for a long time, people were not sufficiently educated about either the need to or the possibility to take charge of their health. Jorge Gronda saw that this situation had already begun to change—a "paradigm change," as he called it: "Many women now know that they can and need to take care of themselves, get their regular Pap smear tests, etc." But more would need to be done. There was still an extremely high rate of cervical cancer and other preventable diseases in the region with significant socio-economic consequences.

Another issue occurred even when members of BOP communities did succeed in seeing a physician. They often faced discrimination. While many were of indigenous roots, their physicians were mostly white. The doctors were sometimes reluctant to treat people from the BOP so as not to scare away their white patients; or, when they did treat members of the BOP, they would do so in a dismissive way. A 33-year-old woman who was originally from Bolivia recalls her experience: "The physician did perform a test, but he didn't tell us what he was doing and why he was doing it. Even when we asked him, he didn't give us an answer…. It was because of the color of our skin."

Without formal employment, lacking social insurance, and often receiving insufficient, low-quality health care—if at all—many BOP families felt forgotten. Similarly, international studies show that "[t]he absence of formality, both in regards to autonomy and dependence, implies an isolation of the worker from the system and its various benefits, increasing his/her marginality and, consequently, the perceived exclusion" (Estéves & Esper, 2009).

Although a public health care system in Jujuy was supposedly offering health care to the poor and uninsured, it was not effective and actually excluded most people. Hence, there was a highly unfulfilled need for health care services in Jujuy. It was in this context, more than 20 years ago, that Jorge Gronda began to develop a system that would facilitate access to timely, ethical and quality health care services for those being excluded from the current health care system (see Fig. 1). The organization developed along four phases.

Please cite this article as: Bucher, S., et al., Scaling private health care for the base of the pyramid: Expanding versus broadening service offerings in developing nations, *Journal of Business Research* (2015), http://dx.doi.org/10.1016/j.jbusres.2015.07.044