# BUSINESS MODEL, INNOVATION AND ENTREPRENEURSHIP

## ACCESS TO PRIMARY HEALTHCARE IN BRAZILIAN URBAN AREAS

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## ABBREVIATIONS

| ABBREVIATION | MEANING |
|---|---|
| BNDES | THE BRAZILIAN DEVELOPMENT BANK |
| BOP | BASE / BOTTOM OF THE PYRAMID |
| ABCDE POPULATION | COMMON SEPARATION OF INCOME CLASSES IN BRAZIL (NERI, 2014) |
| CEO | CHIEF EXECUTIVE OFFICER |
| CFO | CHIEF FINANCIAL OFFICER |
| CSR | CORPORATE SOCIAL RESPONSIBILITY |
| HR | HUMAN RESOURCES |
| ICD | INTERNATIONAL STATISTICAL CLASSIFICATION OF DISEASES |
| IFC | INTERNATIONAL FINANCE CORPORATION |
| N/A | NOT AVAILABLE |
| S.A. | SOCIEDADE ANÔNIMA / PUBLIC LIMITED COMPANY |
| SUS | SISTEMA UNICO DE SAÚDE, BRAZILIAN PUBLIC HEALTHCARE SYSTEM |
| UN | UNITED NATIONS |
| VC | VENTURE CAPITAL |
| WHO | WORLD HEALTH ORGANISATION |

# 01 | INTRODUCTION AND BACKGROUND

Innovative entrepreneurial initiatives can be a valid solution when providing services and supplying goods to parts of the population that have been neglected by public or government services and other existing services. These businesses can close an important gap, especially in low- to middle-income countries by integrating solutions to pressing social problems in their models and thus changing the day-to-day lives of the citizens.

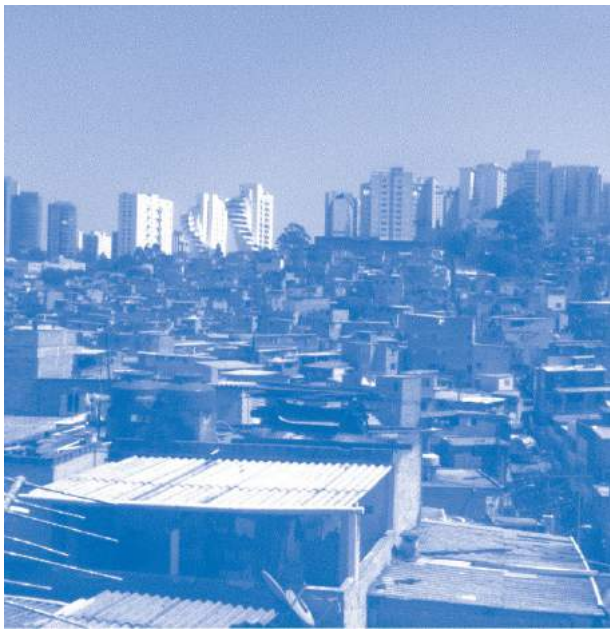
The health care industry provides a fruitful example of interesting ventures exploring entrepreneurial solutions, business models and innovations for the low- and mid-income population of Brazil. The market of access to healthcare faces difficulties and shortages in supply, services and management. These difficulties create opportunities for the successful entry of private, entrepreneurial ventures.

This report investigated 7 entrepreneurial projects that provide primary healthcare in Brazilian urban areas. Data was assessed during the period from October to December 2015. While ventures develop rapidly, the current report investigates enduring factors of the structure of business models. We assume that these factors are connected to a more stable pattern of fundamental business ideas and organisational culture and thus do not change rapidly over time. Data was mainly gathered throughout field visits to the healthcare providers under analysis. Interviews were conducted with healthcare entrepreneurs, clinic staff, investors and healthcare experts. This interview material constitutes the primary source for the analysis.

Complementary secondary information was taken from the internet, press articles and the like. The analysis will provide the reader with an insight into the business environment of healthcare ventures and the functioning of such businesses.

The report will first provide an overview of the challenges facing the healthcare system in Brazil, define the understanding of access to healthcare and summarize some main factors of business models that are important for the investigation. Afterwards, we will go into more detail and explain the specific business model elements that we consider to have innovative character. Every section closes with lead questions we extracted from the data that serve investors and entrepreneurs to reflect upon their own activities and perspectives as a basis to inspire further development of their respective businesses.

This report provides one of the first insights into innovative business models that offer health services for the low- and middle-income population in Brazil. With its reflective questions at the end of each chapter, we invite practitioners to consider new ideas for their businesses and to further develop their own activities within this field.



# 02 | THE MEANING OF ACCESS TO HEALTHCARE

## 2.1 THE BRAZILIAN DILEMMA

Healthcare in Brazil is a constitutional right (Art. 196)[1] that is put into action through a unified and decentralized health system (Sistema Unico de Saúde, SUS). In theory, Brazil's public health system seems to be among the most equal and accessible. The vision of the SUS is to promote health, health surveillance, and health education, as well as to ensure continuity in the care of all Brazilians at primary, specialist outpatient, and hospital levels (Paim, Travassos, Almeida, Bahia, & MacInko, 2011). Yet, despite comprehensive reform attempts over the last 20 years, the SUS fails to meet up to the expectations it has created. Healthcare services in Brazil face difficulties in providing unconditional and universal access to different levels of care for their patients (Marinho & Cardoso, 2007; Marinho, 2006; Sarmento, Tomita & Kos, 2005).

With 75% of the Brazilian population who rely on the public health system (Agência Nacional de Saúde Suplementar, ANS, 2014; Soares, 2013), the SUS is confronted with the problem of satisfying such an incessant demand, although inefficient financing and a shortage of qualified employees and equipment prevail (Formenti, 2015; Noronha, Santos & Pereira, 2011). It also suffers from corruption and dysfunctional governance models (Biderman & Avelino, 2014; Dias, Matias-Pereira, Farias & Pamplona, 2013). Alongside these struggles, inefficient management practices further impede the implementation of basic services, an example being the resistance of integration with the private healthcare system (Noronha, Santos & Pereira, 2011).

These deficiencies result in the population's dissatisfaction with the public healthcare system and long waiting times for patients (Deloitte, 2015). To access the free of charge public healthcare system, 47% of clients have to wait up to 6 months for consultation, examination, and medical procedure or surgery (Datafolha, CMF & APM, 2014).

In addition to the public system, Brazil disposes of a private, pay-for-service healthcare sector, which faces similar problems (Fraga, 2014). The situation of immediate access to services is especially precarious in both systems with patients either congesting emergency rooms for minor problems or self-medicating, which is a driver for high shares of out-ofpocket spending in Brazil (30%) (Drug Utilization Research Group, Latin America, 1997; World Bank, 2013; Paim et al., 2011).

[1] *BRASIL. Constituição (1988). Constituição da República Federativa do Brasil. Brasília, DF, Senado.*

## 2.2 ACCESSING HEALTHCARE THROUGH SOCIAL VENTURES

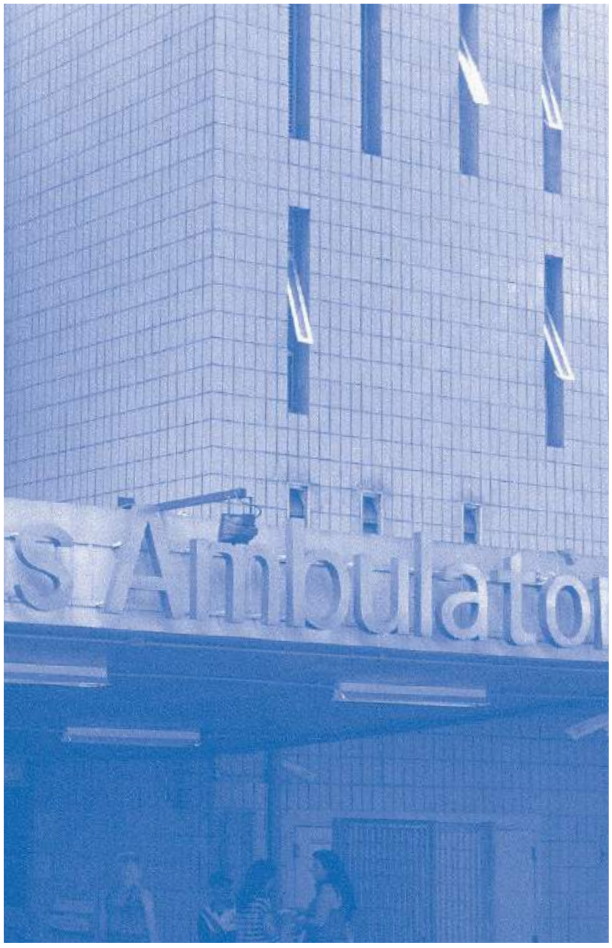
Access to healthcare services has been defined as a key target among the Sustainable Development Goals in 2015 (UN, 2015). Consequently, policy-makers worldwide seek to create a more dynamic and innovative healthcare sector to come up with solutions to face cost-inflation in industrialized countries, accessibility in emerging countries and to deal with a growing number of hybrid structures everywhere where stakeholders from various backgrounds coexist.

Since access to healthcare is especially limited for people with low- to lower-middle income (IFC, 2007), so-called *"clínicas populares"* (low- and middle-income primary healthcare providers) have emerged over recent years to fill a niche and to cope with some of these deficiencies. Those, often market-based, enterprises complement existing public and private services and emerge as a third pillar of healthcare delivery to complement the existing structures. Their value proposition consists of providing accessible primary healthcare services at affordable prices and high quality of service, thereby contributing to a more complete system along with better coverage. The rise of such ventures is an observable phenomenon in many emerging countries (see for example Goyal et al., 2014). Although this report focuses on Brazil, its results may also apply to contexts of other emerging markets.

## 2.3 THE MEANINGS OF ACCESS IN BRAZILIAN PRIMARY HEALTHCARE

This report investigates entrepreneurship and business model innovation in the context of access to healthcare. In our white paper, the respondents that were questioned expressed a wide variety of meanings for the word "access". Table 1 gives an overview of these different meanings that we found within the data.

Given the wide variety of meanings, "access" serves as an umbrella term to point at major challenges within the Brazilian healthcare system. As a working definition for our investigation, the data suggests that the term "access" is primarily used to describe three aspects: (1) the fast availability of services, (2) the financial affordability and (3) the geographic accessibility of the clinic sites (reachability). The researched clinics aim to address the gaps related to these three main different meanings of "access".



## TABLE 1 // THE MEANINGS OF ACCESS IN BRAZILIAN PRIMARY HEALTHCARE

| REASONING | CITATION |
|---|---|
| FAST AVAILABILITY OF QUALITY CARE AND EXAMS | **CASE 1** "ACCESS IS THE CONVENIENT AND FAST POSSIBILITY TO PROVIDE HEALTHCARE."<br><br>**CASE 2** "FROM MY UNDERSTANDING OF CARE, IT IS FUNDAMENTAL THAT PATIENTS RECEIVE THE DIAGNOSTICS ON THE SAME DAY."<br><br>**CASE 3** "THE OBJECTIVE IS TO OFFER DIGNIFIED EXAMS WITH HIGH QUALITY AND AGILITY AT AN ACCESSIBLE PRICE FOR THE MOST VULNERABLE PART OF OUR SOCIETY."<br><br>**CASE 5** "SPEED IN ARRANGING A MEDICAL APPOINTMENT AND SEE A DOCTOR IS WHAT WE CALL ACCESS."<br><br>**CASE 5** "I THINK THIS IS OUR BIG DIFFERENTIAL. THE PRIVATE HOSPITAL IS VERY EXPENSIVE AND THE PUBLIC ONE IS ALWAYS CROWDED. WE SOLVE BOTH PROBLEMS AND GIVE ACCESS."<br><br>**CASE 6** "[THIS CLINIC] REPRESENTS AN ALTERNATIVE SOLUTION AS IT IS A SOCIAL ENTERPRISE WHICH OFFERS MULTIDISCIPLINARY SERVICES WITH QUALITY AT ACCESSIBLE PRICES." |
| FINANCIALLY AFFORDABLE | **CASE 2** "WE OFFER SERVICES IN COLLABORATION WITH THE PUBLIC SECTOR WHICH MEANS THAT THE PATIENT DOES NOT NEED TO PAY ANYTHING FOR THE SERVICE – AND WE DECIDED TO OFFER HEALTHCARE SERVICES AT POPULAR PRICES AT ANOTHER UNIT AS PART OF OUR STRATEGIC DECISIONS."<br><br>**CASE 3** "I SOUGHT TO ESTABLISH THIS CLINIC BECAUSE I KNEW THAT IT WAS POSSIBLE TO ALIGN EXCELLENT HEALTHCARE SERVICES WITH FINANCIAL AVAILABILITY."<br><br>**CASE 4** "PROVIDING CHEAPER AND THUS ACCESSIBLE HEALTHCARE SERVICES."<br><br>**CASE 5** "WHEN WE TALK OF ACCESS WE MEAN THE FINANCIAL POSSIBILITY FOR THE CLIENT TO RECEIVE QUALITY CARE."<br><br>**CASE 5** "I THINK THIS IS OUR BIG DIFFERENTIAL. THE PRIVATE HOSPITAL IS VERY EXPENSIVE AND THE PUBLIC ONE IS ALWAYS CROWED. WE SOLVE BOTH PROBLEMS AND GIVE ACCESS."<br><br>**CASE 6** "OUR INNOVATION AND DIFFERENTIAL IS TO PROVIDE A MEDICAL SERVICE OF HIGH QUALITY, WITH RESPECT, AFFECTION AND DIGNITY AT AN AFFORDABLE VALUE TO LOW-INCOME PEOPLE WITHOUT ACCESS TO PRIVATE HEALTH INSURANCE AND WHO COULD NOT WAIT FOR AN OPPORTUNITY TO BE TREATED AT THE PUBLIC HEALTH SYSTEM." |
| GEOGRAPHIC ACCESSIBILITY OF THE CLINICS | **CASE 1** "WE LOOK FOR UNITS WHICH ARE EASILY ACCESSIBLE FOR OUR PATIENTS SUCH AS SHOPS AT THE METRO STATION OR SHOPPING CENTRES FOR EXAMPLE."<br><br>**CASE 2** "WITH OUR FLEXIBLE SERVICE DELIVERY AND HIGH-TECHNOLOGY EQUIPMENT WE CAN GO WHEREVER THERE IS NEED – NO MATTER THE GEOGRAPHICAL DISTANCE."<br><br>**CASE 2** "IF YOU CANNOT COME TO US, WE'LL COME TO YOU."<br><br>**CASE 3** "TO GUARANTEE EASY ACCESS TO QUALITATIVE HEALTHCARE, OUR UNITS ARE SITUATED IN AREAS WHICH ARE EASILY ACCESSIBLE BY PUBLIC TRANSPORTS." |

## 2.4 INSIGHTS AND SUMMARY

From the investigation and the data we learned that the clarification of the term "access" is important in several ways. First, it helps to clarify the service segment the entrepreneur is trying to deliver. Second, a firm definition of the access problem that is to be solved by the venture helps to determine targeted outcome variables and the company's success factors. We summarized the following lead questions to apply the findings into practice:

### FOR ENTREPRENEURS

**01 CLARIFICATION**

- How can you divide your services into sub-categories of different aspects of the term "access"?
- How can these classes of "access" clarify new business opportunities? How can these denominations help in adapting your business's strategy or marketing? (e.g. (1) the problem of fast availability can possibly be solved with applying adequate technological tools (e.g. booking your appointment online and via smartphone); (2) fast access to diagnostic services can be facilitated by the set-up of independent and geographically near laboratories or by partnering with 3rd companies).

**02 MEASUREMENT**

- How can you introduce outcome variables that evaluate your success in providing "access" and socioeconomic impact?
- What would in the case of your company be a clearly define and measurable outcome variable for "access"?
- How could such a variable help to eventually readjust activities?
- Think about setting up a quality control based on the outcome variables.

### FOR INVESTORS

**01 CLARIFICATION**

- What is the gap in healthcare services or products you want to fill and why?
- What is your central idea of for the investment and how can you pursue this aim with the management in the company?
- What kind of knowledge have you accumulated about the market? How can you use this knowledge to support your entrepreneurs?

**02 SUPPORT**

- What are the value-adding elements you will provide to the investee and what are your expectations to company in this regard?
- How can you aggregate value to the investment by using interdisciplinary approaches or learning's from other investments?

# 03 | OVERVIEW OF BUSINESS MODELS AND CASE SELECTION

## 3.1 BUSINESS MODEL EXPLAINED

Business Models draw on a long history in management science which offers different definitions of the concept (e.g. Brea-Solís, Casadesus-Masanell & Grifell-Tatjé, 2015; Drucker, 1986, 2002). We use the "business model" as an analytic frame in order to structure business relevant variables and show how different ventures provide access to healthcare for low- and middle-income groups (Georg & Bock, 2010; Prahalad & Hart, 2002). More precisely, we use this framework for the purpose of explaining how a company creates, delivers and captures value (Osterwalder & Pigneur, 2010; Zott, Amit, & Massa, 2011). Thus it adopts a holistic approach in explaining how firms "do business" and what they do by looking at different dimensions of venturing (Gassmann, Frankenberger & Csik, 2015; Zott, Amit, & Massa, 2011; Zott, Amit, & Massa, 2011). Table 2 depicts a summary of the dimensions that will be examined during the report.

TABLE 2 // BUSINESS MODEL DIMENSIONS

| BUSINESS MODEL PILLAR | BUILDING BLOCK | DESCRIPTION |
|---|---|---|
| PRODUCT/ SERVICES | VALUE PROPOSITION | OVERALL VIEW OF THE COMPANY'S PRODUCTS AND SERVICES |
| CUSTOMER INTERFACE | TARGET CUSTOMERS<br>*TARGET MARKET*<br>DISTRIBUTION CHANNEL<br>RELATIONSHIP | SEGMENTS OF CUSTOMERS A COMPANY WANTS TO OFFER VALUE TO<br>*SUB-SEGMENT OF THE TARGET MARKET OF THE VENTURE*<br>MEANS OF THE COMPANY TO CONNECT TO ITS CUSTOMERS (MARKETING)<br>CUSTOMER RELATIONSHIP MANAGEMENT |
| INFRASTRUCTURE MANAGEMENT | VALUE CONFIGURATION<br>CORE COMPETENCY<br>PARTNER NETWORK | ARRANGEMENT OF ACTIVITIES AND RESOURCES<br>COMPETENCES NECESSARY TO EXECUTE THE COMPANY'S BUSINESS MODEL<br>PORTRAYS THE NETWORK OF COOPERATIVE AGREEMENTS WITH OTHER COMPANIES NECESSARY TO EFFICIENTLY OFFER AND COMMERCIALIZE VALUE |
| FINANCIAL ASPECTS | COST STRUCTURE<br>REVENUE MODEL | SUMS UP THE MONETARY CONSEQUENCES OF THE MEANS EMPLOYED IN THE BUSINESS MODEL, MAIN EXPENSES<br>DESCRIBES THE *REVENUE FLOW AND ADDITIONAL INCOME VARIABLES* |
| *BUSINESS CONCEPT* | *FOUNDING CONTEXT*<br>*IMPACT*<br>*STAGES OF LIFE CYCLE*[2]<br>*GOVERNANCE*<br>*MISSION /SOCIAL ENTREPRENEUR* | *STORY AND IDEA BEHIND THE VENTURE INCL. THE INTENTIONALITY*<br>*# BENEFICIARIES, EVALUATE THE AFFORDABILITY OF ITS PRODUCTS/SERVICES*<br>*IN WHICH STAGE OF DEVELOPMENT IS THE COMPANY*<br>*LEGAL STRUCTURE OF THE BUSINESS AND ORGANOGRAM*<br>*LEADERSHIP ASPECTS* |

Adapted from Osterwalder, Pigneur & Tucci, 2005; dimensions in italic added by the authors

[2] *Churchill & Lewis, 1983*

Besides the working models in the primary healthcare market, we give a brief insight into how these ventures simultaneously create social innovation and economic value.

It should be mentioned that even though the businesses provide similar end-services to the clients, we expected that the approach as well as the structure of the ventures would be different. This is because a business model develops over time as well as during the course of the dynamic development of a business, for example through interaction with the target market and the trial and error of the entrepreneur in order to penetrate the respective market segment (Winter & Szulanski, 2001).

## 3.2 OVERALL CASE SELECTION

### *3.2.1 SELECTION CRITERIA*

Besides clarifying and defining the conceptual background of underlining theories, this section depicts the identification of the cases included in the investigation. In Brazil there is a growing number of initiatives trying to solve problems related to the national healthcare system. The selected cases complied with a set of predefined selection criteria (see table) which are mainly that the project has already received investment or is in a stage of business growth. Additional criteria were that the businesses are actuated in Brazilian urban areas, with a focus on primary healthcare (WHO, 2008) for the Brazilian low- and mid-income (CDE) population (Neri, 2014).

**TABLE 3 // INCLUSION AND EXCLUSION CRITERIA FOR ADEQUATE PROJECTS**

| INCLUSION CRITERIA | |
|---|---|
| LOCATION | ~ URBAN AREAS OF LARGE BRAZILIAN CITIES |
| SCOPE | ~ PRIMARY HEALTHCARE RELATED SERVICES ACCORDING TO THE WHO CRITERIA (2014)[3] |
| TARGET GROUP | ~ BOP OR THE BRAZILIAN SOCIAL STRATA CDE[4] |
| STAGE OF THE VENTURE | ~ FROM EARLY PHASE TO MATURITY[5] |
| *CRITERIA OF IMPACT* INVESTING | |
| ACCOUNTABILITY | ~ POSSIBILITY OF IDENTIFYING MEASURABLE EVIDENCE THAT SOCIAL OR ENVIRONMENTAL VALUE HAS BEEN CREATEDCDE |
| PROFITABILITY | ~ COMMERCIALLY SUSTAINABLE AND PROFITABLE BUSINESS |
| INTENTIONALITY | ~ MOTIVATED BY THE INTENTION TO CREATE A SOCIAL (OR ENVIRONMENTAL) GOOD |

[3] *Primary care (first level of care) is the provision of integrated accessible healthcare services through addressing the vast majority of personal healthcare needs, developing a sustained relationship with patients, and practicing in the context of family and community (WHO, 2008)*

[4] *Neri, 2014*

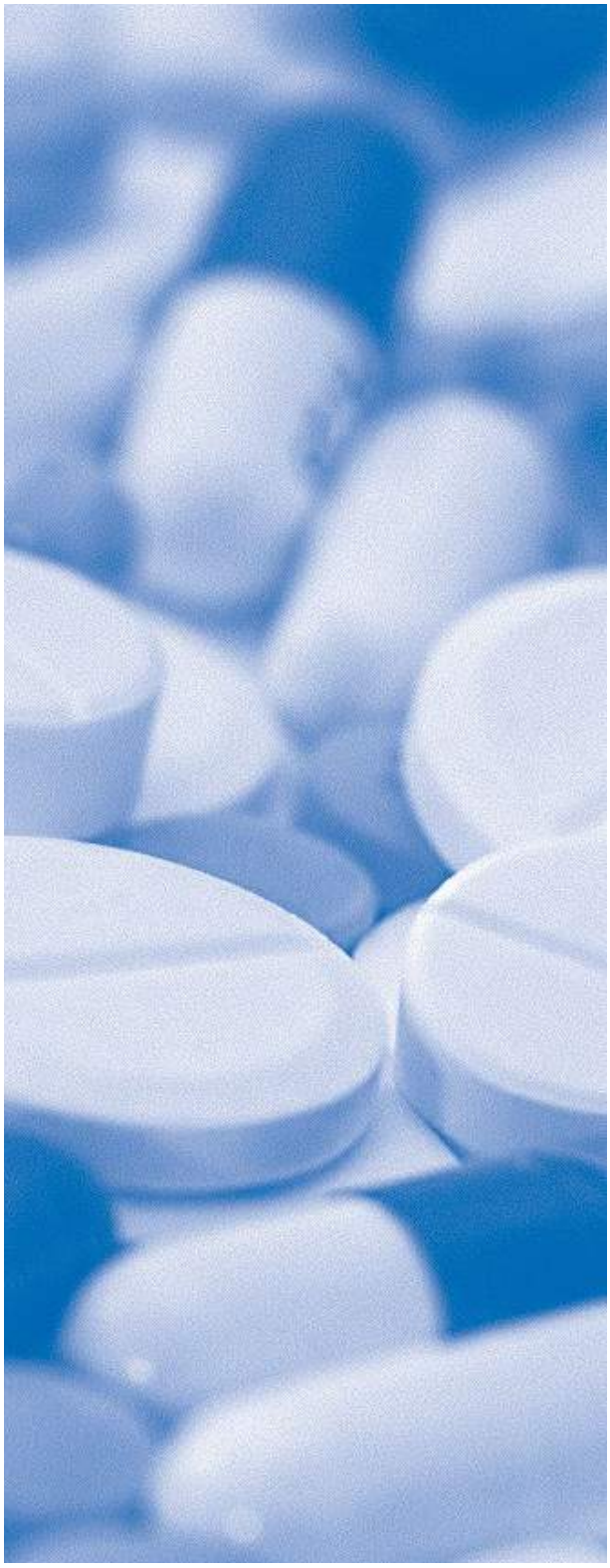
[5] *Churchill & Lewis, 1983*

### *3.2.2 SAMPLE CHARACTERISTICS AND CASE POPULATION*

Based on the above-mentioned criteria, we identified 14 projects and undertook a first screening. This first sample was based on online research and information provided by partner organizations (accelerators, foundations, investment funds). Projects were situated in different geographic regions of Brazil. Out of the screened projects, 10 satisfied the inclusion criteria. Eventually, 7 clinics were selected for the research as three clinics dropped out because their contact did not reply or there was not enough secondary information available for further analysis.

Table 4 shows an overview of the 7 selected cases. Primary data is based on interviews with founders and employees of the clinics. A total of 27 interviews were conducted. For this purpose, one or more clinical units were visited to conduct interviews with different employees (medical staff, administration, etc.), the management team as well as the founder. For data triangulation, we gathered publicly available documents from online resources, newspaper articles and annual reports of the ventures under analysis.

An in depth description of the methodology, of the case selection process and a detailed overview of research relevant characteristics, can be found in the methodology part of the report. Table 4 gives a first description of the sample along with the encountered business models. Additionally, the reader can find a condensed summary of the numerous business models and a complete overview in the annex.



## TABLE 4 // SAMPLE AND BUSINESS MODEL DESCRIPTION (DETAILED DESCRIPTION IN THE ANNEX | DATA FROM 2015)

| UNIT OF ANALYSIS | CASE 1 | CASE 2 | CASE 3 | CASE 4 | CASE 5 | CASE 6 | CASE 7 |
|---|---|---|---|---|---|---|---|
| RESEARCH DATA | | | | | | | |
| **DATA** | PRIMARY[1] & SECONDARY | PRIMARY[1] & SECONDARY | PRIMARY[1] & SECONDARY | PRIMARY[1] & SECONDARY | PRIMARY[1] & SECONDARY | SECONDARY | SECONDARY |
| **BUSINESS REPORT** | NO | YES (PUBLIC) | NO | YES (CONFIDENTIAL) | NO | NO | NO |
| **# OF INTERVIEWS** | 1*40 MIN | 10Ø60MIN | 4Ø40MIN | 8Ø50MIN | 4Ø50MIN | NONE | NONE |
| **INTERNAL INFORMANTS** | CEO | CEO, CFO, MARKETING, DOCTOR, STAFF | CEO, HR, STAFF | CEO, CFO, MARKETING, DOCTOR, STAFF | CEO, MARKETING, DOCTOR/ ADMINISTRATION, STAFF | NO | NO |
| **FIELD VISIT** | YES | YES | YES | YES | YES | NO | NO |
| **# OF UNITS OPEN[2]** | 2 | 5[3] | 3 | 7 | 2 | 3 | 4 |
| **AV. SIZE** | CA. 30M^2 | B/W 30-100M^2 | AROUND 500M^2 | B/W 100-400M^2 | B/W 3000-5000M^2 | N/A | N/A |
| **# OF SPECIALTIES** | ALTERNATIVE TO PRONTO-SOCORRO | > 20 | >40 | 25 | >36 | 25 | 29 |
| **CONSULTATION PRICE (R$)** | FIXED PRICE 89R$ | FOR FREE | 62-72R$ | 90-120R$ | 60R$-X | 90R$ | 90-100R$ |
| **ONLINE BOOKING** | ONE STOP SHOP | NO | YES, "ONE-STOPSHOP | YES | YES | YES | YES |

## TABLE 4 // SAMPLE AND BUSINESS MODEL DESCRIPTION (DETAILED DESCRIPTION IN THE ANNEX | DATA FROM 2015)

| UNIT OF ANALYSIS | | CASE 1 | CASE 2 | CASE 3 | CASE 4 | CASE 5 | CASE 6 | CASE 7 |
|---|---|---|---|---|---|---|---|---|
| BUSINESS MODEL DIMENSIONS | | | | | | | | |
| PRODUCT / SERVICES | *VALUE PROPOSITION* | PRE-PRIMARY CARE | EXAMINATION AND PRIMARY CARE | PRIMARY CARE, DISEASES OF LOW AND MEDIUM COMPLEXITY | PRIMARY CARE, DISEASES OF LOW AND MEDIUM COMPLEXITY | "ONE-STOP SHOP" FOR CLIENTS AND MEDICAL STAFF | AMBULATORY SERVICE, COMPLEMENTARY EXAMS AND SURGERY | PRIMARY CARE, DISEASES OF LOW AND MEDIUM COMPLEXITY |
| | ~ UNIQUE SELLING PROPOSITION | PRICING, TIME EFFICIENCY, COAMPANY CONTRACTS, PRE-PAID CARD | PRICING, TIME EFFICIENCY, COAMPANY CONTRACTS, PRE-PAID CARD | QUALITY, PRICING, ACCESSIBILITY, SPEED | QUALITY, PRICING, ACCESSIBILITY, SPEED | DIAGNOSTICS, EXAMS, REHAB, TREATMENT IN ONE PLACE | QUALITY, PRICES, VISION OF SOCIAL RESPONSIBILITY FOR THE POPULATION | QUALITY, PRICING, ACCESSIBILITY, SPEED |
| CUSTOMER INTERFACE | *TARGET CUSTOMERS* | BCD | CDE | CD (E) | CD, PEOPLE WITHOUT HEALTH INSURANCE | A 5-10%, 20 – 30 % B, C 50-60%, D 5%. | CDE | CDE |
| | *TARGET MARKET* | NON-INSURED & INSURED FOR ACCESSIBILITY AND CONVENIENCE | SUBURBAN REGIONS AND REMOTE AREAS OF BRAZIL | ACCESSIBLE REGIONS (IN THE SUBURBS) OF URBAN AREAS | AREAS OF DENSE POPULATION THAT ARE EASILY ACCESSIBLE BY PUBLIC TRANSPORT | ALL OF BRAZIL | PRIMARY HEALTHCARE SERVICES IN MEDIUM SIZE CITIES | NON-INSURED & FIXED EMPLOYMENT / 1-3 MINIMUM WAGES |
| | *DISTRIBUTION CHANNEL* | FLYERS, INTERNET, WORD OF MOUTH (WOM) | | OFFER FREE SERVICES FOR DIABETES TEST; INFORMATION DIVULGATION VIA HEALTHCARE CAMPAIGNS; WOM, ANNOUNCEMENTS ON GOOGLE ADVERTS | ONLINE, PAPER, RADIO, TELEVISION, WOM | MARKETING ACTIVITIES IN THE COMMUNITY, ADVERTISEMENT, WOM | MARKETING AND FORM CORE BUSINESS SEPARATED SOCIAL PROJECTS, ADVERTISEMENT ON TV AND WOM | ONLINE, PAPER, RADIO, TELEVISION, WOM |
| | *RELATIONSHIP* | N/A | N/A | BONDING THROUGH CLINIC MARKETING | BONDING THROUGH CLINIC MARKETING | BONDING MAINLY THROUGH DOCTORS | INCUBATES VARIOUS ACTIVITIES FOR SOCIAL RESPONSIBILITY | BONDING THROUGH CLINIC MARKETING |

## TABLE 4 // SAMPLE AND BUSINESS MODEL DESCRIPTION (DETAILED DESCRIPTION IN THE ANNEX | DATA FROM 2015)

| | UNIT OF ANALYSIS | CASE 1 | CASE 2 | CASE 3 | CASE 4 | CASE 5 | CASE 6 | CASE 7 |
|---|---|---|---|---|---|---|---|---|
| | BUSINESS MODEL DIMENSIONS | | | | | | | |
| INFRASTRUCTURE MANAGEMENT | *VALUE CONFIGURATION* *CORE COMPETENCY* | CONSULTATION | EXAMS | CONSULTATION, EXAMS | CONSULTATION, EXAMS | CONSULTATION, EXAMS, OPERATIONS | CONSULTATION, EXAMS | CONSULTATION, EXAMS |
| | *PARTNER NETWORK* | PRIVATE SECTOR/ INVESTORS | GOV./ COMPANIES/PRIVATE SECTOR | COMPANIES/ COMM UNITY CENTERS (DISCOUNT) | INVESTORS/ PRIVATE BUSINESS MEN/ DOCTORS | FAMILY BUSINESS DOCTORS | FOUNDATIONS, NGOS, PRIVATE BUSINESSES, REGIONAL AND NATIONAL GOVERNMENT | INVESTORS/ PRIVATE BUSINESS MEN |
| FINANCIAL ASPECTS | *COST STRUCTURE* | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| | *REVENUE MODEL* ~ PRICING STRATEGY | FEE FOR SERVICE | CONTRACTING WITH GOV. & COMPANIES AS WELL AS POPULAR PRICES | FEE FOR SERVICE | FEE FOR SERVICE | FEE FOR SERVICE | 100% DIRECT SALES TO PATIENTS | FEE FOR SERVICE |
| | ~ FACTORS DETERMINE REVENUE | VOLUME OF CLINICAL CONSULTATIONS | | VOLUME OF CLINICAL CONSULTATIONS | VOLUME OF CLINICAL CONSULTATIONS | CONSULTATIONS, EXAMS, SURGERY | 80% CONSULTATION, 15% EXAMS AND 5% SURGERY | |
| | ~ OTHER VARIABLES (FUNDING, SUBSIDIES, DONATIONS) | VENTURE CAPITALISTS | | | VENTURE CAPITALISTS DEVELOPMENT BANK | FAMILY AND PROPRIETARY | N/A | VENTURE CAPITALISTS |
| | ~ MAIN EXPENSES | RENT | N/A | RENT & SALARIES (BY PRODUCTIVITY) | RENT & SALARIES | RENT & SALARIES | N/A | N/A |

## TABLE 4 // SAMPLE AND BUSINESS MODEL DESCRIPTION (DETAILED DESCRIPTION IN THE ANNEX | DATA FROM 2015)

| | UNIT OF ANALYSIS | CASE 1 | CASE 2 | CASE 3 | CASE 4 | CASE 5 | CASE 6 | CASE 7 |
|---|---|---|---|---|---|---|---|---|
| | BUSINESS MODEL DIMENSIONS | | | | | | | |
| BUSINESS CONCEPT | *FOUNDING CONTEXT* | IDEALIZATION OF A "MINUTE CLINIC" IN BRAZIL | STRONG WISH TO CHANGE THE CONDITION OF THE PUBLIC HEALTHCARE SYSTEM | FAMILY HAS A MEDICAL TRACK-RECORD AND STARTED BY DOING CSR CAMPAIGNS, LATER REGARDING THE DIRE CONDITIONS IN PUBLIC HOSPITALS | ENTREPRENEURIAL HISTORY, BUSINESS OPPORTUNITY, HUMANISTIC EDUCATION | FOUNDED BECAUSE OF THE EXPERIENCE OF THE FOUNDER (DOCTOR) WORKING IN THE PUBLIC HOSPITAL HUMANISTIC VISION OF THE FOUNDER | FOUNDER FORMALLY DEDICATED TWO DAYS/WEEK TO VOLUNTARY EXAMINATIONS FOR BOP | BUSINESS POTENTIAL, MINUTE CLINIC, INSPIRATION BY CASE STUDY "FARMACIAS SIMILARES" |
| | *IMPACT* ~ # BENEFICIARIES | BREAK EVEN VOLUME: 3.5 VISITS/ HOUR, 100 VISITS/ MONTHS | 34,000 EXAMS/ MONTH, Ø 6,800 (27 BOXES IN 5 UNITS) | 400-500 EXAMS/ DAY | 8,000 EXAMS/ MONTH (2014) 7,327 PATIENTS/ MONTH IN ONE CLINIC (2015) | 700,000 EXAMS/ MONTH 120,000 PATIENTS P.M. (2 CLINICS) | ~3,000 EXAMS/ MONTH | ~ 5,000 EXAMS / MONTH |
| | ~AFFORDABILITY OF PRODUCTS/ SERVICES | 89R$ | PATIENTS DON'T PAY FOR SERVICES | FROM 72R$ | 90-120R$ | FROM 80R$ | N/A | N/A |
| | *STAGES OF LIFE CYCLE*[1] | SURVIVAL TO SUCCESS | SUCCESS-GROWTH | SUCCESS-DISENGAGEMENT | DIVISIONAL | SUCCESS-GROWTH | DIVISIONAL | SUCCESS-GROWTH |
| | *GOVERNANCE* ~ FOR-PROFIT, NON-PROFIT, HYBRID | FOR-PROFIT; S.A. | STRUCTURALLY DIFFERENTIATED HYBRID (NON-PROFIT AND FOR-PROFIT) | FOR-PROFIT | FOR-PROFIT; S.A. | FOR-PROFIT | FOR-PROFIT | FOR-PROFIT; S.A. |
| | ~ PORTIONS ON THE COMPANY OWNED BY THE FOUNDER | N/A | JOINT OWNER | JOINT OWNER, NO PUBLICLY AVAILABLE INFORMATION ON DISTRIBUTION OF SHARES | N/A | 100% | N/A | 55% OF SHARES |

## TABLE 4 // SAMPLE AND BUSINESS MODEL DESCRIPTION (DETAILED DESCRIPTION IN THE ANNEX | DATA FROM 2015)

| | UNIT OF ANALYSIS | CASE 1 | CASE 2 | CASE 3 | CASE 4 | CASE 5 | CASE 6 | CASE 7 |
|---|---|---|---|---|---|---|---|---|
| | BUSINESS MODEL DIMENSIONS | | | | | | | |
| BUSINESS CONCEPT | *SOCIAL ENTREPRENEUR* ~ MISSION | BUSINESS OPPORTUNITY | ACCESS TO HEALTHCARE TO MOST VULNERABLE URBAN REGIONS | HEALTHCARE SERVICES FOR PEOPLE WHO ARE EXCLUDED FROM THE HEALTHCARE SYSTEM | HEALTHCARE AS A BASIC RIGHT, SOLVE HEALTHCARE PROBLEMS | CREATE A WORKING SPACE FOR DOCTORS IN ORDER TO EXERCISE THEIR PROFESSION ETHICALLY AND IN A SOCIALLY RESPONSIBLE WAY | LOOK AFTER THE BASIC NEEDS OF THE POPULATION WITH ACCESSIBLE AND COMPETITIVE PRICES, TECHNOLOGY AND QUALIFIED DOCTORS | BUILD THE BEST NETWORK OF "CLINICAS POPULARES" IN BRAZIL |
| | ~ GENDER | MALE | MALE | MALE | MALE | MALE | FEMALE | MALE |
| | ~ EDUCATIONAL & PROFESSIONAL BACKGROUND | BUSINESS | MEDICINE | MEDICINE/MBA | BUSINESS | MEDICINE | MEDICINE | BUSINESS |
| MARKET ANALYSIS | *COMPETITORS* | MINUTE CLINICS | NONE | OTHER "CLINICAS POPULARES" | OTHER "CLINICAS POPULARES" | "CLINICAS POPULARES" ONLY PARTIALLY, HOSPITALS | OTHER "CLINICAS POPULARES" | OTHER "CLINICAS POPULARES" |
| | *ENTRY BARRIERS* | LOW | LOW | LOW | LOW | LOW | LOW | LOW |
| ADDITIONAL INFORMATION | *EXPANSION* | 1ST PHASE: GROWTH TO 5 CLINICS; 2ND PHASE: 10 MORE CLINICS | EXPANDING BUSINESS CONCEPT TO OTHER COUNTRIES | UNTIL 2016 - 5 UNITS | ONGOING EXPANSION IN URBAN AREAS | ONGOING EXPANSION IN URBAN AREAS, COUNTRY WIDE EXPANSION PLANS | ESTABLISHMENT OF A THIRD UNIT | 63 UNITS UNTIL 2019 |
| | *INVESTMENT (INFORMATION OPEN TO THE PUBLIC)* | 7.5M R$ FOR 5 CLINICS | | N/A | 2014: 20M R$ FOR 20 CLINICS IN 2016 MORE FUNDING IN '14 AND '15 | N/A | N/A | 2015: 30M R$ |

**Table structured from Santos & Eisenhardt, (2009)**

[1]interviews and questionnaires

[2]number of clinics is subject to change because of expansion operations

[3]cannot be quantified to the same extent as the n° of units varies

## 3.3 EXEMPLARY CASES EXPLAINED

We would like the reader to gain a figurative insight into the market. Thus in the following paragraph we will summarize three exemplary business cases that can give a descriptive base before entering the more detailed discussion of business innovation. The authors decided to select the following presented cases as they assemble characteristics and business elements on interesting arrangements of human resource management, expansion strategy and social impact. These characteristics can be found in all of the cases, however the three examples provide a very clear and illustrative insight. We do not intend to make any judgment on the success or financial sustainability of the ventures.

### *3.3.1 CASE 2*

The goal of Case 2 is to take high-quality, affordable and personalized healthcare to under-served urban districts as well as remote areas of Brazil. This distinct social mission drives the configuration of its business activities. Case 2 possesses a variety of delivery systems that confer the project with a high degree of flexibility and adaptability. On the basis of this distribution channel they are able to provide viable primary care services for low and medium complexity cases to different urban and rural locations that would otherwise not be accessible. A strong driver of organizational culture is the will to change the condition of the public healthcare system and to bring quality healthcare to the most vulnerable populations.

The success of this project is incontestable: it treated patients in more than 30 cities in different Brazilian states. It does not only stand out for its delivery model but also for its organizational structure. A hybrid organization allows Case 2 to be financially sustainable and attract different sources of capital, ranging from private investors to cooperation with public institutions. This hybrid structure is one of the success factors of this case as it combines the best of both worlds: a non-profit organization that delivers personalized medical services and a for-profit organization that produces high-quality medical equipment.

The project's social mission can be summarized in three points: firstly, it provides access to high quality and specialized healthcare for all, secondly, it seeks to minimize waiting lines in the public sector and thirdly, it recognizes the need to educate patients on health prevention. The founder's strong personal motivation to make this venture a success can be sensed across the organizational structure, the organizational culture and the way he incessantly looks for new opportunities to develop and thrive. Case 2's success story is manifold - a holistic offering of healthcare services which are anchored.

During the project's pilot phase, Case 2 operated on a small scale, primarily in municipalities of merely 100-1000 inhabitants where it cooperated with private companies, NGOs or with the municipalities themselves. This concept can be compared to the idea of subsidiarity in which local governance structures are established and the service implementation is left to local stakeholders. This concept remains a very important aspect of the organizational approach. Yet, it has been complemented by a variety of different stakeholders that support the well-functioning of this case. Especially its partnership and reliance upon the public sector distinguishes Case 2 from other privately organized for-profit ventures. It has recognized the need to combine private sector approaches with the expertise and scope of the public sector. While the project started on a small scale with the provision of primary healthcare and in cooperation with Brazilian municipalities, it has now grown into a project that works in cooperation with the government and even executes smaller surgeries in their mobile units. Healthcare services especially need a strong cooperation between public and private providers as it is fundamental in creating necessary synergy effects and in relieving the overly burdened public sector. Moreover, the idea of bundling a vast array of services in mobile units distinguishes the venture from other similar, mobile clinics - not only in terms of quantity (numerous services offered) but also in terms of quality as it is convenient for patients to get different services in one place at a time.

While Case 2 seems to be a role model for a social venture in healthcare for the low-income population, it also comes with trade-offs. Especially the combination of public, private and social sector rationales bear some difficulties. There is a subliminal conflict between these rationales as they all seek different primary goals.

### 3.3.2 CASE 4

Healthcare in Brazilian urban areas is a market with potential. It is relatively stable, crisis-proven and particularly with the growing financial power of the general population, combined with the difficulties of the public sector, it is an interesting segment for for-profit institutions. Several cases in the sample focus on this market opportunity and pay-for-service models with a business mind-set. With the entry of more players into the market, this share of the healthcare sector is becoming more segmented and competition is increasing. A strategy to gain costumers and market shares in this particular situation is to focus on brand development, rapidly increase size of operations and thus bind patients to the clinic.

Case number four is an example of this business-driven approach with a strong emphasis on process optimization that leads to cost savings and to higher quality for the client. Even though this case has a clear objective of exploiting the commercial potential and penetrating the market in the most efficient way, the founders emphasize the social component in the mission and marketing of the company. This two-sided approach is also visible in the acquisition of several external investors that range from traditional to social focused investment capitalists. Thus the company has been growing in an investment cycle based on a strong basis of angel investors, binding highly value-adding venture capitalists and introducing interesting models of equity participation of early respectively key employees. The future development of the commercial strategy and corporate governance structure have the potential to be an interesting showcase for the current market.

The company under discussion is offering treatment and diagnostics for primary care problems and diseases of low and medium complexity. Thereby the medical specialities have quickly grown from the initial rather basic service offerings to a sophisticated range of medical and esthetical services that best sell and penetrate the current market. In doing so, it is not only the identification of a precise range of demanded services that are the focus of the business strategy but also the optimisation of the capital incentive process of opening new locations in strategic areas and the consequent organisational adaption of the business to the flow of patients. Before now a new clinic infrastructure was set up, locations are, amongst other things, elaborately analysed to see if it is generally accessible by public transport or if the clinic lies on the transport-lines that the target group uses to get to work. Also, the services offered are adapted to the demands of the specific locations.

Thus the value-creation in the core business is fundamentally based on the planning, process optimization and standardisation of the company's procedures. This will essentially support the clinics to achieve their aim, which is to provide affordable, accessible and high quality immediate medical services to their local population. As well as the focus on business process optimization, the company has given special care to sensitizing and training their staff to provide a distinguished service that respects and guides the patients through the medical consulting process. So, besides the focus on back-office efficiency, the front-desk is trying to implement a patient-centred approach that brings a distinguished added value to the patients and binds them to the clinic.

The aim to rapidly gain market shares expresses itself in an expansion approach similar to the market penetration often found in retail businesses. It manifests itself by rapidly setting up new locations and building the brand in order to gain coverage. Aside from the efficient standardisation of the locations and gaining market shares, the company is unlocking new markets as a contractor for big companies in employee healthcare or as an innovator of digitalisation in medical services.
To sum up, we can identify interesting characteristics in process optimization, lean management and business innovation. Several cases in the sample fall into the same business-oriented category and somehow try to pursue the same characteristics of efficiency, processes, organisation and execution in order to boost their businesses. Thus the competition between healthcare ventures with a comparable strategy and the focus on market share is suspected to grow. A crucial factor as a consequence appears to be the speed of expansion and the access to growth capital.

### *3.3.3 CASE 5*

The experience with the existing public and private healthcare services in Brazil is rated as miserable (Folha de São Paulo, 2015) and healthcare is highlighted as one of the main problems within Brazilian society (Leite, 2014). However, it does not only appear to be the patients that think that the conditions of the healthcare system are difficult. In our interviews we received feedback, that also shows doctors and other medical employees are unhappy with the general situation. In addition to their wish to simply execute the medical profession with quality and dignity, they have to walk a thin and often conflicting line. Especially with bureaucracy, budget restrictions from public agencies or for-profit oriented private insurances and the pressure of time-management seem to compromise quality work. Consequently health personnel seem to feel degraded when used as an extended arm of a system they do not agree with.

In this context case number five gives the example of constructing a business model around not only the opportunities within the healthcare market but also of the needs and the strife of the medical staff. In short, the clinic solves administrative and infrastructural problems for the doctors and enables the medical staff to focus on problem-solving and relationship building with the patient. One of the central pillars of success is the doctor-patient-relationship where fragmented medical services are again integrated and patients have to some extent a family doctor to turn to.

Compared to the other businesses in our sample, Case 5 has been in the business for the longest time. Starting as a provider of medical services, it has developed into a "one-stop shop" for diagnostics, laboratory work and exams, treatment, small operations and rehabilitation. Expertise, material or services that are not (yet) part of the facilities are strategically acquired through partnerships with different stakeholders, such as hospitals.

Besides providing a vast array of medical infrastructure, equipment and facilities to the doctors, the clinic also takes care of administrative questions (marketing, accounting, organising consultation, maintenance, etc.). The company is very eager to provide a physical space

of mutual exchange for the doctors, where short paths and good communication between the medical staff can benefit the patients and increase the overall quality of services.

The administrative work such as marketing, organisation of appointments, infrastructure or accounting is separated from the medical treatment. This provides the doctors with more time and flexibility to work on treatment, problem-solving and the relationship-building process. Medical staff are recruited with the premise that they get the possibility to execute their profession without the obstacles they would face in other workplaces. Additionally doctors will have a competitive, over market rate compensation that is strongly based on the achievements in service quality, patient satisfaction and the number of patients treated. This focus on creating a strong and satisfied medical body is intentional. In turn the company will profit from doctors that focus on the quality of services and the bonding process with the clients.

Marketing wise this company uses its unique selling point as the "one-stop shop" and positions itself as a high quality medical service provider for the mid- to low-income population of the districts in which they are strategically situated. Additionally and in line with the idea of empowerment of the medical staff, the company tries to reconnect the doctors not only with the patients but also with the social surrounding they are working in by organising marketing events in the neighbouring districts.
So far the for-profit family businesses have been financed through debt and family equity capital. Financial stability in this model that strives for a capital incentive hospital-like structure is based on the customers' out-of-pocket payments. Moreover, Case 5 balances its accounts by cooperating with selected insurances and thus provides an additional incentive for clients to choose this option.

## 3.4 MODELS OF VALUE CREATION - SOME CONSIDERATIONS

Based on these three showcases and the overview of the sample in table 4, we can draw our first major conclusion. We learned that even though the investigated ventures tackle a slightly similar target population, provide somehow related services and operate in the same market, the sample shows differences in how the ventures work and what kind of founding values seem to be behind the operations. Based on this impression, we asked ourselves if there is any structured description of how the businesses aim to create value for the involved parties (patients, employees, other stakeholders).

**QUESTION I**

**ARE THERE DIFFERENCES IN VALUE CREATION THROUGH THE BUSINESS MODEL AND HOW CAN IT BE SYSTEMATISED?**

The data shows that in spite of all the similarities, the ideas of entrepreneurial, organisational and company related creation of value differs in several aspects. Consequently the differences in value-creating logics between the ventures are pronounced and this in turn determines variations in the business strategy and model. The entrepreneurial idea of how to bring value to the patient especially seems to influence the organizational set-up. The sample illustrates several patterns that appear to be present in all the ventures:

1. Clinic solves administrative and infrastructural problems for the medical staff. Consequently doctors bring value through relationship building with the patients. Therefore the businesses create value for both the clients and the doctors.

2. Clinic focuses on brand development in order to gain customers and market shares and thus rapidly bind patients.

3. Clinic is mainly patient centred and wants to establish an immediate connection to the patient with a focus on social impact.

Table 5 gives some insight into the data to support the three dimensions that were before mentioned.

## TABLE 5 // LOGIC PATTERNS OF SERVICE

| REASONING | CITATION |
|---|---|
| **(1) THE MEDICAL BONDING APPROACH** | |
| 1. CLINIC FOCUSES ON RELATIONSHIPBUILDING WITH THE DOCTORS<br>2. DOCTORS ARE PROVIDED WITH QUALITY MATERIAL, A FUNCTIONING ADMINISTRATIVE BODY TO FACILITATE THE EXECUTION OF THEIR PROFESSION<br>3. DOCTORS BOND WITH THE PATIENT AND BIND THEM TO THE CLINIC | **CASE 2** "FOR ME, WORKING FOR [PROJECT XY] GAVE ME A CHANCE AND OPPORTUNITY TO TRAVEL TO A REGION THAT NEEDED MEDICAL CARE AND SERVICES."<br>**CASE 5** "WE PERCEIVE OURSELVES AS "CONCIERGES" OF THE MEDICAL BODY. THAT'S WE HAVE DOCTORS THAT ARE WORKING WITH US FOR NEARLY 20 YEARS."<br>**CASE 5** "IT IS THE DOCTOR THAT BUILDS THE RELATION TO THE PATIENTS AND NOT THE CLINIC. THIS IS AN ENORMOUS VALORISATION OF THE WORK OF THE DOCTOR." |
| **(2) THE RETAIL APPROACH** | |
| 1. CLINIC FOCUSES ON SETTING UP THE INFRASTRUCTURE AND OPTIMIZING THE ORGANIZATION<br>2. CLINIC BRINGS EFFICIENCY AND DELIVERS THE CORE VALUE TO THE PATIENT<br>3. CLINIC CREATES THE REPUTATION AS A BUSINESS AND WORKS RETAIL STYLE | **CASE 1** "WE ARE LOOKING FOR A FAST "ROLL OUT" AND TO EXPAND THE SCOPE OF OUR BUSINESS."<br>**CASE 3** "WE ARE A "ONE-STOP-SHOP" WHERE THE PATIENT HAS ACCESS TO A VARIETY OF EXAMS AND RECEIVES THE DIAGNOSTICS ON THE SAME DAY."<br>**CASE 4** "[THE COMPANY] EXISTS TO ORGANIZE THE ACCESS [TO HEALTH] IN AN AGILE AND PROBLEM-SOLVING MANNER."<br>**CASE 5** "OUR CLINIC PROMOTES AN EXHAUSTIVE ACCESS TO HEALTHCARE, ALL IN ONE PLACE, WITH THE HIGHEST NUMBER OF CLINICAL HOURS FOR OUR PATIENTS FROM THE CITY OF SÃO PAULO."<br>**CASE 7** "I WANT TO BUILD THE BIGGEST AND BEST CLINIC NETWORK IN BRAZIL."[1] |
| **(3) MISSION-DRIVEN APPROACH** | |
| 1. CLINIC IS SHAPED BY THE MISSION OF THE ENTREPRENEUR<br>2. THE MISSION DEFINES THE VALUE CREATION PROCESS AND STRONGLY INFLUENCES THE ORGANIZATIONAL CULTURE | **CASE 2** "THE SOCIAL VALUE OF [THE COMPANY] IS ITS ACCESSIBILITY: WE TREAT THE INDIVIDUAL HEALTH INTEGRALLY. [THE COMPANY] PARTICIPATES WITH ACCESSIBILITY TO HEALTH FOR THE PEOPLE AND DEVELOPS THE PRODUCT THAT MAKES THIS POSSIBLE. WE ARE A FACILITATOR FOR OUR CLIENTS AND THAT [THE COMPANY] CAN PROVIDE AN INTEGRAL SERVICE."<br>**CASE 6** "WE ARE STRIVING TO BE A REFERENCE IN HEALTHCARE FOR THE COMMUNITY AND ESPECIALLY FOR THE LOWER SOCIAL CLASSES WITH LOWER FINANCIAL MEANS." I |

[1]Secondary information

The separation of these approaches is only conceptual and projects integrate the different attitudes at varying degrees. Faith in these different approaches appears to be the main driver behind the clinics' development and ultimately their success.

## 3.5 INSIGHTS AND SUMMARY

Our analyses depict several basic findings. First, even though the ventures seem to have a similar target market, we have seen in the data and the exemplary case studies that the businesses **differ in the scope of their value propositions.** The service offerings range from very basic pre-primary healthcare services that mainly consist of diagnostic and prescription of medication, to medium-complexity services, such as minor surgeries as well as healthcare prevention programs for individuals and companies. Therefore the analysis is compelling, as rather than constituting direct competitors, most of the projects complement the public and private healthcare offered by entering different niches. All ventures included in the sample, target a similar customer group and propose a set of comparable services, which target patients that are not satisfied with the services of the public healthcare system or the performance / coverage of the insurance companies. The expectation of clients to receive a service that efficiently solves or clarifies any medical problems when going to a private healthcare clinic drives out-of-pocket payment.

Secondly, as was argued above, the data shows that there are pronounced differences in **the main drivers for value creation in the business.** We assume that different emphasises and views on the customer, the medical staff and the role of the enterprise in this relation lead to various approaches in e.g. constructing and structuring the business, its organization, strategy and human resources. Consequently, even though the aim of giving access to an underserved population is similar, the strategy of the companies to achieve this aim seems to differ and thus influences the structure, elements and organisation of the business model.

Thirdly, the first insights into the business model as well as its overview, revealed factors **in services, processes and organizational development,** which distinguish the projects from the already existing public or private services as well as from each other. We will discuss these dimensions in more detail in the following section and put them into the context of innovation. Those dimensions are meant to be innovative because (1) they constitute new elements or new combinations of elements that have not yet been present in the Brazilian primary healthcare sector and (2) they seem to solve several problems of access, primarily focusing on the extremely efficient execution of medical as well as administrative services and procedures.

Fourthly, we think that it is worth taking a closer look at the **partner network and the investor base** of the cases. One of the aims of the investigation was to connect facets of the business concepts with the notion of social entrepreneurship and double bottom line – a concept referring to the combination of social and financial return. The businesses in the sample show several characteristics of innovative partnerships that are worth exploring in more detail.

This paragraph started with the description of the business model to depict how a company does business and how it creates, delivers and captures value. From our sample and the description of the three cases we may deduce that a business model is an "organic concept" that develops over time and is constantly adapted during the development of the company. New circumstances, client demands or situations in terms of rules and regulations shape unique business models for each case. Thus we will not directly compare the cases but rather describe the different business ideas, the resulting business model and factors that can partially explain and track the entrepreneurial undertaking.

# 04 | BUSINESS INNOVATIONS: SERVICES, PROCESSES, ORGANIZATION AND CAPITAL

Besides technological progress and invention, innovation can also take place in services, processes, business models or others (Hoffmann, Lennerts, Schmitz, Stölzle & Uebernickel, 2015; Phills, Deiglmeier & Miller, 2008; Ziegler, 2010). Those objects of innovation can arise either from already existing "bricks" that are combined in a new manner or may be invented from scratch. This process comprises of a systematic regulation and control of the respective "objects" of innovation in and within organisations (Hoffmann et al., 2015). Based on this background the subsequent questions guided the research relating to business innovation:

**QUESTION 2**

**WHAT ARE THE FACTORS IN THE PROJECTS' BUSINESS MODEL AND ACTIVITIES THAT CAN BE SEEN AS DISTINGUISHING AND INNOVATIVE?**

The following paragraphs will illustrate the areas of innovation that we detected in the data. We will analyse those innovations along the business model pillars that are depicted in the business model structure that was presented previously (table 2).

The first paragraph works along the building block of value proposition and present innovations that introduce new business ideas or make services and products better for the client. The second paragraph refers to factors that look to enhance the customer interface and the infrastructure management of the companies. Among those are the application of technology, several organizational elements of the ventures and human resource strategies that were found in the data. The third paragraph groups organisational and business concept dimensions as well as innovations of financial aspects. Among those are the governance structures such as hybrid organizing, broadened partner networks and shared responsibility among stakeholders, organisational structures that eliminate the intermediary as well as variables of the revenue model. An important challenge for the researched ventures was the question of access to capital. Consequently we will dedicate one separate paragraph to a description of how the cases solve this problem.

## 4.1 SERVICES INNOVATION

Case number one introduced a service segment that had not previously existed in the market. The business focuses solely on low complexity diseases. This model that we labelled as *Pre-Primary Care Model* (Minute Clinic) works within the ICD criteria (WHO, 1992) to identify the patients' medical problem, provide the patient with a diagnosis and a prescription for the adequate treatment / medication. Additional innovation in services segments in future could be derived from prevention, especially of chronic, non-communicable diseases, which was recognized by a majority of the clinics as a viable additional service to be offered to the clients and integrated into a for-profit oriented business model.

Besides the introduction of these new service arrangements we found some characteristics in the sample of improvements in services and products. Services innovations mainly include *rapid access and convenience* for the patient. Thereby the rapid availability in terms of access can be seen as one unique selling point of all ventures. The businesses try to achieve access and convenience by geographically spreading out and establishing units across the urban centres in easily accessible areas close to public transport. Another benefit in terms of convenience is

that the clinics assemble numerous healthcare services in one unit. Those services range from examinations, diagnostics, prevention programs and sometimes even minor surgeries. Hence, not only the clinics benefit from economies of scale (volume of patients), but more importantly patients save time and energy by doing all of their exams and diagnostics in one place.

## INTEGRATED SERVICES: ONE-STOP-SHOP

A basic problem of several ventures as well as the entire healthcare system is the fragmented solution of the client's medical problem, which means that the interaction and communication between medical specialities is often difficult. Thus patients are only treated for separate symptoms and not in an integrated fashion.

Case number 5 has been especially interesting because it solves the problem of service for the client in terms of speed, convenience with a focus on medical problem solving and treatment of the diagnosis in an especially complete way. This is done primarily through the provision of a much elaborated infrastructure that includes modern equipment, diagnostic possibilities as well as rehabilitation facilities either in one facility or within walking distance. Additionally, the medical body is managed in a way that makes nearly every medical specialisation available under the same roof and makes it much easier for the client to look for treatment.

This all-in-one service or one-stop-shop facilitates integrated care, stimulates professional exchanges among medical doctors and avoids unnecessary expenses and trouble for the patient.

EXAMPLE 1

The investigated ventures focus predominately on *efficient and immediate problem-solving* of the clients' medical issues. The focus is the aspiration to provide tangible, immediate solutions to the clients over a short period of time.

The next characteristics that make companies competitive and appealing to the clients are *personalized services* (or "humanized") where clients are treated with dignity and respect, which is a differential to the existing healthcare system. The focus is on customer relations and on them bonding with either the brand or the doctors. Even though the main pressure is on the doctor/ nurse - patient-relationship, the personalization of services includes several other held professions that are trained in patient contact. For example, most of the cases are concerned with setting up an organizational culture that incentivizes and facilitates a respectful and caring behaviour with the patient. In order to enable patient-time, most of the cases work with highly separated and professionalized operations. Consequently, instead of spending time on administrative work, the doctor's time with the patient is maximized by delegating these processes to administrative staff. Along with this claim of personalized, patient-centred services, the objective of an integral care program that values the patient in their entirety gains importance. We observed that some services, besides including an integrated vision of the patient, offer regular follow-up exams as a pivotal component of preventive healthcare programs.

These factors can be taken for granted in a developed country, but are still seen as innovative in Brazil. Even though many of the named elements are recognized in the public or private system, the execution and availability of such services are only partially existent.

## TABLE 6 // SERVICE INNOVATION WITH EVIDENCE FROM THE DATA

| PLACE OF INNOVATION | RESULTS FROM THE DATA |
|---|---|
| SERVICES INNOVATION… | |
| 1. PRE-PRIMARY CARE MODEL | **CASE 1, FOUNDER:** "WE INVENTED A CYCLE OF CARE AND A SERVICE THAT HAS NOT EXISTED SO FAR IN THE BRAZILIAN MARKET." |
| 2. FOCUS ON SPEED AND CONVENIENCE FOR THE PATIENT | **CASE 1, FOUNDER:** "THE UNIQUE SELLING POINT IS THE SPEED IN WHICH WE CAN OFFER CONSULTATION AND EXAMS."<br><br>**CASE 1, FOUNDER:** "OUR PATIENTS THAT ARE NOT INSURED CHOOSE US BECAUSE OF THE IMMEDIATE ACCESS TO HEALTHCARE. THE INSURED PATIENTS OUT OF CONVENIENCE."<br><br>**CASE 4, ADMINISTRATOR:** "WHY SHOULD A PERSON WAIT 3 MONTHS WHEN FOR A SMALL FEE IMMEDIATE ACCESS IS POSSIBLE."<br><br>**CASE 5, FOUNDER:** "THE CLINIC HAS THE CAPACITY TO REALIZE FROM THE MOST EASY UNTIL MORE COMPLEX EXAMS. AND EVERYTHING IN ONE PLACE. IN OUR CLINIC YOU CAN SOLVE ALL PROBLEMS IN ONE DAY."<br><br>**CASE 4, FOUNDER:** "WE ARE SITUATED NEXT TO THE PATIENT, SO IT IS CONVENIENT FOR HIM TO COME."<br><br>**CASE 2, EXECUTIVE DIRECTOR:** "YES, WE ARE A VERY INNOVATIVE COMPANY, NOT ONLY IN TERMS OF ORGANIZATIONAL STRUCTURE BUT ALSO IN CONCERNING THE TYPE OF SOLUTION FOR HEALTHCARE ACCESS THAT WE OFFER." |
| 3. FOCUS ON MEDICAL PROBLEM-SOLVING | **CASE 5, FOUNDER:** "THE MODEL OF CASE 5 IS INNOVATIVE BECAUSE IT HAS A ROBUST CLINICAL BODY THAT WORKS PROBLEM ORIENTED AND HAS THE CAPACITY TO SOLVE."<br><br>**CASE 4, FOUNDER:** "OUR BIGGEST DIFFERENTIAL IS OUR CAPACITY TO SOLVE THE PATIENTS' PROBLEMS BY PROVIDING HIM IMMEDIATE ACCESS."<br><br>**CASE 2, MEDICAL DIRECTOR:** "WE WANT TO CONDUCT OUR BUSINESS DIFFERENTLY AND ARE LOOKING TO SOLVE PROBLEMS WHICH REMAIN INSUFFICIENTLY ADDRESSED BY THE SUS. THIS IS WHY WE WANT TO OFFER A PREVENTION PROGRAM WHICH CAN BE INCLUDED IN AN INTEGRAL HEALTHCARE PROGRAM." |
| 4. PERSONALIZED ("HUMANIZED") SERVICE DELIVERY | **CASE 5, FOUNDER:** "BESIDES THE MEDICAL EXPERTISE WE TRY TO PROVIDE THE PATIENTS WITH A WELCOMING AND HUMANIZED SETTING WHERE HE WILL FEEL WELCOME AND CARED FOR."<br><br>**CASE 4, MEDICAL STAFF:** "WE HAVE SPECIAL "HUMANIZATION" TRAININGS FOR OUR STAFF IN ORDER TO GIVE ATTENTION TO THE CLIENTS WHEN THEY ENTER OUR CLINIC."<br><br>**CASE 3, FOUNDER:** "WE SEEK TO BE DIFFERENT THAN THE SUS BY BRINGING THE DOCTOR AND THE PATIENT CLOSER TO EACH OTHER. THEREFORE, HUMANIZATION (PERSONALIZATION) IN HEALTHCARE REMAINS A TOP PRIORITY OF OUR SERVICE DELIVERY." |

## WALK IN CLINICS

One of the main problems with healthcare in Brazil is access (financially, geographically and in terms of availability of quality care and exams). Medical infrastructure can be quite expensive. How can those two prerequisites be solved efficiently?

Case number 1 is offering a distinct service that focuses on a so called "pre-primary care model", the model of a minute or walk-in clinic. It solves the availability problems by quickly identifying the client's medical problem (only simple problems) and diagnosing it so that the client can move on to treatment. The contact time with the doctor is reduced to a minimum and the treatment of only simple medical conditions shortens the duration of treatment.

Furthermore, this venture reduces medical infrastructure to a minimum. Thus they can be quickly set-up and dismantled. Both components combined create an interesting solution, assisting clients in very crowded areas such as subway stations.

Retail clinics and urgent care mentioned as top 10 healthcare innovation in Deloitte Center for Health Solutions, 2016 (p.21)

**EXAMPLE 2**

## 4.2 PROCESS INNOVATION

The second set of innovation shows factors that enhance the customer interface and the infrastructure management of the companies. These business processes in particular make services more efficient. Process innovation is an important prerequisite to accelerate and thus enable the service innovations and unique selling points of the ventures. It can be found in digitalization and in the use of technology (e.g. optimizing capacity, big data, applying medical high-technology), the organizational and administrational areas of the ventures (e.g. separating medical from administrative operations) and in human resource management, such as the over market rate remuneration of doctors.

Several *aspects of technology* and especially digitalization were observed in the clinics. Among these is the possibility of optimizing the capacity utilization through big data, which helps to adapt the allocation of doctors to the flow of patients. Other technological factors that support the innovation of processes are the application of medical high-tech equipment (diagnostics, treatment). Online-tools are applied frequently for patients to make appointments, to access the results of exams online and to evaluate the treatment afterwards.

When shifting the attention to *organizational* and administrational *areas*, the cases show how a stronger division of labour can lead to more efficiency. The clinics manage to improve efficiency especially by separating administrative and clinical work, which has already been mentioned above in connection to increased patient-time.

Innovation and the introduction of new aspects were also observed in *human resource management*. Some projects introduced a performance-quality based remuneration for doctors. Others are able to pay wages that are 50% higher than in public markets. Additionally, quality medical staff are attracted by a high degree of self-determination, which gives them a competitive advantage over other traditional employers. Furthermore, we found that particularly when ventures seek to fulfil the double bottom line of being financially sustainable businesses with a social mission, the creation of a uniform vision and strong organizational culture is fundamental to the venture's success.

## TABLE 7 // PROCESS INNOVATION WITH EVIDENCE FROM THE DATA

| PLACE OF INNOVATION | RESULTS FROM THE DATA |
|---|---|
| PROCESS INNOVATION… | |
| 1. TECHNOLOGY (E.G. OPTIMIZING USED CAPACITY, BIG DATA, CLOUD SOLUTIONS, APPLYING MEDICAL TECHNOLOGY) | **CASE 5, FOUNDER:** "INFORMATION TECHNOLOGY IS A COMPLEMENTARY AND NECESSARY RESOURCE THAT ALLOWS FOR MORE PRECISE PLANNING IN OUR BUSINESS."-<br><br>**CASE 4, MANAGEMENT:** "OUR BIGGEST DIFFERENTIAL IS OUR USE OF TECHNOLOGY IN ORDER TO PUSH OUR SERVICES TO THE NEXT LEVEL."<br><br>**CASE 3, STAFF:** "PROSPECTIVE PATIENTS CAN BOOK THEIR APPOINTMENT ONLINE AND GET A RESPONSE WITHIN ONE DAY." |
| 2. ORGANIZATION (E.G. SEPARATING MEDICAL AND ADMINISTRATIVE TASKS) | **CASE 4, ADMINISTRATOR**: "THE PROJECTS PROVIDE ALL THE ADMINISTRATIVE, BUSINESS AND FINANCIAL KNOWLEDGE. THE DOCTOR AND THE MEDICAL STUFF DO NOT HAVE TO WORRY ANY MORE."<br><br>**CASE 4, MEDICAL STAFF:** "THE DOCTOR CAN WORK WITH A VERY GOOD INFRASTRUCTURE AND DO A GOOD JOB WITH DIGNITY FOR THE PATIENTS."<br><br>**CASE 4, MEDICAL STAFF**: "IT IS VERY CONVENIENT FOR THE DOCTORS TO WORK WITH ADEQUATE MATERIAL AND ALL THE SERVICES THE CLINIC IS OFFERING."<br><br>**CASE 5, FOUNDER:** "THE P5 IS A CLINIC OF SEVERAL SPECIALIZATIONS THAT REUNITES ALL IN ONE LOCATION."<br><br>**CASE 2, FOUNDER:** "I LOST 15 MINUTES ONLY TO FILL OUT THE FORMS. THIS IS WHY WE NEED TO EMPLOY PEOPLE WHO TAKE CARE OF ADMINISTRATIVE PAPER WORK TO MAXIMIZE THE TIME A DOCTOR CAN SPEND WITH THE PATIENT. THIS IS HOW WE CAN OPTIMIZE PROCESSES AND ENHANCE THE PERSONALIZED SERVICE WE CAN OFFER TO THE PATIENT." |
| 3. HUMAN RESOURCES (E.G. VERY COMPETITIVE COMMISSION FOR DOCTORS) | **CASE 5, FOUNDER:** "OUR DOCTORS GAIN ON AVERAGE 50% BETTER THAN THE MARKET RATE."<br><br>**CASE 5, MEDICAL STAFF**: "THE DOCTORS ARE ASSOCIATED TO THE CLINICS AND ANSWER ONLY TO THE SERVICES THAT THEY ARE PROVIDING. THE CLINIC PROVIDES THE INFRASTRUCTURE." |

EXAMPLE 3

## OPTIMIZING BUSINESS PROCESSES

Boosting the efficiency of processes is not only necessary in order to provide a better customer service, but also to raise the revenue of the ventures and to save valuable resources, especially time.

Case 4 is pioneering in several branches of process innovation in order to execute services with more efficiency. Among which are primarily the use of various digitalisation elements, data gathering for controlling e.g. the degree of capacity utilization, cloud solutions or the integration of digital application that were initially developed for different areas (e.g. supply chain). Consequently, not only does this venture use big data for making the services, the organisation and the processes more efficient but it also identifies user habits and elaborates models on health behaviours of its customers. This data is used for medical purposes (e.g. elaboration of adaptive prevention programs), but also for business aims such as arguing for the superiority of the ventures services over its competitors.

## HUMAN RESOURCE MANAGEMENT: THE DOCTORS ARE THE KEY

The task of acquiring excellent doctors is a challenge for every venture we investigated. Thus several modalities of innovative human resource management can be observed in the businesses. Case number 5 is an interesting example that showcases how to incentivise doctors to work in a certain place.

This case offers the doctors the option to become associates of the clinic. Thus on the one hand the physician is completely responsible for the client, has autonomy over time-management and works at his own expense. The clinic on the other hand considers itself as the "concierge" of the doctors, providing the infrastructure, including equipment, organisation, administrative staff and marketing. A percentage of the doctors' earnings go to the clinic.

As clients are paying out of pocket and the clinic only accepts insurances that pay better margins, the doctors have a considerable financial incentive. Consequently, with the strategy of commission in clinic in question, doctors could earn up to 50% more than in the public healthcare market. Additionally, the doctor is able to receive a higher share if they complete specific thresholds, for instance the rating of client satisfaction.

This differential attracted doctors that work at prestigious private hospitals alongside working part time at the clinic.

EXAMPLE 4

## 4.3 ORGANIZATIONAL AND REVENUE MODEL INNOVATION

The next section contains innovations which we group into organisational and business concept dimensions, along with innovations of financial aspects.

First, we have observed innovative organizational structures. The most striking example is the formation of *hybrid models* that consist of a non-profit and a for-profit branch. The establishment of hybrid business models has been described in academic literature as a growing trend and encompasses a way of dealing with regulatory and legal grey areas as well as of tackling institutional complexity when sectorial boundaries are blurring (see for example Battilana & Dorado, 2010; Battilana & Lee, 2014; Besharov & Smith, 2014; Birkholz, 2015; Doherty, Haugh & Lyon, 2014; Jay, 2010; Pache & Santos, 2011).

Secondly, as a separate component of the business model, the data suggests pinpointing the *stakeholder networks and partnerships* which these ventures have formed. Among these are investors, industry partnerships, other healthcare partners but also business incubators and mentoring partnerships that have gained in significance. Some companies in the sample have initiated industry partnership with multinational companies (MNCs) such as software firms or medical engineering companies. Such partnerships can be of mutual benefit as they may facilitate the market entrance for MNCs while in return can provide ventures with capital and expertise. Among such initiatives there is for example the Emerging Entrepreneur Initiative instigated by SAP, with activities in healthcare.[6]

In terms of additional non-industrial partnerships, the possibility of cooperating with the government is a relevant approach

[6] *For more information see: http://news.sap.com/tags/emerging-entrepreneur-initiative/.*

that needs to be considered in areas of social service provisions such as healthcare. Yet, many of the interview partners in the sample regard partnering with the public sector with increased reservation. Such scepticism arises from the current problems that are present in the public healthcare system such as corruption and government budget shortages (Biderman & Avelino, 2014; Dias, Matias-Pereira, Farias & Pamplona, 2013). Thus entrepreneurs avoid these partnerships as they assume the government to be an unreliable partner who delays payments and may be driven by political electoral cycles. Others, however, see an opportunity in a holistic cooperation with representatives from the private, public and social sector. They consider this multi-stakeholder approach as a joint management initiative which is at the origin of innovation and value creation. Their hope is to institutionalize the project's activities and to integrate them into a broader political and social program in their pursuit of triggering systemic change.

Even though the sample was characterised by the initiation of new partnerships with stakeholders from different areas, the ventures show radical *elimination of* traditional *intermediaries* such as insurance companies or public healthcare services. The strategy to put the patient into direct contact with the adequate medical staff, without the interference of an intermediary institution has important implications, as it can lower the prices, can make services more controllable for the single companies and moreover will accelerate the process for the patient. It points towards the elaboration of an alternative healthcare system that establishes itself independently to existing mainstream services.

## TABLE 8 // ORGANIZATIONAL AND REVENUE MODEL INNOVATION WITH EVIDENCE FROM THE DATA

| PLACE OF INNOVATION | RESULTS FROM THE DATA |
|---|---|
| **ORGANIZATIONAL AND REVENUE MODEL INNOVATION** | |
| 1. HYBRID ORGANIZING | **CASE 2, EXECUTIVE DIRECTOR:** "THE EXISTENCE OF THIS ENTERPRISE [ADDITIONAL TO THE HEALTHCARE VENTURE] CAN BE SEEN AS VERY INNOVATIVE IN TERMS OF THE MEDICAL EQUIPMENT IT PROVIDES. AND ALSO IT IS A VERY PROMISING ORGANIZATION TWIST BECAUSE IT IS CONNECTED TO THE PRIVATE SECTOR BUT AS WELL LINKED TO OUR MEDICAL PROJECT." |
| 2. PARTNERSHIPS AND SHARED RESPONSIBILITY AMONG STAKEHOLDERS | **CASE 2, FOUNDER:** "THIS IS A PROJECT WHERE WE THINK OF A NEW HEALTHCARE SYSTEM WHERE GOVERNMENT, COMPANIES AND SOCIETY ARE PARTICIPATING – THIS CAN BE DESCRIBED AS A NEW TYPE OF SOCIAL CONTRACT AND SHARED GOVERNANCE THAT IS GIVING GREATER VALUE TO THE MOST IMPORTANT FACTOR: THE CLIENT."<br><br>**CASE 5, FOUNDER:** "WE HAVE PARTNERSHIPS WITH SEVERAL HOSPITALS. THOSE PARTNERSHIPS ENABLE US TO ORGANIZE HOSPITAL ATTENDANCE FOR OUR SURGERY PATIENTS. THE VOLUME WITH WHICH THIS IS DONE HELPS US TO REDUCE UP TO 70% OF THE COSTS COMPARED TO MARKET PRICES."<br><br>**CASE 5, FOUNDER:** "WE MAINTAIN A CLOSE PARTNERSHIP WITH A MEDICAL DIAGNOSTICS CENTRE THAT ALLOWS US TO TRAIL ALL EXAMS IN REAL TIME." |
| 3. ELIMINATING THE INTERMEDIARY (E.G. INSURANCES, PUBLIC SERVICES) | **CASE 4, ADMINISTRATOR:** "PUT THE PATIENT DIRECTLY WITH THE DOCTOR AND THE SPECIALTIES HE NEEDS."<br><br>**CASE 4, FOUNDER:** "I CAN'T PAY A HEALTHCARE PLAN, BUT I CAN AFFORD THE SOLUTION THAT P4 IS OFFERING."<br><br>**CASE 1, FOUNDER:** "THE PRICING STRATEGY IS VERY INTERESTING FOR THE GROWING MIDDLE CLASS."<br><br>**CASE 1, FOUNDER:** "WE DON'T NEED A REFERENCE DOCTOR. THE PATIENT CAN EMPOWER HIMSELF IN SEARCHING FOR ADEQUATE ACCESS."<br><br>**CASE 4, MANAGEMENT:** "THE EXAMINATIONS ARE ACCESSIBLE FOR THE PATIENTS. I AM GOING TO PAY A FEE AND I AM GOING TO ORGANIZE MYSELF TO GET THE EXAM AND CAN BACK TO WORK SOON."<br><br>**CASE 4, MANAGEMENT:** "OUR CLIENTS COME FOR THE PRICE AND STAY FOR THE QUALITY." |
| 4. REVENUE MODEL | **CASE 5, MEDICAL STAFF:** "WE HAVE A HIGH VOLUME OF SELF-PAYING PATIENTS IN THE CLINIC. THUS IT IS VERY IMPORTANT THAT THE MEDICAL STAFF IS BONDING WITH THE PATIENT AND MAKING HIM COME AGAIN. IN ORDER TO DO SO YOU HAVE TO CREATE A STRONGER PATIENT-DOCTOR RELATIONSHIP." |

A fourth remarkable area of innovation is the *revenue model* which is composed of how to sustain and acquire capital. We can observe several revenue models in our sample. First, the majority of the cases have adopted market-based business models, and function as for-profit companies applying private sector rationale. The patient pays for the healthcare service that is delivered (business-to-customer model). All procedures from examinations to the subsequent laboratory exams or smaller operations are out-of-pocket payments. Many entrepreneurs argue that below the line patients have fewer costs if they only pay when they really need medical services instead of contributing to a monthly health insurance. This pay-for-service model has gained prominence in venturing at the BoP (Prahalad & Hart, 2002). Yet, depending on the pricing model, out-of-pocket payments overlook weaker fractions of the population that are unable to afford medical services. Thus, on the one hand the revenue-generating model is not the panacea for success for the companies. Especially in primary healthcare, as profit margins can remain low due to high infrastructure investments and can in turn compromise profit generation. On the other hand this business model is not an inclusive solution for a society that has just only recently made impressive progress in poverty alleviation and is currently threatened by a reverse effect (The Economist, January 2, 2016).

In a second example on revenue models the venture is contracted by a private enterprise to deliver healthcare services for the company's employees. The respective company covers the cost of the services and pays a fee based on the prices of the procedures within the public system (SUS). For enterprises, a business-to-business contract with the healthcare provider can on one hand be a way of engaging in Corporate Social Responsibility campaigns and on the other a viable solution to supply the employees with on-going healthcare programs that can substitute another service.

A third revenue stream exists where companies partner up with the public sector establishing a public-private business-to-government partnership. The public sector identifies medical necessities in given areas and opens a call for lenders. Subsequently private providers can apply and are integrated within the public healthcare offer. The government covers expenditures based on the official price chart of the public healthcare system. We encountered lump compensation or fixed price payments in the sample.

Fourthly, the option of collaborating with private insurances is yet another revenue-generating possibility that we found in the cases. Case 5 adopted this strategy and mentioned in the interviews that in contrast to healthcare plans, private insurances refund easier and most importantly, it does not work with predefined, associated hospitals or laboratories. Thus they leave the patient with a free choice to select the doctor and the hospital.

Last but not least, two entrepreneurs in our sample have shown their intention of establishing a pre-paid healthcare card, which can be toped-up with a certain amount of money and used to pay for medical services. Specialized providers already introduced healthcare cards, which are considered particularly valuable for offering services to the BoP as they allow small deposits or instalments to be used directly when the person needs the service. The same idea of a membership or pre-paid card is also discussed in some clinic networks for prevention programs. Rather than paying a lump sum for a yearlong prevention program, it would be possible to pay a monthly fee.

## 4.4 ACCESS TO CAPITAL: FUNDING AND THE ROLE OF SOCIALLY ORIENTED INVESTORS

During the interviews, several respondents raised the question of access to capital as one of their greatest challenges when setting-up and further developing their companies. Therefore, we include this topic in the following section

to complement the previous sections that highlighted the challenges of recruiting and retaining human resources in a competitive market, along with organisational factors that hinder the expansion and successful implementation of activities. Table 9 offers an insight into the data.

## TABLE 9 // MAJOR DIFFICULTIES THE ENTREPRENEURS ENCOUNTERED IN THEIR VENTURES

| WHAT ARE SOME OF THE MAJOR DIFFICULTIES THE ENTREPRENEURS ENCOUNTERED DURING THE IMPLEMENTATION AND DEVELOPMENT OF THE PROJECT | RESULTS FROM THE DATA |
|---|---|
| 1. ACCESS TO CAPITAL | **CASE 1, FOUNDER:** "CAPITAL RAISING AND HENCE, FINDING A POWERFUL INVESTOR BASE IS THE MOST CHALLENGING TASK FOR SETTING UP A BUSINESS."<br><br>**CASE 3, FOUNDER:** "TO SCALE THE BUSINESS ACCESS TO MORE PATIENT CAPITAL IS NEEDED – AND THIS ACCESS IS VERY DIFFICULT, ESPECIALLY AT TIMES OF ECONOMIC DOWNTURN IN BRAZIL."<br><br>**CASE 7, FOUNDER:** "THE FACT THAT FOREIGN CAPITAL IN HEALTHCARE-RELATED VENTURES WAS FORBIDDEN PROVED EXTREMELY CHALLENGING" |
| 2. HUMAN RESOURCES | **CASE 2, FOUNDER:** "THERE ARE TWO MAJOR DIFFICULTIES: (1) FINDING MOTIVATED DOCTORS AND KEEPING THEM MOTIVATED AND (2) PUBLIC POLICIES AND REGULATIONS CONTINUE BEING ENTREPRENEURIAL BARRIERS."<br><br>**CASE 3, FOUNDER:** "A MAJOR DIFFICULTY IS TO FORM A CAPABLE MEDICAL TEAM WHO SHARE THE SAME IDEALS AND IS WILLING TO TAKE RISKS."<br><br>**CASE 5, FOUNDER:** "THE BIGGEST CHALLENGE THAT I SEE IS TO KEEP THE DOCTORS WORKING FOR THE COMMUNITIES." |
| 3. ORGANISATIONAL CHALLENGES | **CASE 4, FOUNDER:** "ONE OF THE MAJOR PROBLEMS WAS TO INTRODUCE PROCESSES AND I AM TALKING ABOUT THE FLOW [OF PATIENTS] AND THE INTRODUCTION OF A SYSTEM THAT ALLOWS THIS FLOW TO HAPPEN." |

In the following part, we report the different ways to access capital in the different cases. Some ventures seek to attract mainly banks or institutional investors. Other businesses employ a different focus and prefer socially oriented investors.

With regards to the *type of investor* attracted by the entrepreneurs, the data from the sample varies from institutional investors to development banks and equity holders (see table 10). The type of capital that has been invested also ranges over the entire spectrum of capital from traditional to impact investing and philanthropic resources. Although, the trend on attracting more mainstream investors for social ventures is on the rise, accessing capital remains difficult. Potential investors could be put off by the long period of time to simply break-even, due to high initial investments for financing the infrastructure of a medical clinic or the risk of regulatory changes in the healthcare market and its

dependence on public policies. Thus mainstream VC investors seem to prefer innovation that is mainly focused on IT-services or application, with a lower initial investment and fewer obligations. A precise segmentation of investors can be seen in table 10. Our sample confirms that those ventures that we would more likely classify as "traditional businesses" with a relatively stronger focus on economic value creation seem to access more mainstream-like capital, which facilitates the respective expansion and growth strategies.

An additional type of external capital acquisition found in our sample constitutes a new way of engaging multinational companies. Partnerships between social ventures and multinationals can bring mutual benefits but have so far been given little attention. Ashoka (2007) confirms the potential mutual gains and states that *"businesses can enter these markets more efficiently, and can provide a more integrated solution to low-income clients, by partnering with citizen sector organizations 'along the value chain' [of product and service development, production, distribution and logistics, sales and marketing, and financing]."* (as cited in Nelson & Jenkins, 2006; p.7) This would apply to pharmaceutical companies for instance in the case of healthcare, but it also proves true for other types of companies such as technology or software companies, as examples in our data confirm.

## HEALTHCARE AS INVESTMENT

One of the main difficulties named by the projects under investigation was the access to capital (see table 9). However several cases show impressive success and a variety of fundraising examples that include tapping different investor bases.

For instance case four has undergone a model investment cycle from co-funding, the entrance of a strong foundation of angel investors to the entrance of VC and several equity holders. Case two built its expansion strategy with the support of impact investors that invested mainly through debt in several stages of the company and additionally includes company partnerships for fundraising. Again another case has family funds among its supporter's and works mainly with traditional debt.

Consequently even though the access to capital has been named as a difficulty, it seems as though the projects in the sample achieved at least preliminary success in raising capital through the diversification of different sorts of capital, different investment entities and a strong diversified investor base. Thus they include supporters that besides money can also bring knowledge, network and other competences to the table.

EXAMPLE 5

## TABLE 10 // DIFFERENT TYPES OF INVESTORS ENCOUNTERED IN THE SAMPLE

INVESTMENT MECHANISM

| | GRANT | DEBT | VENTURE CAPITAL | PRIVATE EQUITY | MEZZANINE CAPITAL | HYBRID CAPITAL | RESULTS FROM THE DATA |
|---|---|---|---|---|---|---|---|
| 1. INSTITUTIONAL INVESTORS | | | | | | | ONE PROJECT RECEIVED AN INVESTMENT BY A NON-PROFIT CIVIL SOCIETY[1] |
| A) SOCIALLY ORIENTED INVESTORS | | | ✓ | ✓ | ✓ | ✓ | ONE PROJECT RECEIVED A DOUBLE DIGIT MILLION R$ INVESTMENT FROM AN IMPACT INVESTING FUND[1] |
| B) TRADITIONAL INVESTOR | | | ✓ | | ✓ | ✓ | ONE PROJECT RECEIVED SERIES B AND C INVESTMENTS FROM A GROUP OF PRIVATE INVESTORS[1]<br>"TODAY, 55% BELONGS TO A FOREIGN INVESTOR BASE." |
| 2. FAMILY FUND | ✓ | | ✓ | ✓ | | | "TODAY, A LARGE AMOUNT OF OUR INVESTORS ARE FROM FAMILY OFFICES – PEOPLE WHO SEEK TO INVEST IN THE 'GOOD'." |
| 3. PROPRIETARY CAPITAL | | | ✓ | ✓ | | | "I WILL INVEST MY OWN CAPITAL INTO THE EXPANSION PLANS OF THE CLINIC." |
| 4. DEVELOPMENT BANKS AND GOVERNMENT | | ✓ | | | | | "THE EXPANSION PLANS ALSO RELY ON THE INVESTMENT OF THE BNDES2 TO FINALIZE THE PROJECT AND BACK IT UP FINANCIALLY."<br>"WE HAVE A STRONG INVESTOR BASE. NEXT TO INSTITUTIONAL, NATIONAL INVESTORS, THE VENTURE ALSO RECEIVES INVESTMENT FORM MULTILATERAL DEVELOPMENT BANKS SUCH AS THE IDB AND THE BNDES." |

*[1] Openly available secondary data; 2 The Brazilian Development Bank (BNDES);*
*Table adapted from Social Investment Taskforce / Schwab Foundation for Social Entrepreneurs (2011)*

In addition to the type of investor, we found that considerations of external capital depend on a number of organizational arrangements along with the life cycle of the venture (Social Investment Taskforce, 2011). The data shows that o*rganizational arrangements* and the legal status condition the type of investment. As these legal questions have not been sufficiently addressed in all countries, some organizations exploit loopholes by forming two legally separate organizational entities (Doherty, Haugh, & Lyon, 2014). In our sample, we can find ventures which function as traditional for-profit enterprises and hybrids that have created two legally separate entities. Under the umbrella term of a

hybrid organization they unite a classical non-profit enterprise and a for-profit social enterprise. In terms of acquired funding, for-profit ventures are more inclined to attract a commercially oriented investor base that cares primarily about profit margins and financial return. Non-profits, however, traditionally rely on grants and charitable foundations as another group of potential funders and capital providers. Hybrids, with their for-profit and non-profit branches, can tap into both these types of capital (Lee, 2014; Shaffer, 2014).

Last but not least the dependence of the investment on the *life cycle of the venture* is prominent also in our sample. Several clinics have already passed through repeated investment rounds from building the model to scaling the business. We encountered the example of a clinic that received two investments (early & late stage) to expand, professionalize and scale. Having moved to a more extensive expansion phase, the company is about to complete a further deal with a development finance institution (status 2016). A second example achieved its first investment rounds by a conglomerate of several Brazilian private investors. Those six investors currently hold 45% of the business. Yet, another example illustrates the importance of matching the stage of the venture's life cycle with the "right" type of investor for a clearly proclaimed social enterprise. As the venture has not reached an adequate size to partner with one of the multilateral development banks, it continues to receive loans from a Brazilian social investor to finance its expansion plans. This also concurs with the assumption made, that those clinics/ventures clearly labelled as a "social business," tend to recur to grants from philanthropic entities as well as loans from social investors and multilateral development banks. Yet, while the availability of philanthropic capital may not suffice in sustaining large-scale growth of scale ventures, they can still play a pivotal role by acting as "strategic investors and intermediaries to help safety net providers and commercial companies to work together more efficiently" as Goldstein & Laws (2011) argue.

## 4.5 INSIGHTS AND SUMMARY

The preceding paragraphs started off by questioning what factors in the projects' business models can be perceived as distinguishing and innovative. We encountered answers within service and process innovation, new organisational set-ups and revenue models as well as in the approach on how to access capital. Such solutions tackle market failures that we assume consist mainly of missing supply due to a lack of amongst other things efficiency, organization, strategy and execution of services. The following section sums up the previous findings.

### SERVICE INNOVATION

Obviously services are the most visible area of innovation. The clients are suspect of services that differentiate the private, entrepreneurial businesses in the public healthcare sector from the private, supplementary services. Consequently the factors of service innovation encountered in the sample focus on providing client satisfaction especially in areas that are perceived as incomplete within the traditional healthcare supply.

### PROCESS INNOVATION

The data shows that the introduction of new approaches in the conduction and organization of business processes can not only make services for the clients more efficient but can also reduce costs and open new areas of actuation. The main factors exposed in the sample are the use of technology, a stricter division of labour in organizational matters and building human resource incentives.

### ORGANISATIONAL & REVENUE MODEL INNOVATION

The investigation shows several innovative aspects that can be considered in a business providing healthcare. The paragraph shows that organizational models and innovative partnerships can help the ventures to secure legal status, capture different capital or bring additional value and expertise to the company.

## FUNDING AND THE ACCESS TO CAPITAL

We have seen that the sample exhibits several different types of investors that range from institutional investors and family funds to development banks. Thereby we found different approaches concerning the social vs return-driven orientation of the investors. Strong influencing factors regarding access to capital that were identified in the data encompass mainly organizational arrangements and the venture's life cycle.

We propose the following lead questions to apply the findings to practice:

## FOR ENTREPRENEURS

### 01 SERVICE INNOVATION

- Define what you see as the biggest challenge for healthcare access for your target market? And consequently evaluate in which way you can solve those challenges?
- Which array of medical services do you want to or are you able to offer? (prevention, especially of chronic, non-communicable diseases).
- What are the solutions you can offer to your clients in order to increase geographical accessibility of your services? (on-line solutions, network of physical facilities, etc.).
- Which factors can you intensify in organization of processes or training of staff and doctors that will make services more pleasant for your clients? How will you proceed and which strategy will bring a sustainable improvement to your services? (personalization of services).

### 02 PROCESS INNOVATION

- How can you assess and use big data to make processes more efficient? In which way can technological solutions accelerate or facilitate your efforts?
- Which areas can be specialised or divided in a way that makes them more efficient? (e.g. division of organizational and administrational areas).

### 03 ORGANISATIONAL & REVENUE MODEL INNOVATION

- What are the pros and cons of developing a hybrid business model for your company? What is your position towards the idea of you collaborating with the government?
- Which associates from other industries such as investors, industry partners, other healthcare partners, business incubators and mentoring partnerships can aggregate value to your company? How can you proceed to engage them?
- In which organisational and service areas could you eliminate intermediaries? How could you put your ideas into action and which expertise are you still missing?

### 04 FUNDING AND THE ACCESS TO CAPITAL

- In what way does the potential investor match your profile and convictions? How can your investor be an interesting strategic partner besides a sole loan-giver and what do you expect from them?
- What are the implications in terms of governance and decision-making processes in your company after acquiring an investor? Are you comfortable with this next step?

## FOR INVESTORS

### 01 SERVICE INNOVATION

- In which areas of efficiency and execution can you support your investee in order to make the service better for the end-user?

### 02 PROCESS INNOVATION

- How can you support the growth process of the entrepreneur? What are the possibilities of including the company's entire team in the development process of the venture?
- Can you help to rearrange the organisational responsibilities in order to make organisational and internal processes more efficient?

### 03 ORGANISATIONAL & REVENUE MODEL INNOVATION

- What are the main sources of revenue? And what will be the revenue model? Pay-for-services? What are the pros and cons of perusing a PPP or a cooperation with insurances?
- What are your possibilities of supporting human resource development and speeding-up the organisational process?

### 04 FUNDING AND THE ACCESS TO CAPITAL

- What type or profile would you expect from a co-investment?
- What is the match of your investment values and the entrepreneur's mind-set?
- Where are sources of conflict?

# 05 | SOCIAL INNOVATION AND THE DOUBLE BOTTOM LINE

The preceding paragraphs described factors of business innovation ranging from services to processes. We have seen that especially in the context of businesses that touch social or environmental issues, the innovative element is present in addressing social needs that have not yet been provided by the market or are not met by the public sector (Phills, Deiglmeier & Miller, 2008; Mulgan et al., 2007)[7]. These ventures foster the inclusion and empowerment of a particular part of the population by providing healthcare services. This process can be seen as a part of social innovation (Nicholls & Dees, 2015) that is created as an imminent outcome of the businesses activities. Most cases of our sample prefer to improve the situation at the base of the socio-economic pyramid (BoP, Prahalad & Hart, 2002) whilst creating a financially sustainable business.

In the following we will have a closer look at the possible social innovations and the implications for the businesses that we considered in the sample. Subsequently we will complement this perception with concrete findings from the data that will explain the double bottom line and introduce the concept of social venture.

**QUESTION 3**

**WHAT KIND OF SOCIAL INNOVATION IS CREATED BY THE ANALYSED VENTURES IN HEALTHCARE? HOW DO SOCIAL ENTREPRENEURS SOLVE THE DOUBLE BOTTOM LINE REQUIREMENTS IN THEIR BUSINESS MODELS?**

## 5.1 SOCIAL INNOVATION

In our cases, the encountered elements of social innovation are mainly for creating more efficient products and services that have been so far neglected or underserved by the market (Nicholls & Dees, 2015). The ventures focus on agility, quality and low prices. Additionally, results show client-centred aspects of service delivery such as cordiality, transparency and problem-solving orientation.

Based on this analysis, the main social innovation can be described as *the satisfaction of needs that are **not** provided by the market or the public sector in Brazil.* This is related to access as a possibility to gain more self-determination when looking after one's health and can imply several aspects of social and human inclusion and empowerment. This assumption is supported by the data of the businesses, summarized in table 11. This information is mainly extracted from the secondary data such as newspaper articles, marketing material and insofar as accessible, business reports. The data complies with the hypotheses that disruptive (social) innovation and thus the possibility for systemic change, *will come from […] entrepreneurs who are inventing new ways of delivering […] health-care for a fraction of the cost of current market leaders* (The Economist, online article, January 25, 2015).

[7] *A more detailed analysis of definitions, historical development and the background of the term social innovation can be found for example in Choi & Majumdar, 2015, Nicholls & Dees, 2015, Pol & Ville, 2009.*

## TABLE 11 // FACTORS OF SOCIAL INNOVATION ENCOUNTERED IN THE SAMPLE

| SOCIAL INNOVATION | |
|---|---|
| **(1) SOCIAL PROCESSES / SOCIAL RELATION** | • EMPOWERMENT OF PATIENTS THROUGH MORE OPTIONS TO SEARCH AND RECEIVE HEALTHCARE<br>• EMPOWERMENT OF PATIENTS THROUGH MORE INDEPENDENCE FROM EXISTING SERVICES<br>• INCLUSION OF UNDERSERVED POPULATIONS THROUGH FINANCIAL ACCESSIBILITY<br>• NO MORE UNILATERAL DEPENDENCE ON THE PUBLIC HEALTHCARE SERVICE<br>• INDIRECT CONSEQUENCE: IMPROVED HEALTHCARE INCREASES PRODUCTIVITY OF PATIENTS THEREBY INDIRECTLY AFFECTING THEIR PERFORMANCE IN THE LABOUR MARKET<br>• CHANGE IN THE RELATION OF THE DOCTOR TO:<br>- HEALTHCARE INSURANCES<br>- PATIENTS<br>- ADMINISTRATION |
| **(2) ANSWERS MARKET FAILURES** | • ACCESS TO HEALTHCARE CLOSES A GAP IN THE TRADITIONAL SERVICES. THE CLINICS FILL A NICHE AS THEY PROVIDE SERVICES FOR LOW- TO MEDIUM-COMPLEXITY DISEASES AND THUS ARE NOT DIRECTLY CONCURRING WITH THE EXISTING PUBLIC/PRIVATE SYSTEM<br>• HUMANIZED TREATMENT THAT IS MISSING IN CONVENTIONAL TREATMENT |
| **(3) PURPOSE, INTENTIONALITY AND MOTIVATION** | SOCIAL ENTREPRENEURSHIP WITH THE INTENTION TO BRING SOCIAL AND PUBLIC GOOD BY CONSTRUCTING A SUSTAINABLE BUSINESS THAT HAS THE POTENTIAL FOR SCALED SOLUTIONS THAT IMPROVE THE HEALTH OF THE BRAZILIAN POPULATION. |

The interdisciplinary integration of innovation from technology, administration and finance in order to offer services and products cheaper, simpler and more convenient for the clients, has a disruptive potential (Christensen, 2003). The analysed enterprises are (partially) independent from the existing, established healthcare system and only to some extent integrated within the insurance market as well as the public healthcare system. Consequently, these entrepreneurial solutions that began emerging in Brazil in growing numbers can be described as a 3rd pillar of healthcare.

In addition to the social innovation that is provoked by the services of the clinics, the working models of most of the healthcare providers incorporate social and financial revenue perspectives (double bottom line). However, it is clearly visible that they put different foci on social vs. economic value creation. This alignment influences strategic decisions, choices of partners and investors and ultimately expansion plans.

Hence for example, one of the analysed businesses' founders affirms that *"the creation of social value is a logical consequence of the business model since it allows wide-and-open access for a large part of the population from different social strata". Others confirm explicitly that the creation of social value – "doing good for society"* – has been central to venturing. Table 12 gives an overview of the self-perception of the creation of social value in the different ventures.

## TABLE 12 // SELF-PERCEPTION OF THE CREATION OF SOCIAL VALUE IN THE DIFFERENT VENTURES

| CASE | CITATION |
|---|---|
| CASE 1 | 1. "THE CREATION OF SOCIAL VALUE IS A LOGICAL CONSEQUENCE OF THE BUSINESS MODEL SINCE IT ALLOWS WIDEAND- OPEN ACCESS FOR A LARGE PART OF THE POPULATION FROM DIFFERENT SOCIAL STRATA." |
| CASE 2 | 1. "WITH THE PROJECT I SAW AN OPPORTUNITY TO CONTRIBUTE TO A BIGGER SOCIAL CAUSE WHICH ALSO FUNCTIONS IN COOPERATION WITH THE PUBLIC SECTOR.""<br><br>2. "I WANTED TO BRING THE CLINIC AND PERSONALIZED EXAMS TO THE MOST VULNERABLE PEOPLE. WE WANTED A LUCRATIVE PROJECT BUT ONE WHICH ABOVE ALL CREATED SOCIAL IMPACT."<br><br>3. "I AM A PERSON WHO BELIEVES A LOT IN SOCIAL VALUE CREATION. I SUSPECT THAT THERE ARE INVESTMENT FUNDS WHICH ONLY LOOK AT THE LUCRATIVE PROSPECTS OF THE PROJECTS – THIS IS WHAT I FEAR MOST – THAT ULTIMATELY I WILL LOSE POWER BECAUSE OF FUNDS WHICH ARE HUNTING FINANCIAL RETURNS ONLY." |
| CASE 3 | 1. "WHEN I WAS DOING MY MEDICAL INTERNSHIP, I ALREADY DECIDED TO OPEN A LABORATORY FOR PEOPLE WHO DO NOT HAVE A HEALTHCARE PLAN. THIS WISH ACCENTUATED WHEN I ACTUALLY WITNESSED THE POOR CONDITIONS IN THE PUBLIC HOSPITALS AND THE MANY PEOPLE WHO COULD NOT GET ADEQUATE MEDICAL TREATMENT."<br><br>2. "I THINK THAT THE PRINCIPAL GAIN IN TERMS OF SOCIAL VALUE CREATION CAN BE LABELLED BY INCLUSION. WE OFFER SERVICES FOR PEOPLE WHO HAVE PREVIOUSLY BEEN DENIED ACCESS FOR FINANCIAL SERVICES. NOW, THEY HAVE A CHOICE AND CAN TAKE CARE OF THEIR HEALTH."<br><br>3. "WITH HEALTH CAMPAIGNS WE TRY TO COMMUNICATE WITH OUR TARGET GROUP AND DEMONSTRATE THAT THE SERVICES WE OFFER ARE PRECISELY DESIGNED FOR THEIR NEEDS AT PRICES THEY CAN AFFORD." |
| CASE 4 | 1. "BY ESTABLISHING THE CLINIC I SAW A BUSINESS OPPORTUNITY, BUT ALSO A NECESSITY TO REACH OUT FOR A PART OF THE POPULATION THAT WAS NEGLECTED FROM SERVICES."<br><br>2. "THOSE CLINICS STARTED AS A SOCIAL VENTURE AND TODAY ARE A COMPANY THAT IS GROWING VERY FAST. […] WE HAVE THE INTENTION TO ATTEND A POPULATION THAT TODAY DOES NOT HAVE CONDITIONS TO PAY FOR A HEALTHCARE PLAN, WE CONSIDER OURSELVES AS A SOCIAL PROJECT THAT BRINGS A NEW OPTION FOR THE LOW-INCOME POPULATION.""" |

## TABLE 12 // SELF-PERCEPTION OF THE CREATION OF SOCIAL VALUE IN THE DIFFERENT VENTURES

| CASE | CITATION |
|---|---|
| CASE 5 | 1. "OUR INTENTION IS TO CARE FOR THE PATIENT WITH A MAXIMUM OF QUALITY AND OFFER THE BEST POSSIBLE STRUCTURE IN ORDER TO DO SO. BESIDES THIS CONCEPT OF COMPLETENESS AND ACCESSIBILITY, HUMANIZATION OF HEALTHCARE IS PLACED IN THE CENTRE OF OUR MODEL."<br><br>2. "OUR INTENTION IS TO OFFER AN ALTERNATIVE IN HEALTHCARE FOR A MAJORITY OF PEOPLE THAT DO NOT HAVE ACCESS."<br><br>3. "THE BIGGEST CHALLENGE FOR ME IS TO CONVINCE THE DOCTOR TO FIX HIMSELF CLOSE TO THE COMMUNITY. […] SO HE WILL INITIATE AN EXCHANGE OF THE CLINIC WITH THE COMMUNITY. THIS IS MY MODEL. I DON'T WANT TO EARN MONEY. I WANT THAT THE PEOPLE FEEL HAPPY. EVERYBODY IS SUSPICIOUS OF MEDICAL SERVICES, INSURANCE COMPANIES, DOCTORS… […] I WANT TO CREATE A RELATIONSHIP OF TRUST AND RESPECT BETWEEN THE PATIENT AND THE DOCTOR." |
| CASE 6 | 1. "BEING A REFERENCE IN QUALITATIVE HEALTHCARE SERVICES FOR THE COMMUNITY IS OUR VISION, ESPECIALLY FOR THE SOCIAL CLASSES WITH LOW PURCHASING POWER."<br><br>2. "WE UPLIFT THE DIGNITY AND SELF-ESTEEM OF THE CITIZENS WHO ARE TIRED OF LONG WAITING TIMES…CROWDED HALLWAYS … AND WE CONTRIBUTE TO EASING THE PUBLIC SERVICE AS WE SERVE 10% OF [THE REGION'S] MONTHLY SUS VOLUME." |
| CASE 7 | 1. "WE WANT TO DO GOOD FOR SOCIETY."<br><br>2. THE FOUNDER ESTABLISHED THE NETWORK OF CLINICS AFTER THE EXPERIENCE HE WITNESSED IN HOSPITALS, ESPECIALLY CONCERNING THOSE PEOPLE IN NEED WHO DON'T HAVE INSURANCE PLANS. |

These statements are the self-perception of the entrepreneur regarding the importance of the double bottom line in the company. In order to gain a more structured insight and knowledge of the social orientation of the projects, we have complemented our analysis with a set of additional indicators which are summarized in the table below, plus in the paragraphs that follow they are described in the case of the evaluated enterprises.

## TABLE 13 // FRAMEWORK FOR ASSESSING SOCIAL VENTURES

| | EMPHASIS ON ECONOMIC VALUE CREATION | EMPHASIS ON SOCIAL VALUE CREATION |
|---|---|---|
| LEGAL FORMAT | PRIVATE-SECTOR COMPANIES | CIVIL SOCIETY ORGANIZATIONS |
| MAIN OBJECTIVE | ACCESS TO A GREAT MARKET (BOP) | POVERTY REDUCTION AND IMPROVING THE LIVING CONDITIONS OF THE MOST VULNERABLE |
| INTENTIONALITY | SOCIAL VALUE CREATION IS AN IMPORTANT BUT NON-CORE ELEMENT | SOCIAL VALUE CREATION IS THE CORE OF THE BUSINESS |
| BASE OF THE PYRAMID | MAINLY AS CONSUMERS | MAINLY AS PRODUCERS, SUPPLIERS OR BENEFICIARIES |
| SOCIAL VALUE | TANGIBLE INDICATORS | INTANGIBLE INDICATORS |
| ECONOMIC VALUE | PROFIT BASED ON SALES MINUS EXPENSES | PROFIT DOES NOT EXCLUDE CROSS SUBSIDIES AND FISCAL BENEFITS DONATIONS |
| PROFIT DISTRIBUTION | DIVIDENDS DISTRIBUTION | PROFIT IS TOTALLY REINVESTED INTO THE ENTERPRISE |

*adapted from Comini, Barki & Aguiar, 2012

### LEGAL FORMAT

The sample is divided into for-profit and non-profit entities or a mix of both. Furthermore, the data has shown that although the recognition of a market opportunity was non-negligible in the motivation to implement the clinics ("access to a great market"), all clinics still share the same objective of giving access to qualitative healthcare for an underserved community.

### MAIN OBJECTIVE

Nearly all ventures (6 out of 7) in our sample explain their main objective for the creation of the venture by their ambition to improve the living conditions of the most vulnerable. Another objective, which is a primary objective for one of the ventures, is the possibility to access a growing market at the BoP.

### INTENTIONALITY

Thus far, first divergences emerge when we look at the intentionality of the ventures as the citation above already demonstrates. Social value creation for some is just a necessary by-product of a viable business strategy.

### BASE OF THE PYRAMID

Likewise, we can observe differences in the way patients are considered, either as clients and beneficiaries or as mere beneficiaries of the services being offered. Six out of the seven clinics under analysis confirm the finding that people belonging to the BoP are willing to spend part of their income on healthcare and hence, commercializing social services to the BoP appears to be a viable approach for ventures.

### SOCIAL VALUE

When asked if and how they deliver social value, all interviewees replied affirmatively and listed elements of the above-mentioned (social) innovations. Their social value proposition consists of providing accessible, affordable and quality healthcare services to the low-income population thereby helping them to exit the vicious circle and poverty penalty in which they have been captured. An emphasis also lies in treating the patients with dignity by personalizing their service and fostering the patient-doctor relation.

### ECONOMIC VALUE

Economic value-creating factors are key drivers for the ventures in our sample. All use business rationales to generate income from their core activities and apply the logic of conventional for-profit companies to be financially sustainable and scale their impact.

### PROFIT DISTRIBUTION

Yet, another differentiator according to Comini et al.'s assumptions, is what happens to the generated profit. Some clinics distribute dividends to their shareholders. The difference in their legal set-up – for-profit or non-profit entity – partially captures this difference.

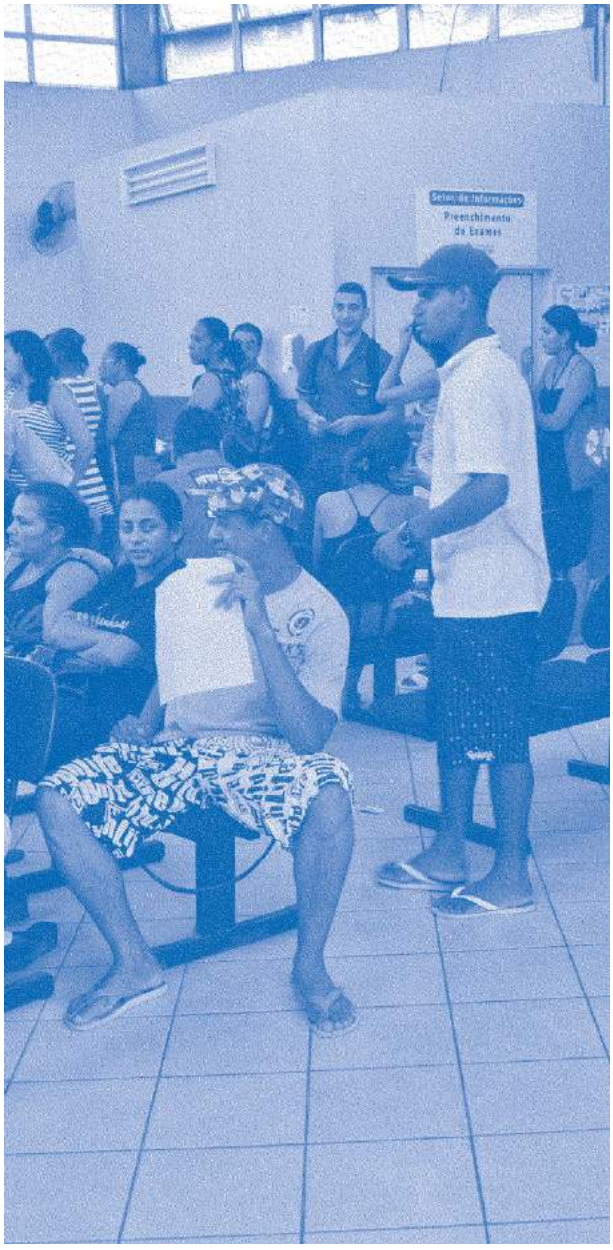
Finally, to answer the question on how social entrepreneurs solve the double bottom line, one can infer from table 11 and 12 that success when dealing with this concept lies with the individual motivation and objectives of the entrepreneurs that finally determine the business strategy.

## 5.2 INSIGHTS AND SUMMARY

Social innovation can be an important consideration when attempting to further improve business. Especially the awareness of the social good can create an interesting business, strategic and marketing differential. It should be mentioned that we did not have access to information that evaluates the impact of the different projects. Thus even though obviously all cases claimed a social innovation component, we were not able to verify these assumptions based on concrete data. This is also due to the lack of measurement of an impact that goes beyond the number of patients treated and would imply more elaborated indicators such as social developmental factors, the creation of public value in the low- to middle-income districts or numbers of cases prevented.

However, in addition to the financial sustainability of the businesses that social ventures require to the same extent as traditional ventures, the focus on social innovation and high quality services are conditions that we assume to be essential in order to be profitable in healthcare. Any breach in quality or social component of services can jeopardize the reputation of the organization and thus risk the business' success.

In summary, a balance of the double bottom line, of financial sustainability and the creation of social impact seem to be important considerations that entrepreneurs and investors should speculate about especially in the healthcare market.



## FOR ENTREPRENEURS

### 01 SOCIAL INNOVATION

- What explicit social cause do you want to achieve with your company (for instance empowerment of stakeholders of the healthcare market)? How can this mission and vision help you to position and guide your venture?

### 02 DOUBLE BOTTOM-LINE

- How do you want to reconcile social and economic revenue?
- How can you apply the social mission in a way that helps your company to gain financial revenue?

### 03 IMPACT MEASUREMENT

- In which way can the social mission help to set better or additional performance indicators?
- How can you use your social mission first for matchmaking with investors and second as a strategic guideline for business decision-making?

## FOR INVESTORS

### 01 SOCIAL INNOVATION

- How important is the social value creation for the investors?

### 02 DOUBLE BOTTOM-LINE

- How do you position yourself on the continuum of traditional investor to philanthropist? And what does that mean for your investment decisions?

### 03 IMPACT MEASUREMENT

- In which way can the measurement of social impact be a control variable that can help to achieve the aim of the investment?

# 06 | CLOSING REMARKS

## 6.1 DISCUSSION

With its foundations in the areas of entrepreneurship and business model analysis, the report investigated areas of innovation in several healthcare ventures, aiming to provide primary care services to the low-mid-income population, in Brazilian urban areas. Thereby we looked at aspects of service, processes, organisation and financial arrangements.

We argued that the access to healthcare in Brazil is a unique showcase because it is characterized by difficulties and short cuts in supply, services and management, in public healthcare and partially in supplementary medical healthcare offers. Consequently, the population's need for the provision of adequate diagnostics, patient-centred care as well as the provision of basic diagnostic services, constitutes an interesting market for private, entrepreneurial ventures.

Based on these assumptions, the aim of the paper was to investigate and describe the entrepreneurial innovations concerning access to the healthcare market of Brazil, and thus to provide an informative overview and a stimulating document for entrepreneurs, investors, academics and other interested parties.

The report addressed several questions. First it presents what kind of different business models are present in the market and which type and factors of business innovation they possess. Secondly, the report integrates the learnings into a classification of how the businesses create value. The third set of questions systemizes the social innovation that is thought to be created by the ventures and how the entrepreneurs solve the double bottom line of social and financial return.

These questions were analysed on the bases of the data that has been collected in interviews, field visits and from secondary sources. The results show a first panorama of the market for private healthcare services in Brazilian urban areas. We labelled the solutions that are not part of either the public or the supplementary system, as a 3rd pillar of healthcare.

The results of every paragraph were condensed into exemplary questions that are meant to be helpful for entrepreneurs and investors in bringing consciousness and an additional angle of analysis to business factors that could so far have not been investigated.

Additionally, the findings have revealed that the market shows several interesting aspects of innovation that could be labelled as disruptive (Bower & Christensen, 1995; Christensen, 2003). In the course of the report it becomes clear that the investigated cases focus on the provision of cheaper, simpler, more convenient products or services for the population. The concept of disruptive innovation (Christensen, 2003) establishes the precondition that businesses enter the market by either addressing the needs of less-demanding or new customer segments, otherwise by targeting new markets in the pursuit of a new category of customers (The Economist, online article, January 25, 2015). Even though the investigated cases exhibit several elements of "disruption" in patient-centred care, throughout our analysis we have seen that businesses are mainly addressing underserved market segments by boosting efficiency and continuously implementing services. They are not establishing a new market. Thus the detected factors of new technology, simplification of management, new approaches to service or care processes and so forth make our assumption of a third pillar of healthcare in Brazil even more compelling.

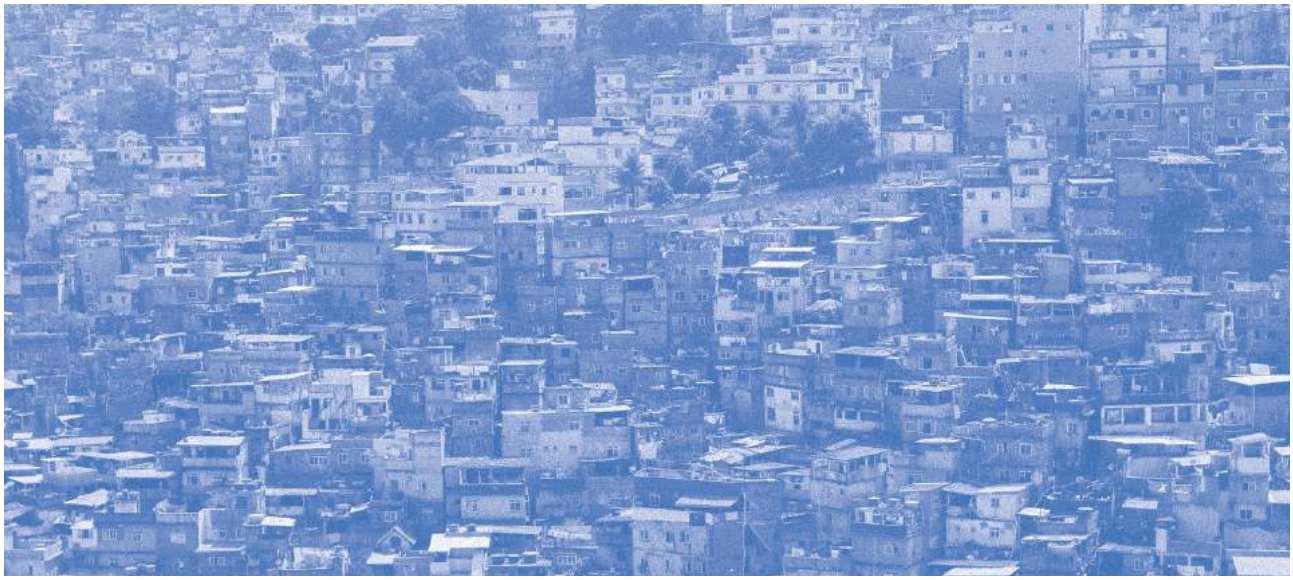
## 6.2 LIMITATIONS OF THE REPORT

As any academic investigation, the report faced limitations that may inspire further research. First of all our information is based mainly on outside information. Even though the authors gathered roughly 60 hours of interview material with 27 internal sources, ranging from CEOs, CFOs, management staff and doctors, very little quantitative data such as business reports, sales, generated revenue and investment costs were available. This lack of information was only partially compensated by secondary data. Thus we consider our data as biased to the perspective of what the ventures wanted to display.

The first limitation is somehow interconnected to a second difficulty encountered in data assessment. The sharing of information was in some cases difficult and some projects declined when asked to participate in interviews.

Thirdly, although the understanding of a social mission was assessed in the interviews, the report does not contain a thorough analysis of the founder's social motivation or a solution to the double bottom line nor does it give a detailed measure of the tangible impact the venture actually produces. For future research we would recommend doing a data-driven assessment on social impacts and social innovation. Thereby we would advocate to measures that go beyond the number of patients treated and include indicators such as social developmental factors, the creation of public value in the low- to middle-income districts or health economics, such as prevention statistics.

Fourthly, the report ceases to look at leadership characteristics of social entrepreneurs, which are assumed to be directly connected to their motivations to drive social innovation (Mulgan, Tucker, Ali, & Sanders, 2007, see also Mayer-Haug, Read, Brinckmann, Dew, & Grichnik, 2013).



## 6.3 INSIGHTS AND SUMMARY

In sum, the report illuminates entrepreneurship in Brazilian healthcare. The differentiating factor from other studies is the clarification and inclusion of the term innovation. This examination supported the identification of several areas (services, processes, business model) that contribute to innovative business models.

In terms of applicability the results identified several factors that investors, entrepreneurs and business incubators can include for the purpose of matchmaking, for professionalizing the business or for helping with the construction of a solid business model. The report at hand can lead to several tangible follow-up studies that can answer a large array of questions. Some of the following themes can be addressed after further research.

As the report was only focusing on primary healthcare, future research could investigate a broader spectrum of healthcare and focus on current trends that are developing in Brazil. Consequently, different services could be examined, ranging from matchmaking platforms between patient – doctor – pharmacies, care for the elderly or prevention programs for non-communicable diseases to initiatives for alternative healthcare plans. A solid preliminary overview has already been given by Potencia Ventures in 2012. Such a study could reveal the different business opportunities and development challenges for the healthcare ecosystem connected to for-profit entrepreneurship. In this sense future studies could look at, for example prevention programs or Impact Bonds in healthcare.

Even though much has been written on the differentiation of capital that is destined to social ends (Social Investment Task Force, 2011) and the differentiation of philanthropy, venture philanthropy or impact investing (Bridges Ventures, 2012), it is still a question under debate regarding how this capital can be best applied to match the expectations of financial return and social impact. Therefore it can be helpful to initiate a review or meta-analysis on the best practice cases that have already been disinvested by the financier and investigate the relation between impact and return.

Further research can also look at how investors and business incubators can support the entrepreneurs, help them to succeed and construct an ecosystem that facilitates innovation and entrepreneurial activities. Some studies have already looked at the post-investment engagement of impact investing funds (Kuonen, 2014) in Brazil.

Also, investigating different partnership structures with the involvement of multinational companies in supporting start-ups, entrepreneurship and social ventures can be highlighted.

We believe that the investigation of these factors as well as the results of the current report can further illuminate the potential of disruptive innovations by entrepreneurs who are inventing new ways of delivering health-care primarily to underserved populations as it stands.

To sum up our findings, our data and the above-mentioned conclusions, we assume that the drivers of innovation are a combination of the entrepreneur, the ecosystem and the historical context in which the clinics operate (Cajaiba-Santana, 2013; Mulgan et al., 2007). In the following segment we present the last set of recommendations based on suggestions made by our interview partners and deduced from our analysis. The following statements can help to inspire practitioners to further improve their own activities:

## FOR ENTREPRENEURS

01
### THE CORE VISION

Entrepreneurs need to have a clear vision of their objectives and set realistic expectations accordingly. Additionally, entrepreneurs need to be persistent and tolerant to frustration, especially when breaking the rules of traditional venturing.

02
### THE EXTENDED VISION

The company's vision needs to be shared by the team and reflected in the organizational culture to keep the team motivated and to make sure staff are moving in the same direction. Training measures should be offered to the core (management) team and the staff. Especially in the growth phase of the venture, communication has to be intense and include all parts of the company in a transparent way.

03
### A VISIONARY MULTIPLICATOR EFFECT

As attracting talent – the "right" people – stipulates among the major challenges mentioned by our interview partners, this is another element on which entrepreneurs need to focus. This implies that entrepreneurs need to put in place attractive incentive structures to recruit and retain people that combine technical competence with a personality that can carry on the mission of the company.

04
### THE IMPLEMENTATION OF VISION

Last but not least, entrepreneurial acumen and the agility to negotiate with policymakers, investors and other stakeholder are indispensable, even more so for ventures in the social sector which are under constant public scrutiny.

## FOR INVESTORS

01
### ALIGNMENT

Successful matchmaking between investors and entrepreneurs and the alignment of their objectives remains a necessary prerequisite for successful cooperation.

02
### DISRUPTION

It is especially important for social oriented investors to look for disruptive potential, innovation and social impact. This should be done by reviewing innovation in products, services, processes, business model and the respective factors mentioned in the report.

03
### SUPPORT

As mentioned by some entrepreneurs, investors not only can promote business growth by allocating funds for scaling but can support activities by e.g. connecting to a broader network of health professionals, introducing marketing strategies, intensifying the brand perception, supporting governance and supervising financial sustainability.

# 07 | METHODOLOGICAL BACKGROUND: QUALITATIVE CASE STUDIES

## 7.1 RESEARCH APPROACH

Considering the definitions, structures and arguments mentioned above, this report seeks to identify patterns of innovation contained in several building blocks of the business model of private, (profit-oriented) ventures that provide healthcare access to the base-of-the-pyramid (BoP) in Brazilian urban areas. Thus, it aims to increase knowledge on innovation and the popularity of the term "social innovations" by clarifying these concepts and analysing them alongside the data.

Firstly, the paper merged the literature of social entrepreneurship and innovation, and adapted it to the situation of private (for-profit) primary healthcare providers for the BoP of Brazil.

Secondly, the paper analysed the descriptive findings of the interviews and additional data and consolidated them in an overview of the business models and venture history that is present in the field.

Thirdly, the study included and discussed perspectives from (Impact) Investors that can shed light on possibilities of how to finance social innovation and social entrepreneurs (Nicholls & Dees, 2015). Thereby we looked into the role of actors involved in innovation partnerships (private investors, government agencies, foundations) and approaches for hybrid-models that were mentioned as under-researched (Phillips et al., 2015).

Hence, the overall objective of this report is to provide a consolidated view of the business models and use them to look at innovation and characteristics that are created by the enterprises under scrutiny.

## 7.2 ASSESSING THE FIELD: CASES AND INTERVIEW APPROACH

### *7.2.1 CASE SELECTION*

The aim of this report is to gain information and insight into the business models and their specific distinguishing or innovative factors of private primary healthcare providers in Brazil. Information was collected from July to October 2015. One project had already been analysed in 2014. The identification of adequate projects for this study was conducted through different channels. First, Brazilian social business accelerators were contacted and asked for adequate projects. Second, several entities (impact investing funds, foundations, academic partners) active in the healthcare sector supported the authors with contacts and data. Third, the authors contacted Brazilian entities that award social entrepreneurship prizes. And fourth, the authors accessed the personal network for indications of projects and stakeholders.

In order to gain a broader insight into the Brazilian healthcare system, external stakeholders were selected from different backgrounds for interviews. Thus, besides from interviews with the case clinics where we interviewed the founders, members of the management teams and doctors, additional conversations were conducted with policy makers (1), representatives from academia (2), business accelerators (3), healthcare investors (4) and strategy consultants (5). In addition, meta-organizations were contacted (publishers, news-centres) to gain a broader overview on the complexity of the topic. No contact was made with insures or supplementary healthcare payers.

### 7.2.2 INCLUSION AND EXCLUSION CRITERIA

The selected cases complied with a set of predefined selection criteria (see Table 2). Principally, the projects had already received investment or are in a growth stage in which they can receive external capital/investment. The focus is on Brazilian urban areas, primary healthcare (WHO, 2008) for the Brazilian CDE population (Neri, 2014).

**TABLE 15 // INCLUSION AND EXCLUSION CRITERIA FOR ADEQUATE PROJECTS**

| INCLUSION CRITERIA | |
|---|---|
| LOCATION | ~ URBAN AREAS OF LARGE BRAZILIAN CITIES |
| SCOPE | ~ PRIMARY HEALTHCARE RELATED SERVICES ACCORDING TO THE WHO CRITERIA (2014)[3] |
| TARGET GROUP | ~ BOP OR THE BRAZILIAN SOCIAL STRATA CDE[4] |
| STAGE OF THE VENTURE | ~ FROM EARLY PHASE TO MATURITY[5] |
| *CRITERIA OF IMPACT* INVESTING | |
| ACCOUNTABILITY | ~ POSSIBILITY OF IDENTIFYING MEASURABLE EVIDENCE THAT SOCIAL OR ENVIRONMENTAL VALUE HAS BEEN CREATEDCDE |
| PROFITABILITY | ~ COMMERCIALLY SUSTAINABLE AND PROFITABLE BUSINESS |
| INTENTIONALITY | ~ MOTIVATED BY THE INTENTION TO CREATE A SOCIAL (OR ENVIRONMENTAL) GOODCDE |

[3] *Primary care (first level of care) is the provision of integrated accessible healthcare services through addressing the vast majority of personal healthcare needs, developing a sustained relationship with patients, and practicing in the context of family and community (WHO, 2008)*

[4] *Neri, 2014*

[5] *Churchill & Lewis, 1983*

Based on these criteria, 14 projects were identified and underwent a first screening. As mentioned, this first sample was based on online research and information provided by partner organizations (accelerators, foundations, investment funds). Projects were situated in different geographic regions of Brazil. Out of the screened projects 10 satisfied the inclusion criteria. Eventually, 7 clinics were selected for the research as 3 clinics dropped out because there was a breakdown in communication or there was not enough secondary information available.

### 7.2.3 SAMPLE DESCRIPTION

Out of the 7 projects included in the report, 5 projects are represented with primary and secondary data. 2 are merely based on secondary data of which 1 clinic was concerned with confidentiality issues and the other did not reply to follow-up.

Primary data is based on interviews with the clinic's founders and employees. A total of 27 interviews were conducted with representatives from the respective clinics. For this purpose one or more clinical units were visited to conduct interviews with different employees (medical staff, administration, etc.), the management team and the founder. For data triangulation, documentary evidence has been collected from online resources, newspaper articles and annual reports of the ventures under analysis, as long as they existed or were publicly available. While the projects appeared to be comparable one-on-one at first glance seeing as they provide the same services and target the same customer group, yet the detailed analysis demonstrated high diversity between them. The most visible facts are the size and modalities of the healthcare units, hence the volume of treated patients and start of operation. The details can be seen in table 3.

## TABLE 16 // SAMPLE DESCRIPTION DATA OVERVIEW | DATA FROM 2015

| | CASE 1 | CASE 2 | CASE 3 | CASE 4 | CASE 5 | CASE 6 | CASE 7 |
|---|---|---|---|---|---|---|---|
| RESEARCH INFORMATION | | | | | | | |
| **CONTACT** | POSITIVE | POSITIVE | POSITIVE | POSITIVE | POSITIVE | CONTACTED, NO REPLY TO CONSTANT FOLLOW-UP | CONTACTED, WITHDRAWAL FROM PARTICIPATION |
| **DATA** | PRIMARY[1] & SECONDARY | PRIMARY[1] & SECONDARY | PRIMARY[1] & SECONDARY | PRIMARY[1] & SECONDARY | PRIMARY[1] & SECONDARY | SECONDARY | SECONDARY |
| **BUSINESS REPORT** | NO | YES (PUBLIC) | NO | YES (CONFIDENTIAL) | NO | NO | NO |
| **# AUDIO/VIDEO SOURCES** | 0 | 0 | 1 | 4 | 4 | 10 | |
| **APPROX. INT. SOURCES** | 1 | 10 | 4 | 8 | 4 | NONE | NONE |
| **# OF INTERVIEWS** | 1*40 MIN | 10Ø60MIN | 4Ø40MIN | 8Ø50MIN | 4Ø50MIN | NONE | NONE |
| **INTERNAL INFORMANTS** | CEO | CEO, CFO, MARKETING, DOCTOR, STAFF | CEO, HR, STAFF | CEO, CFO, MARKETING, DOCTOR, STAFF | CEO, MARKETING, DOCTOR/ ADMINISTRATION, STAFF | NO | NO |
| **SECONDARY DATA** | NEWSPAPER, WEBSITE, YOUTUBE | NEWSPAPER, WEBSITE, YOUTUBE | YOUTUBE, INTERNET | NEWSPAPER, WEBSITE, YOUTUBE, ACADEMIC RESEARCH PAPER (2014) | NEWSPAPER, WEBSITE, YOUTUBE | NEWSPAPER, INTERNET, YOUTUBE | NEWSPAPER, WEBSITE, YOUTUBE, ACADEMIC RESEARCH PAPER (2013) |
| **FIELD VISIT** | YES | YES | YES | YES | YES | NO | NO |

[1] *Interviews and questionnaires*

Table structured from Santos & Eisenhardt, (2009)

### 7.2.4 DATA MEASURES AND ASSESSMENT

The report analyses the business model of the (social) ventures with the totality of how the different businesses work and create value (Gassmann, Frankenberger & Csik, 2015). To assess the elements of the business model, we constructed a semi-structured interview guide. The different contexts in which social entrepreneurs operate provide the building blocks for the assessment. Looking at the interface of content, context and processes can provide an insight into the specific factors which contribute to the ventures' development and success (Mair & Martí, 2006).

For this purpose, Pettigrew and Whipp's (1991) three dimensional perspective on strategic change, which consists of context (the 'why' of change), process (the "how" of change) and content (the 'what' of change) will be used as the basis for the methodological approach. This approach underlines the strategic change of enterprises as being an "interactive, multilevel process with outcomes shaped by interests and commitment of individuals and groups, the force of bureaucratic momentum, gross change of the environment and the manipulation of structural context around decisions" (Pettigrew, 1992).

The framework developed by Pettigrew and Whipp enables a holistic analysis of the underlying dynamics of the venture, which includes looking at it from a historical, cultural and political perspective. The three dimensions suggested by Pettigrew are:

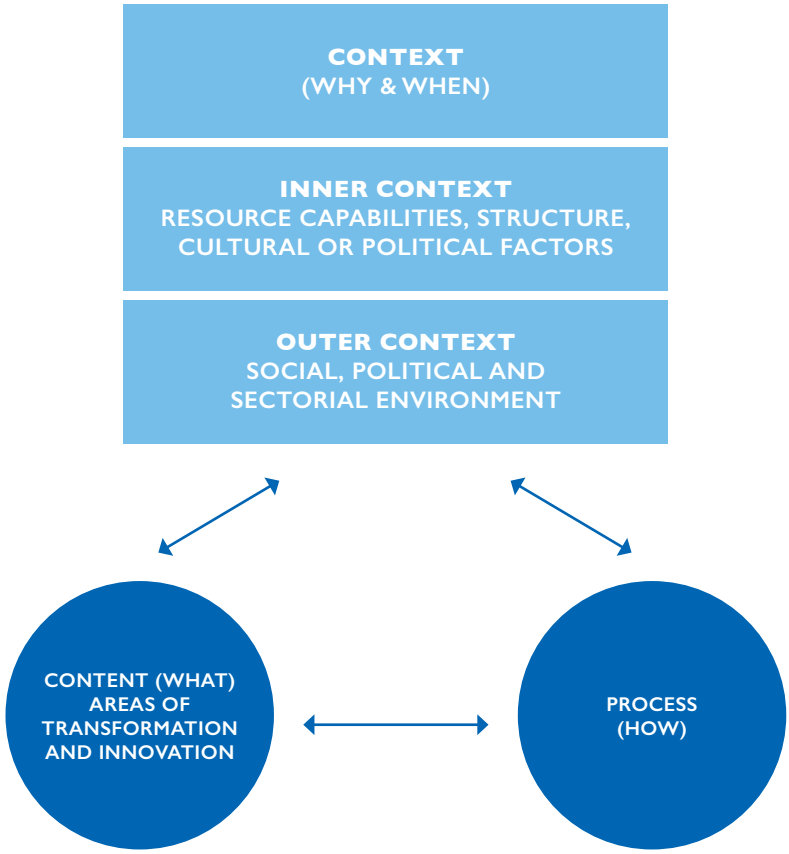
1. CONTENT (WHAT OF CHANGE) WHICH DEALS WITH THE OBJECTIVES, GOALS AND PURPOSE OF THE VENTURE.

2. CONTEXT (WHY AND WHEN OF CHANGE), WHICH IS DIVIDED INTO THE INNER (INTERNAL) AND OUTER (EXTERNAL) CONTEXT. WHILE THE EXTERNAL CONTEXT IS CONCERNED WITH THE ENVIRONMENTAL CIRCUMSTANCES AT A MACRO-LEVEL, THE INTERNAL CONTEXT FEATURES INTRA-ORGANIZATIONAL CONTEXTS SUCH AS RESOURCE CAPABILITY AND STRUCTURE AS WELL AS INTEREST GROUP BEHAVIOUR (PETTIGREW, 1990). IT CAN BE FURTHER SUBDIVIDED INTO TANGIBLES, WHICH REFER TO STRUCTURE AND RESOURCES OF THE ENTERPRISE, AND INTANGIBLE ELEMENTS, WHICH ALLUDE TO FOR EXAMPLE THE ORGANIZATIONAL CULTURE (PETTIGREW, WOODMAN, & CAMERON, 2001; PETTIGREW, STARKEY, & HAMBRICK, 2001; PETTIGREW & WHIPP, 1991; PETTIGREW, 1990).

3. PROCESS (HOW OF CHANGE) WHICH FRAMES THE STEPS NECESSARY FOR IMPLEMENTING CHANGE. IT REFERS TO THE LIFE-CYCLE OF AN ORGANIZATION AND EXAMINES THE CORE COMPETENCIES INVOLVED IN CHANGE.

The interconnection of the three dimensions is illustrated in Figure 1.

FIGURE 1 // THREE DIMENSIONS OF CHANGE (PETTIGREW & WHIPP, 1991), FIGURE ADAPTED FROM CHEAH (2015)




An approach that looks at change from a contextual perspective fits in well with the assumptions that successful change and impact of a social enterprise are inextricably linked with the context in which it operates (Austin et al., 2012). Furthermore, Austin (2012) assumes "an inhospitable context" as the driving force for the birth of entrepreneurial ventures as is the case of the analysed healthcare ventures in Brazil that emerge as a result of unmet social needs and basic social services. The contextual aspect of the framework will therefore form the focus of the methodological approach and analysis. With the goal to examine the performance of the ventures' under analysis, Pettigrew's framework allows for a comprehensive strategy to look at essential elements of the business and performance over time and in different dimensions.

### 7.2.5 SEMI-STRUCTURED INTERVIEWS

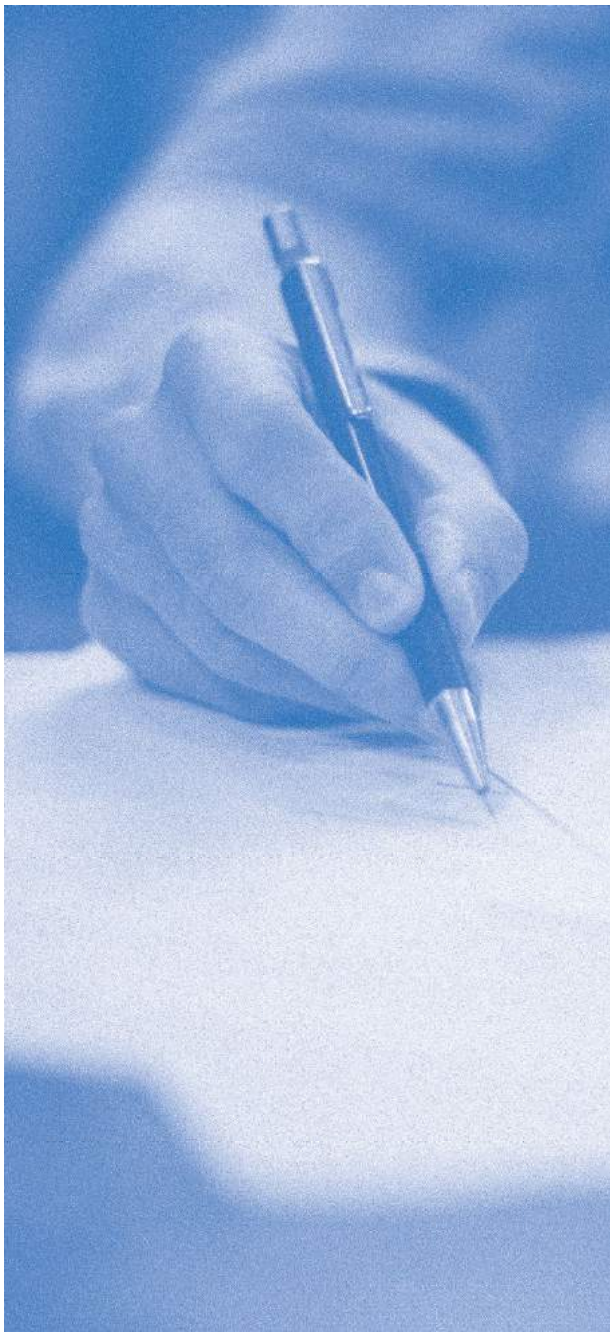
Based on the above-mentioned methodological background, the authors constructed a semi-structured interview guideline for data assessment (see sample questions in the annex). Thereby, the external context was assessed through the socio-economic context and the external environment. The content was operationalized by questions evaluating intentionality and accountability of the interview partner as well as realized milestones in the past. The internal context questioned factors of team, leadership, financial and organizational partnerships as well as the ventures' network. Additionally, the perception of the businesses innovativeness and uniqueness was investigated. Pettigrew & Wipp's process variables were defined through the added value, reach and expansion strategies, the financial sustainability and financing model (General, Revenue, Costs, Investments and subsidies) of the enterprise.

### 7.2.6 DATA ANALYSIS

All interviews were recorded in audio with the permission of the interviewee. The authors also took notes during the interviews that helped structuring the final analysis. Subsequently all audio was transcribed by the authors. The interviews were mainly conducted in Portuguese.

In a second step, the resulting documents were entered into ATLAS.ti (Friese, 2013). This program serves for the analysis of large bodies of qualitative data (structuring and analysing). In ATLAS.ti the transcripts of the interviews are inserted as documents (word, pdf, etc.). Following this, the program allows us to highlight different text passages or words in the documents. In our case we connected this marking process with the assignment of different codes to the data. Consequently, the program can finally group the data together into the variables that were defined in the interview guide. Thus specific data could be assigned to the dimensions that were considered as business model innovation.

Hence, the results of this process facilitated grouping the assigned quotations and codes across all interviews, thereby producing data driven results for the research questions. Ultimately, findings can be clearly structured and analysed accordingly.



# 08 | LITERATURE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# 09 | ANNEX

## 9.1 SAMPLE DESCRIPTION DATA OVERVIEW AND THE PROJECTS BUSINESS MODELS | DATA FROM 2015

| | CASE 1 | CASE 2 | CASE 3 | CASE 4 | CASE 5 | CASE 6 | CASE 7 |
|---|---|---|---|---|---|---|---|
| RESEARCH INFORMATION | | | | | | | |
| **CONTACT** | POSITIVE | POSITIVE | POSITIVE | POSITIVE | POSITIVE | CONTACTED, NO REPLY TO CONSTANT FOLLOW-UP | CONTACTED, WITHDRAWAL FROM PARTICIPATION |
| **DATA** | PRIMARY[1] & SECONDARY | PRIMARY[1] & SECONDARY | PRIMARY[1] & SECONDARY | PRIMARY[1] & SECONDARY | PRIMARY[1] & SECONDARY | SECONDARY | SECONDARY |
| **BUSINESS REPORT** | NO | YES (PUBLIC) | NO | YES (CONFIDENTIAL) | NO | NO | NO |
| **# AUDIO/VIDEO SOURCES** | 0 | 0 | 1 | 4 | 4 | 10 | |
| **APPROX. INT. SOURCES** | 1 | 10 | 4 | 8 | 4 | NONE | NONE |
| **# OF INTERVIEWS** | 1*40 MIN | 10Ø60MIN | 4Ø40MIN | 8Ø50MIN | 4Ø50MIN | NONE | NONE |
| **INTERNAL INFORMANTS** | CEO | CEO, CFO, MARKETING, DOCTOR, STAFF | CEO, HR, STAFF | CEO, CFO, MARKETING, DOCTOR, STAFF | CEO, MARKETING, DOCTOR/ ADMINISTRATION, STAFF | NO | NO |
| **SECONDARY DATA** | NEWSPAPER, WEBSITE, YOUTUBE | NEWSPAPER, WEBSITE, YOUTUBE | YOUTUBE, INTERNET | NEWSPAPER, WEBSITE, YOUTUBE, ACADEMIC RESEARCH PAPER (2014) | NEWSPAPER, WEBSITE, YOUTUBE | NEWSPAPER, INTERNET, YOUTUBE | NEWSPAPER, WEBSITE, YOUTUBE, ACADEMIC RESEARCH PAPER (2013) |
| **FIELD VISIT** | YES | YES | YES | YES | YES | NO | NO |

| UNIT OF ANALYSIS | CASE 1 | CASE 2 | CASE 3 | CASE 4 | CASE 5 | CASE 6 | CASE 7 |
|---|---|---|---|---|---|---|---|
| OVERVIEW | | | | | | | |
| **GEOGRAPHY** | SOUTHEAST | SOUTHEAST | SOUTHEAST | SOUTHEAST | SOUTHEAST | SOUTHEAST | SOUTHEAST |
| **START OF OPERATION** | 2015 | 2007 | 2008 | 2011 | 1988 | 2001 | 2007 |
| **# OF UNITS OPEN**[2] | 2 | 5[3] | 3 | 7 | 2 | 3 | 4 |
| **AV. SIZE** | CA. 30M^2 | B/W 30-100M^2 | AROUND 500M^2 | B/W 100-400M^2 | B/W 3000-5000M^2 | N/A | N/A |
| **# OF SPECIALTIES** | ALTERNATIVE TO PRONTO-SOCORRO | > 20 | >40 | 25 | >36 | 25 | 29 |
| **CONSULTATION PRICE (R$)** | FIXED PRICE 89R$ | FOR FREE | 62-72R$ | 90-120R$ | 60R$-X | 90R$ | 90-100R$ |
| **ONLINE BOOKING** | ONE STOP SHOP | NO | YES, "ONE-STOPSHOP | YES | YES | YES | YES |
| **# MONTHLY VOLUME (# OF PATIENTS)** | BREAK EVEN VOLUME: 3.5 VISITS/ HOUR, 100 VISITS/ MONTHS | 9'000 EXAMS/ MONTH | 400-500 EXAMS/ DAY | 8'000 EXAMS/ MONTH (2014) | 15'000 ULTRASOUND/ MONTH, POTENTIAL FOR 200'000 EXAMS/ MONTH, 125'000 PATIENTS/ MONTH (2 CLINICS) | N/A | 3'000 EXAMS / MONTH (2013) |
| **# OF DOCTORS** | UP TO 2 DOCS / TURN | 82 (2014) FULL EMPLOYMENT | > 200 | > 110 (2014) | 300 DOCTORS, 400 STAFF | 52 | 10 P/UNIT AT TOP TIMES |

| UNIT OF ANALYSIS | | CASE 1 | CASE 2 | CASE 3 | CASE 4 | CASE 5 | CASE 6 | CASE 7 |
|---|---|---|---|---|---|---|---|---|
| BUSINESS MODEL DIMENSIONS | | | | | | | | |
| PRODUCT / SERVICES | *VALUE PROPOSITION* | PRE-PRIMARY CARE | EXAMINATION AND PRIMARY CARE | PRIMARY CARE, DISEASES OF LOW AND MEDIUM COMPLEXITY | PRIMARY CARE, DISEASES OF LOW AND MEDIUM COMPLEXITY | "ONE-STOP SHOP" FOR CLIENTS AND MEDICAL STAFF | AMBULATORY SERVICE, COMPLEMENTARY EXAMS AND SURGERY | PRIMARY CARE, DISEASES OF LOW AND MEDIUM COMPLEXITY |
| | ~ UNIQUE SELLING PROPOSITION | PRICING, TIME EFFICIENCY, COAMPANY CONTRACTS, PRE-PAID CARD | PRICING, TIME EFFICIENCY, COAMPANY CONTRACTS, PRE-PAID CARD | QUALITY, PRICING, ACCESSIBILITY, SPEED | QUALITY, PRICING, ACCESSIBILITY, SPEED | DIAGNOSTICS, EXAMS, REHAB, TREATMENT IN ONE PLACE | QUALITY, PRICES, VISION OF SOCIAL RESPONSIBILITY FOR THE POPULATION | QUALITY, PRICING, ACCESSIBILITY, SPEED |
| CUSTOMER INTERFACE | *TARGET CUSTOMERS* | BCD | CDE | CD (E) | CD, PEOPLE WITHOUT HEALTH INSURANCE | A 5-10%, 20 – 30 % B, C 50-60%, D 5%. | CDE | CDE |
| | *TARGET MARKET* | NON-INSURED & INSURED FOR ACCESSIBILITY AND CONVENIENCE | SUBURBAN REGIONS AND REMOTE AREAS OF BRAZIL | ACCESSIBLE REGIONS (IN THE SUBURBS) OF URBAN AREAS | AREAS OF DENSE POPULATION THAT ARE EASILY ACCESSIBLE BY PUBLIC TRANSPORT | ALL OF BRAZIL | PRIMARY HEALTHCARE SERVICES IN MEDIUM SIZE CITIES | NON-INSURED & FIXED EMPLOYMENT / 1-3 MINIMUM WAGES |
| | *DISTRIBUTION CHANNEL* | FLYERS, INTERNET, WORD OF MOUTH (WOM) | | OFFER FREE SERVICES FOR DIABETES TEST; INFORMATION DIVULGATION VIA HEALTHCARE CAMPAIGNS; WOM, ANNOUNCEMENTS ON GOOGLE ADVERTS | ONLINE, PAPER, RADIO, TELEVISION, WOM | MARKETING ACTIVITIES IN THE COMMUNITY, ADVERTISEMENT, WOM | MARKETING AND FORM CORE BUSINESS SEPARATED SOCIAL PROJECTS, ADVERTISEMENT ON TV AND WOM | ONLINE, PAPER, RADIO, TELEVISION, WOM |
| | *RELATIONSHIP* | N/A | N/A | BONDING THROUGH CLINIC MARKETING | BONDING THROUGH CLINIC MARKETING | BONDING MAINLY THROUGH DOCTORS | INCUBATES VARIOUS ACTIVITIES FOR SOCIAL RESPONSIBILITY | BONDING THROUGH CLINIC MARKETING |

| UNIT OF ANALYSIS | | CASE 1 | CASE 2 | CASE 3 | CASE 4 | CASE 5 | CASE 6 | CASE 7 |
|---|---|---|---|---|---|---|---|---|
| BUSINESS MODEL DIMENSIONS | | | | | | | | |
| INFRASTRUCTURE MANAGEMENT | *VALUE CONFIGURATION* *CORE COMPETENCY* | CONSULTATION | EXAMS | CONSULTATION, EXAMS | CONSULTATION, EXAMS | CONSULTATION, EXAMS, OPERATIONS | CONSULTATION, EXAMS | CONSULTATION, EXAMS |
| | *PARTNER NETWORK* | PRIVATE SECTOR/ INVESTORS | GOV./ COMPANIES/ PRIVATE SECTOR | COMPANIES/ COMM UNITY CENTERS (DISCOUNT) | INVESTORS/ PRIVATE BUSINESS MEN/ DOCTORS | FAMILY BUSINESS DOCTORS | FOUNDATIONS, NGOS, PRIVATE BUSINESSES, REGIONAL AND NATIONAL GOVERNMENT | INVESTORS/ PRIVATE BUSINESS MEN |
| FINANCIAL ASPECTS | *COST STRUCTURE* | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| | *REVENUE MODEL* ~ PRICING STRATEGY | FEE FOR SERVICE | CONTRACTING WITH GOV. & COMPANIES AS WELL AS POPULAR PRICES | FEE FOR SERVICE | FEE FOR SERVICE | FEE FOR SERVICE | 100% DIRECT SALES TO PATIENTS | FEE FOR SERVICE |
| | ~ FACTORS DETERMINE REVENUE | VOLUME OF CLINICAL CONSULTATIONS | | VOLUME OF CLINICAL CONSULTATIONS | VOLUME OF CLINICAL CONSULTATIONS | CONSULTATIONS, EXAMS, SURGERY | 80% CONSULTATION, 15% EXAMS AND 5% SURGERY | |
| | ~ OTHER VARIABLES (FUNDING, SUBSIDIES, DONATIONS) | VENTURE CAPITALISTS | | | VENTURE CAPITALISTS DEVELOPMENT BANK | FAMILY AND PROPRIETARY | N/A | VENTURE CAPITALISTS |
| | ~ MAIN EXPENSES | RENT | N/A | RENT & SALARIES (BY PRODUCTIVITY) | RENT & SALARIES | RENT & SALARIES | N/A | N/A |

| UNIT OF ANALYSIS | | CASE 1 | CASE 2 | CASE 3 | CASE 4 | CASE 5 | CASE 6 | CASE 7 |
|---|---|---|---|---|---|---|---|---|
| BUSINESS MODEL DIMENSIONS | | | | | | | | |
| BUSINESS CONCEPT | *FOUNDING CONTEXT* | IDEALIZATION OF A "MINUTE CLINIC" IN BRAZIL | STRONG WISH TO CHANGE THE CONDITION OF THE PUBLIC HEALTHCARE SYSTEM | FAMILY HAS A MEDICAL TRACK-RECORD AND STARTED BY DOING CSR CAMPAIGNS, LATER REGARDING THE DIRE CONDITIONS IN PUBLIC HOSPITALS | ENTREPRENEURIAL HISTORY, BUSINESS OPPORTUNITY, HUMANISTIC EDUCATION | FOUNDED BECAUSE OF THE EXPERIENCE OF THE FOUNDER (DOCTOR) WORKING IN THE PUBLIC HOSPITAL HUMANISTIC VISION OF THE FOUNDER | FOUNDER FORMALLY DEDICATED TWO DAYS/WEEK TO VOLUNTARY EXAMINATIONS FOR BOP | BUSINESS POTENTIAL, MINUTE CLINIC, INSPIRATION BY CASE STUDY "FARMACIAS SIMILARES" |
| | *IMPACT* ~ # BENEFICIARIES | BREAK EVEN VOLUME: 3.5 VISITS/ HOUR, 100 VISITS/ MONTHS | 34,000 EXAMS/ MONTH, Ø 6,800 (27 BOXES IN 5 UNITS) | 400-500 EXAMS/ DAY | 8,000 EXAMS/ MONTH (2014) 7,327 PATIENTS/ MONTH IN ONE CLINIC (2015) | 700,000 EXAMS/ MONTH 120,000 PATIENTS P.M. (2 CLINICS) | ~3,000 EXAMS/ MONTH | ~ 5,000 EXAMS / MONTH |
| | ~AFFORDABILITY OF PRODUCTS/ SERVICES | 89R$ | PATIENTS DON'T PAY FOR SERVICES | FROM 72R$ | 90-120R$ | FROM 80R$ | N/A | N/A |
| | *STAGES OF LIFE CYCLE*[1] | SURVIVAL TO SUCCESS | SUCCESS-GROWTH | SUCCESS-DISENGAGEMENT | DIVISIONAL | SUCCESS-GROWTH | DIVISIONAL | SUCCESS-GROWTH |
| | *GOVERNANCE* ~ FOR-PROFIT, NON-PROFIT, HYBRID | FOR-PROFIT; S.A. | STRUCTURALLY DIFFERENTIATED HYBRID (NON-PROFIT AND FOR-PROFIT) | FOR-PROFIT | FOR-PROFIT; S.A. | FOR-PROFIT | FOR-PROFIT | FOR-PROFIT; S.A. |
| | ~ PORTIONS ON THE COMPANY OWNED BY THE FOUNDER | N/A | JOINT OWNER | JOINT OWNER, NO PUBLICLY AVAILABLE INFORMATION ON DISTRIBUTION OF SHARES | N/A | 100% | N/A | 55% OF SHARES |

| UNIT OF ANALYSIS | | CASE 1 | CASE 2 | CASE 3 | CASE 4 | CASE 5 | CASE 6 | CASE 7 |
|---|---|---|---|---|---|---|---|---|
| BUSINESS MODEL DIMENSIONS | | | | | | | | |
| BUSINESS CONCEPT | *SOCIAL ENTREPRENEUR* ~ MISSION | BUSINESS OPPORTUNITY | ACCESS TO HEALTHCARE TO MOST VULNERABLE URBAN REGIONS | HEALTHCARE SERVICES FOR PEOPLE WHO ARE EXCLUDED FROM THE HEALTHCARE SYSTEM | HEALTHCARE AS A BASIC RIGHT, SOLVE HEALTHCARE PROBLEMS | CREATE A WORKING SPACE FOR DOCTORS IN ORDER TO EXERCISE THEIR PROFESSION ETHICALLY AND IN A SOCIALLY RESPONSIBLE WAY | LOOK AFTER THE BASIC NEEDS OF THE POPULATION WITH ACCESSIBLE AND COMPETITIVE PRICES, TECHNOLOGY AND QUALIFIED DOCTORS | BUILD THE BEST NETWORK OF "CLINICAS POPULARES" IN BRAZIL |
| | ~ GENDER | MALE | MALE | MALE | MALE | MALE | FEMALE | MALE |
| | ~ EDUCATIONAL & PROFESSIONAL BACKGROUND | BUSINESS | MEDICINE | MEDICINE/MBA | BUSINESS | MEDICINE | MEDICINE | BUSINESS |
| MARKET ANALYSIS | *COMPETITORS* | MINUTE CLINICS | NONE | OTHER "CLINICAS POPULARES" | OTHER "CLINICAS POPULARES" | "CLINICAS POPULARES" ONLY PARTIALLY, HOSPITALS | OTHER "CLINICAS POPULARES" | OTHER "CLINICAS POPULARES" |
| | *ENTRY BARRIERS* | LOW | LOW | LOW | LOW | LOW | LOW | LOW |
| ADDITIONAL INFORMATION | *EXPANSION* | 1ST PHASE: GROWTH TO 5 CLINICS; 2ND PHASE: 10 MORE CLINICS | EXPANDING BUSINESS CONCEPT TO OTHER COUNTRIES | UNTIL 2016 - 5 UNITS | ONGOING EXPANSION IN URBAN AREAS | ONGOING EXPANSION IN URBAN AREAS, COUNTRY WIDE EXPANSION PLANS | ESTABLISHMENT OF A THIRD UNIT | 63 UNITS UNTIL 2019 |
| | *INVESTMENT (INFORMATION OPEN TO THE PUBLIC)* | 7.5M R$ FOR 5 CLINICS | | N/A | 2014: 20M R$ FOR 20 CLINICS IN 2016 MORE FUNDING IN '14 AND '15 | N/A | N/A | 2015: 30M R$ |

**Table structured from Santos & Eisenhardt, (2009)**

[1]interviews and questionnaires

[2]number of clinics is subject to change because of expansion operations

[3]cannot be quantified to the same extent as the n° of units varies

## 9.2 SUMMARY OF BUSINESS MODEL CHARACTERISTICS ENCOUNTERED IN THE SAMPLE

| BUSINESS MODEL PILLAR | BUILDING BLOCK | DESCRIPTION |
|---|---|---|
| **SERVICES** | VALUE PROPOSITION | (1) DIAGNOSTICS<br>(2) DIAGNOSTICS + CARE<br>(3) DIAGNOSTICS + CARE + FOLLOW-UP CARE<br>(4) DIAGNOSTICS + CARE + SURGERY + FOLLOW-UP CARE + PREVENTION<br>→ CAN BE GROUPED ON THE CONTINUUM OF CONTINUED CARE AND PROBLEM SOLVING ORIENTATION |
| **CUSTOMER INTERFACE** | TARGET CUSTOMER: | SOCIAL STRATA: BCDE<br>1. MOTIVATION OF CLIENTS<br>(1) DO NOT WANT TO RELY ON THE SUS<br>(2) NO INSURANCE<br>(3) WITH INSURANCE<br>2. CLIENTS ARE WILLING TO PAY FOR SERVICES |
| | *TARGET MARKET* | PRIMARY AND SECONDARY CARE IN MOST OF THE CASES |
| | DISTRIBUTION CHANNEL | COMPANY, DOCTOR, MEDICAL OR ADMINISTRATIVE STAFF, CUSTOMER |
| | RELATIONSHIP | SEVERAL RELATIONSHIP-BUILDING MECHANISMS IN PLACE<br>(1) ONLINE (WEB-BASED, SMARTPHONE)<br>(2) OFF-LINE (E.G. COMMUNITY ACTIVITIES, HEALTH CAMPAIGNS) |
| **INFRASTRUCTURE MANAGEMENT** | VALUE CONFIGURATION | (1) THE MEDICAL BONDING APPROACH<br>(2) THE RETAIL APPROACH<br>(3) MISSION-DRIVEN APPROACH |
| | CORE COMPETENCY | **MANAGEMENT:** ADMINISTRATION, TI, HUMAN RESOURCE MANAGEMENT, MARKETING<br>**MEDICAL:** EXPERTISE, WILLINGNESS TO CONNECT TO THE COSTUMER SEGMENT |
| | PARTNER NETWORK | 1. PUBLIC SECTOR AND GOVERNMENT<br>2. PRIVATE SECTOR: HEALTHCARE INDUSTRY (LABORATORIES, HOSPITALS), FINANCIAL INDUSTRY (INVESTMENT BANK, DEVELOPMENT BANK) |
| **FINANCIAL ASPECTS** | COST STRUCTURE | MAIN FIX COSTS ARE ATTRIBUTED TO PERSONAL COSTS.<br>INITIAL INVESTMENT IN MATERIAL, LOCATION ETC. ARE HIGH. |
| | REVENUE MODEL | REVENUE IS MAINLY GENERATED BY CONSULTATIONS AND EXAMS.<br>THIS REVENUE IS PAID EITHER IN THE FORM OF A FEE FOR SERVICES DIRECTLY BY THE COSTUMER OR IS REFUNDED BY A 3RD ORGANIZATION. |
| ***BUSINESS CONCEPT*** | *FOUNDING CONTEXT* | THE EXTENT TO WHICH THE VENTURES ARE MISSION-DRIVEN DIFFERS ACROSS THE SAMPLE. |
| | *IMPACT* | PRICES FOR SERVICES ARE COMPARABLE BETWEEN THE PROJECTS.<br>VARIATION IS OBSERVED IN THE NUMBER OF SERVICES THAT ARE OFFERED.<br>THE NUMBER OF BENEFICIARIES VARIES STRONGLY AMONG THE SAMPLE. |
| | *STAGES OF LIFE CYCLE*[2] | PROJECTS INVESTIGATED ARE IN GROWTH PHASE OR EVEN FURTHER IN DEVELOPMENT OF BUSINESS. |
| | *GOVERNANCE* | FROM FOR-PROFIT TO NON-PROFIT AND HYBRID MODELS. |
| | *MISSION /SOCIAL ENTREPRENEUR* | THE SPECTRUM RANGES FORM STRONG LEADERSHIP FIGURES OVER FAMILY BUSINESSES TO SHARED COMPANIES. |

[2] *Churchill & Lewis, 1983*

## 9.3 INTERVIEW GUIDE EXAMPLE

### 1. EXTERNAL CONTEXT: SOCIO-ECONOMIC CONTEXT AND EXTERNAL ENVIRONMENT

a.) What were your main reasons/motivations for the foundation of this venture?
b.) Is this reflected in the mission of the venture?
c.) …
d.) …
e.) …
f.) When did you encounter most difficulties in the implementation of the project and why?
g.) …

### 2. CONTENT: INTENTIONALITY AND ACCOUNTABILITY

a.) Does the venture intend to create social value?
b.) …

### 3. INTERNAL CONTEXT: TEAM AND LEADERSHIP

a.) Describe the structure and the strategy of the venture
b.) …
c.) Do you believe that you have managed to create an organizational culture? How?
c.a.) …
c.b.) …

### 1. INTERNAL CONTEXT: PARTNERSHIPS AND NETWORK

a.) How would you describe your network of partners and how do you interact with this network?
b.) …

### 2. EXTERNAL CONTEXT: INNOVATIVENESS AND UNIQUENESS

a.) In what way has the venture transcended existing systems and its activities?
b.) …

### 3. PROCESS: ADDED VALUE

a.) What are the main services the venture offers?
b.) …

### 4. PROCESS: REACH AND EXPANSION

a.) What customer group does this venture target?
b.) …
c.) …
d.) …

### 5. PROCESS: FINANCIAL SUSTAINABILITY AND FINANCING MODEL

**General**

a.) How does the company ensure financial sustainability?
b.) …

**Revenue**

c.) What kind of pricing strategy is applied to generate revenues and maintain the activities?
d.) …
e.) …

**Costs**

a.) What are the costs you have for a consultation?
b.) …
c.) …
d.) …

**Investments and subsidies**

a.) Does the project receive any form of private investment or donation?
b.) …
c.) …
d.) …

### 6. CONTENT (OVER TIME): REALIZED MILESTONES

a.) What are and what were the biggest challenges for the well-functioning of the venture?
b.) …
c.) …
d.) …

# 10 | ABOUT THE CONTRIBUTORS

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Johannes has been coordinating the Impact Investing research of the University of St. Gallen Institute of Management Latin America (GIMLA) in São Paulo from 2014 to 2016. He conceptualized and initiated the research Nucleus for Access to Healthcare Studies. He is engaged in advisory projects, research, business development and event organisation. (Email: johannes.boch.business@gmail.com)

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Harald is associated provessor the vice director of the Institute for Systemic Management and Public Governance at the University of St.Gallen. Besides he is head of the Centre of Health Care and co-director of the initiative in HealthCare Excellence at the University of St.Gallen, Switzerland.

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Angélica is the managing director of the St.Gallen Institute of Management Latin America (GIMLA). She is the co-founder of the Impact Investing Latin America Platform (IILA) and of the CooperativeLab Program, a match-making program for students' front-line and hands-on experience in SMEs in the region. Before that she worked for international companies in the areas of communications, branding, public relations and international relations in Brazil, Chile, Argentina and Switzerland.

## MARCELO NAKAGAWA

Marcelo is professor of entrepreneurship at Insper University and director of entrepreneurship at FIAP University in São Paulo. He has an extensive background in entrepreneurship and innovation as an executive, a professor, and a volunteer. Marcelo is an expert in strategic market research, venture capital, entrepreneurship, and analysis of technology innovations. He regularly writes for big newspapers about entrepreneurship and innovation.