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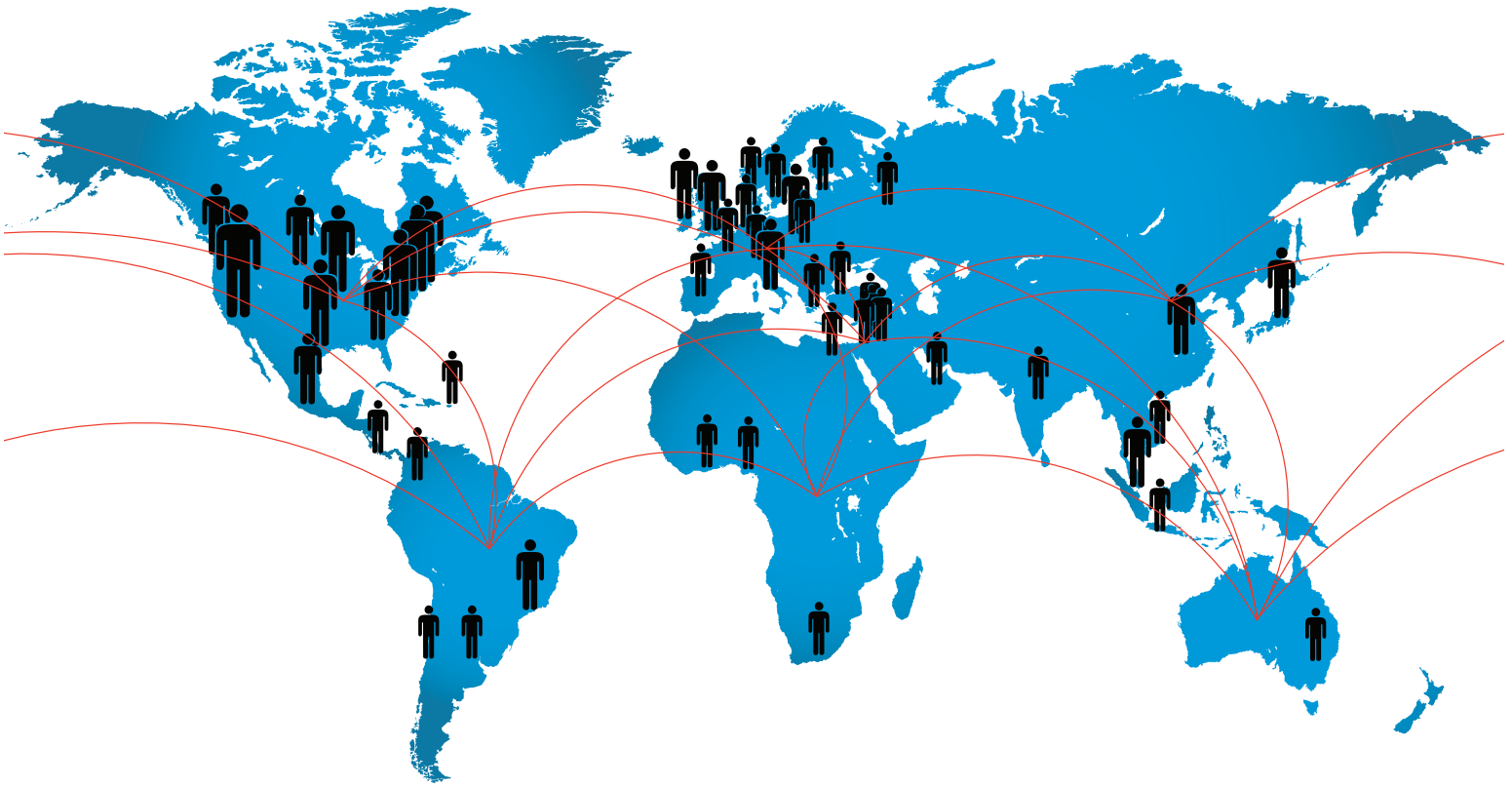

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Rebooting Basic Healthcare in Brazil: Thinking Outside the System

Thomaz Srougi

Class 17

> The right to protect the health and wellbeing of every person—of those we love—is a basic human right, a right defined in the United Nations Universal Declarationon on Human Rights. Yet in the United States today, healthcare is the leading cause of bankruptcy, and the lack of it the leading cause of suffering, associated with finding out, too late in the disease progression process, that someone you love, is really, really sick.
>
> -Elizabeth Holmes, Theranos CEO[1]

Federal authorities in Brazil have done wonders with health care for the Brazilian population. Infant mortality in the year I was born, 1975, was 90 per every 1,000 births—dropped down to 12 in 2013. Life expectancy increased from 61 to 74 years during the same period. In the last few years, medication for chronic conditions has become widely available, thanks to subsidies provided by the government.[2]

Nonetheless, a poll released in March 2014 disclosed that more than 50% of all Brazilians classify healthcare as the main problem of Brazilians (followed by safety issues at 18%, corruption at 10%, and access to education at 9%).[3] Asked what they think of healthcare services in the country, 7 out of 10 Brazilians say that health services are bad or very bad.[4] Two frequent complaints are that doctors have a low level of commitment and that there are long waiting times for medical appointments.[5] The government's ambitious goal to offer universal (qualified and free) healthcare to all citizens, a constitutional right since 1988, has not materialized.

There is still a huge access gap in Brazil for basic and more complex health services, and when there is access, it is both limited and of poor quality. We at dr.consulta estimate that Brazil has an annual deficit of approximately 800 million medical visits. Uninsured individuals demand 1.3 billion medical appointments in the public system per year, yet there are only 500 million available. This gap is only growing.

Lack of investment, poor management, and poor planning are the main causes for this

[1] Elizabeth Holmes, "Elizabeth Holmes, Theranos CEO" (video), TEDMED 2014, uploaded 12 September 2014, 0:41, https://www.youtube.com/watch?v=ho8geEtCYjw&feature=youtu.be.

[2] Statistics gathered from various sections of The World Bank's online database, http://data.worldbank.org/country/brazil.

[3] Marcelo Leite, "Datafolha aponta saúde como principal problema dos brasileiros," *Folha de São Paulo*, 29 March 2014, para. 3, http://www1.folha.uol.com.br/seminariosfolha/2014/03/1432478-datafolha-aponta-saude-como-principal-problema-dos-brasileiros.shtml.

[4] Ibid., para. 4.

[5] Ibid., para. 9.

systemic failure to meet Brazilians' healthcare needs. (Total healthcare expenditure in Brazil is $1,000 per capita, compared to $1,110 in Chile, $2,200 in Israel, $4,700 in Germany, and $6,300 in Denmark.[6]) The result is increased sickness, prolonged suffering, and unnecessary death.

These outcomes are unacceptable.

The Search for a Better Way

I believe the solution to these challenges lies within each individual. Brazilians want to take care of themselves and their families, but 80% of our 200 million people lack the means to do so.

From a different perspective, I also have a deep awareness of how arduous life has been for local doctors in the last 40 years. My father is a urologist surgeon, and I barely saw him growing up because he worked very hard just to get us through each month. He is not alone—many physicians and surgeons barely make it through the month financially, despite their hard work. In addition, there are constraints upon doctors obligating them to work under very specific guidelines—aimed at saving money, not necessarily at saving or improving patient outcomes. They also must often work without adequate resources and equipment.

I believe doctors should be allowed to perform medicine in all its fullness and meaning. In other words, they should have the freedom to practice without such constraints, and they deserve the chance to progress technically (and not be ashamed of progressing economically). I also believe Brazilians deserve preventive health care and top-quality health care, as do all human beings.

In 2011, I began my search for a better way. The resulting enterprise, dr.consulta, has provided health care to more than 100,000 uninsured families since that date. Our service is agile, high-quality, humane, and affordable. Our timeline from appointment request to appointment, diagnosis, and treatment plan is only two weeks—25x faster than the public system, and for 10% of the average price of private healthcare services. We currently have 190 physicians in more than 30 medical specialties, with very low turnover.

Our goal at dr.consulta is to empower all Brazilians by placing outpatient clinics close to each and every citizen, and equipping those clinics to provide primary and secondary health care at extremely low prices. This is a very big mission and a very big goal. In this article, I share the journey of how dr.consulta was born and how we are finding our way to a complementary and successful healthcare model.

The Beginning: An "A-ha" Moment

During graduate school at the University of Chicago, I read a quote posted on a cafeteria wall, attributed to Sarah Bernhardt: "Life begets life, energy creates energy. It is by spending oneself that one becomes rich." These words capture, very elegantly, my deepest and most vehement belief—and reading them changed my life. I began to ask, "How am I spending myself?"

Many years before that day, I had begun my career in banking, moved to corporate finance, and then private equity and venture capital. I had the privilege to become a partner and work with a very special group of seasoned business operators, from Ambev/AB-Inbev,[7] a brewery company in São Paulo.

Working in that environment, I realized that wealth is created by corporations, and ultimately by well-designed and well-run processes and motivated, talented people surpassing their own goals. At Ambev, we hit more than missed. Despite this success, I knew I was not "spending myself" anymore, and that unpleasant awareness became a constant feeling.

Problems in Brazil seem to flourish from the ground; we say they are "as certain as death and taxes." I started talking to people I trusted, including my partners, sharing and learning. I wanted to build something, with

[6] The World Bank, *Health Expenditure per Capita (Current US$)* (2015), http://data.worldbank.org/indicator/SH.XPD.PCAP.

[7] http://www.reuters.com/finance/stocks/overview?symbol=BUD.

great people alongside, that would add value to others, improve our surroundings, and do well if we succeeded.

One day I read that education, infrastructure, and health care were the largest problems in the country. I thought about health care as a leading cause of suffering in Brazil, and the preventable harm of knowing too late that someone you care for is really sick, or dying (in the words of Elizabeth Holmes[8]). Problems are caused by lack of access to information and services, I knew. Coming from a family of urologists, I knew too much about doctors and their unique ways of understanding the world and the problems of life and death.

In November 2010 I was in Cambridge at Harvard Business School attending my alumni reunion, sitting in a class given by Professor Michael Chu (Mentor, Class 15). He was talking about "base of the pyramid" high-impact business models in Mexico. I got really excited. Then he started discussing a successful drugstore chain in Mexico that also offered medical visits at extremely low prices for low-income families.

"F***, that's it!" I thought. After a few seconds I realized I had inadvertently said that out loud, and the person right next to me moved away slightly, as though about to switch seats. (That also happened when I met my wife Karin, but that's another story.) My "a-ha" moments are almost always embarrassing.

I rushed after Professor Chu down the hallway, through the underground tunnels below the school, to learn more. I had many questions. He gave me insights then, and shared his thoughts a few times later when I updated him on my progress. In that class, dr.consulta was conceptualized, and four months later I opened the first clinic.

The Leap of Faith

Back in the country of many problems, I realized I faced many challenges in getting my idea off the ground. I was working alone. I was new to health care, and so, largely ignorant. Those I spoke to were resistant, I found. How could a layperson and not a doctor solve the healthcare problem? Many had tried before, they said, and crashed. Physicians told me I was not going to succeed because "the system did not work as I envisioned."

Thanks to my stubbornness, I simply ignored those kind people and pretended I never had those conversations. "Doctors are so risk-averse," I remember thinking.

I also encountered constraints in the legislation. It is illegal to sell medicine in the same place physicians attend patients, so I could not simply copy the Mexican model (I always believed that well copied is half done). I had to make a decision: launch the six-thousandth low-margin and low-impact drugstore in the country, or risk launching the first outpatient clinic chain in the country targeting the underserved—without having a clue how to do it. The potential profit in a drugstore was marginal to none, and my choice was clear.

I was running against time and had to quickly launch a solution for one of the largest social challenges in Brazil. I went out to find the resources I did not have, mainly knowledge, skills, money, people, and most importantly—information.

From Concept to Execution

I wrote to the management of the Mexican chain, Farmacias Similares. Unfortunately, they were too busy to receive me—but I went to Mexico City anyway. I visited their locations, talked to physicians and sales reps, and did the same with their competitors. Looking back, it was far better than hearing pre-fabricated management speeches.

Excited by what I had seen and learned, I called my partners and a few other individuals whom I trusted a lot. I told them all the same thing:

> There is very large social problem to be solved here. Besides impacting people for the better and being a huge market, I think dr.consulta has the potential to be replicable, scalable, and

[8] Elizabeth Holmes, video, 1:25.

Figure 1. Action Plan for dr.consulta. Author's figure.

> profitable. With our know-how and expertise, I think we have a chance. We will probably fail. But I want to try making a series of experiments and evolve gradually. If we validate our hypothesis, we might be in business. These are the phases I want to go through: launch two clinics, validate the concept, validate the demand, validate the business model, and finally, expand [see figure 1].

They all said they would support me—we were in business.

Looking back now, I guess this spiel was the right approach for everybody—myself and my supporters. When one shows fragility, others may want to help. When one says there is a good chance of failing, expectations remain low. When one has a vision and communicates it reasonably, it helps others to align their efforts. All of this together with an immense market and a strong social cause—it was a solid combination.

dr.consulta became the byproduct of two very different DNAs. We combined the best available managerial expertise in processes and people, from seasoned business operators, with the best available medical care from physicians from University of São Paulo Medical School, the top school in the country.

Phase 1: Launch Two Clinics

I didn't spend time on spreadsheets, but rather in putting two clinics to work. Having ranked all 95 districts in São Paulo by per capita income and demographic density, I spent the next 12 weeks using the subway system to get to those locations. I shopped and ate to absorb the atmosphere for each target area. I walked around in search of houses for rent, talked to people, and visited local public healthcare centers and hospitals to talk to patients and physicians.

After three months, in March 2011, our first experiment got underway (figure 2). I opened the first 90 m^2 clinic with three medical rooms, offering medical visits with general practitioners only. It was located close to 300,000 uninsured, low-income citizens in the São Matheus neighborhood.

I needed another clinic to benchmark results, so in July 2011 we opened a second clinic (figure 3) in the largest favela of São Paulo:

Clinics	1
Physicians	3
Medical Specialties	1
Support Staff	6
Annual Visits Growth Rate	N/A
Annual Visits Capacity	120,750
Services	Medical Visits

Figure 2: dr.consulta Status in March 2011. Author's figure.

Clinics	2
Physicians	6
Medical Specialties	1
Support Staff	10
Annual Visits Growth Rate	N/A
Annual Visits Capacity	241,500
Services	Medical Visits

Figure 3: dr.consulta Status in July 2011. Author's figure.

Heliópolis. This 400 m^2 clinic had 14 exam rooms, and space to offer additional services such as lab work and imaging exams.

We had a blast when the clinics were finally opened. There was a 4-meter-wide, blue dr.consulta logo on the front wall of each location, with a smaller sign reading "medical appointments and exams" in gray letters underneath. Each clinic's interior was well illuminated, simple but functional with light gray and light blue decor. A TV on the waiting room wall displayed health tips on the diseases most common for that specific area and population profile. The whole experience was much different from what uninsured patients were used to in the public system.

Our system had each patient passing through four service stages: the reception and payment area, the pre-appointment area where a nurse entered basic health information into the digital system, the medical rooms, and a post-appointment area where patients could book any exams or tests prescribed by the physician. From day 1, we used an electronic medical records (EMR) system because we wanted to record all available demographic and medical data, as well as monitor how long each service stage took for each patient.

As rewarding as it was to be all set up, though, we needed to start working for real.

Phase 2: Validate the Concept (March 2011 to January 2012)

From Data to Information and Knowledge

The public health system was poorly rated, but we needed to be more specific about what was not working for the majority of uninsured patients. We hired an institute to talk to a sample of our target patient profile, to gather their views on the do's and don'ts of a primary care clinic. It was money well spent. In two weeks, we had our value proposition for the patient—dr.consulta would offer fast, resolute, reliable, qualified, humane, and very affordable healthcare services.

Our pricing strategy was plain and simple: be the lowest in the market. I did all sorts of calculations as well as qualitative research, all to benchmark our intuition that a medical visit should cost $30 for the patient. We cut a deal with a major credit card to offer payment in up to 10 installments. We had a potentially powerful engine to guarantee that almost any Brazilian could have access to the best available basic health care.

We had a plan. Now we needed a team of physicians and clinic staff to execute it.

Our first doctor invited 30 of his colleagues from University of São Paulo Medical School to get together for pizza. I had a PowerPoint deck and pitched them the dream, the goal, and the impact we could make together. Five of them liked it and joined us.

Things began to snowball. We also needed nurses, but through those six doctors, we now had good leverage. We hired six nurses in total, and were ready to start working.

It was a thrill to watch doctors come in and prepare for attending patients. People passed by the clinic, stopped, walked in, and—with suspicion—asked for information; they left with a flyer and our appointment telephone number. There was no formal training for doctors or staff, for we did not know what to be trained in. We were that different.

We began very slowly, and as we serviced our first patients, we adapted (figure 4). By January 2012, we had performed 577 medical visits with high patient satisfaction, and I noted that patients were beginning to return with their relatives.

Information Technology to Validate the Concept

My goal was to channel all resources into developing, implementing, and validating a value proposition—by providing a rudimentary service, smartly collecting data, and analyzing it to continue to evolve. I did not spend time and resources building controls or improving governance, because

Clinics	1
Physicians	15
Medical Specialties	6
Support Staff	10
Annual Visits Growth Rate	N/A
Annual Visits Capacity	120,750
Services	Medical Visits, Lab

Figure 4: dr.consulta Status in January 2012.
Author's figure.

we did not have anything to be controlled yet.

At this stage, our IT infrastructure was rudimentary. I acquired an artless Electronic Medical Records (EMR) system, but we also used Excel a lot for data collection. Every day I received the main spreadsheet by email and could calculate all sorts of operating and financial ratios. I did not have any means to control our service's medical quality, except that our doctors were recruited from the best medical schools. I had to rely on that.

Phase 3: Validate the Demand (January to August 2012)

The Omission that Nearly Killed dr.consulta

A year later, I felt bothered about the first clinic, the smaller one. It had no traction; most of our patients were coming from the larger clinic. So, I decided to close the original, smaller clinic. The two-clinic experiment had demonstrated that the general practitioner-only clinic was not of sufficient value for our patients. Nonetheless, we were very excited with the results and performance of the larger clinic at favela de Heliópolis. This larger clinic became our flagship.

We knew we had a very powerful service that solved a very large problem, and patients loved us. From that point on, my new goal was to validate whether we could offer our solution to a large number of patients, as well as to verify that the number of people without access was indeed huge.

Six months later, in July 2012, after intense months of hard work inside the largest favela of São Paulo, everything seemed stalled. Sales were not increasing as quickly as I had hoped: steadily, but only 5% per month. That figure would be high for many other countries and industries, but given our small starting number, it was a problem.

We were far from breaking even and still operating at only 3% of our capacity. Doctors were starting to doubt the dream was achievable, and every week I had to talk to one of them personally. I was almost begging them to trust us and stay, trying to bring reason to our performance somehow. It was killing me.

dr.consulta was not ramping up, and I was totally burned out.

I don't see a problem in shutting down an operation or giving up an idea, as long as there is truly no future in it. Letting go allows us to move on to other things, and stop wasting time on what's not working. So, at our next board meeting in June 2012, I told my partners:

> I am going to begin this meeting. By the end, I will recommend that we try to sell or shut down dr.consulta, and I will explain why.

I presented my arguments and they all supported me. I remembered feeling relieved, but deep inside I was sad. I knew the problem we were after was huge and we had a positive value proposition in hand—something was not right.

The next step would be to try to sell the one remaining clinic or close it—I thought. To announce the sale, I called a journalist who was fond of us and she published a note in the *Jornal Folha de São Paulo*, one of the largest in the country, about dr.consulta's mission and expansion plans.[9]

Two days later, my phone rang. To my surprise it was another journalist from

[9] Maria Cristina Frias, "Vivo vai investir em televisão até final deste ano," *Folha de S.Paulo*, 1 July 2012, "Clinica na Favela," http://www1.folha.uol.com.br/fsp/mercado/52029-mercado-aberto.shtml.

the largest business journal in São Paulo, *O Estado de São Paulo*. She had read the note and wanted to write a full article about us. My partners and advisors discouraged me, arguing that it was too much personal exposure. Yet I decided to do it anyway, as it felt like a good deal for the company.

The full-page article[10] was published in the last week of July 2012. In the next month, our demand more than tripled!

Unbeknownst to us, we had been operating a secret clinic. After conducting a survey, we learned that only 5% of our surrounding neighborhood knew of us, and half of those thought we were an insurance plan. We had a communication-awareness problem.

How could I have ignored marketing? Naively, I had thought since the access problem was huge, patients would flow in without marketing. So, there I was on the phone calling my board, explaining the "roller coaster" we were on and recommending we give it another try. We were back in business (figure 5).

From January to August 2012 we performed 2,200 medical visits.

Clinics	1
Physicians	20
Medical Specialties	10
Support Staff	15
Annual Visits Growth Rate	700%
Annual Visits Capacity	120,750
Services	Medical Visits, Lab, Imaging, Ultrasound

Figure 5: dr.consulta Status in August 2012.
Author's figure.

[10] Ocimara Balmant, "Médicos do Sírio e do Einstein abrem clínica particular em Heliópolis," *Estadão*, 22 July 2012, http://www.estadao.com.br/noticias/geral,medicos-do-sirio-e-do-einstein-abrem-clinica-particular-em-heliopolis,903810.

Information Technology to Validate Demand

Our focus was outside the clinic. I wanted to generate as many trials as possible, and our call center was the doorway to dr.consulta. The system we used was licensed, and while there were good solutions in the market, we improved financials by internalizing—slashing call center costs by 50%. Because we started offering lab work, imaging exams, and ultrasound, we also started investing more heavily in IT and systems to integrate services and collect and store patient data.

Phase 4: Validate the Business Model (August 2012 to December 2013)

Don't Hire More People—Before that, Rework Processes and Incentives

Next, we polled our patients and identified four main socioeconomic and demographic groups. Based on their particular needs, we created specific messages for each group, which were channeled to them via the most appropriate means for that group.

As demand grew, we began testing our operating system at capacity. New management, medical, and operating problems emerged. A stressed team produced lower quality work. Medical staff relationships deteriorated. Patient no-shows increased relative to booked medical visits. As we got closer to summer, the full waiting room was too hot for comfort and we had no air conditioning. As if all that were not enough, dr.consulta got robbed by a gang. Most of the team felt insecure about working inside the favela. We received a visit from the regulatory health agency, Anvisa, and discovered we were not fully in compliance. We expanded the service area to the second floor to meet the increased demand, which meant the management team had no formal office space. The bulk of our payments (75%) were made in cash—how could we take that money safely to the bank, in the middle of a favela? So many plates in the air, and few hands to keep them there.

One by one, we solved them all. From July to August 2012, we rethought everything from an operational and team perspective. I realized that "management" is solving problems with the least resources possible, with the team, doing what is right.

I renegotiated with suppliers and replaced some, boosted our IT systems, redesigned processes, rewrote reception scripts, produced new training videos, and institutionalized our knowledge in the form of an operations manual.

Above all, I avoided hiring more clinic staff—more people. Nurses and receptionists complained that they were understaffed, but that's the easy answer and usually the wrong one. I advocated more training, better processes to reduce waste, and more IT to leverage our current assets.

Our main challenge became our physician compensation system. We had expected demand to continue to grow at 3x per month, and had hired 30 new physicians to a total of 50. However, we did not achieve that growth rate in the following months and doctors were idle. Our doctors were compensated by the hour, not by productivity—since dr.consulta's brand was not known, I had had to guarantee a minimum for the doctors to attract them. The main weakness of our business model was this high fixed cost.

Clinics	1
Physicians	50
Medical Specialties	12
Support Staff	25
Annual Visits Growth Rate	250%
Annual Visits Capacity	120,750
Services	Medical Visits, Lab, Image, Ultrasound, Micro

Figure 6: dr.consulta Status in December 2013. Author's figure.

It was time to implement a productivity-based compensation system. Despite the workload, the whole team was excited about the patients flowing in and leaving very satisfied. So I had the means to paint a brighter future for our doctors, but at the cost of changing their compensation system. I was in a good position and started renegotiating the compensation model. We only lost 10% of our doctors with what was probably the most important adaptation of our business model.

In healthcare, discussions around productivity and compensation always lead to ethical questions. We learned that we needed to set parameters and monitor them daily. We tracked the average number of lab exams prescribed in our medical appointments. A doctor consistently prescribing more than the high end of that average could indicate an ethical problem (overbilling or inflating), while fewer lab requests indicated a potential problem with diagnostic quality.

We nailed it all without hiring more staff. After important adjustments were deployed, we had more stamina, more alignment, more trust in each other, more confidence in the future, a stronger business model, and a higher quality organization capable of attending more people and better (figure 6).

In January 2013, the clinic broke even—and 95% of patients were "very satisfied" with dr.consulta's service, according to our poll. The business model had been validated, and it was time to start planning for expansion.

We needed more capital, locations, and people in order to tackle the basic healthcare challenge at scale. I started by boosting our IT infrastructure—it was about time.

From August 2012 to December 2013 we performed 20,631 medical visits.

Information Technology to Validate the Business Model

It had become clear that while health care is not an exact science, basic health care almost is—and therefore, we could and should standardize processes at dr.consulta. Physicians and staff were given the freedom to make their own judgment on each case, with medical protocols at their fingertips.

As I envisioned the expansion, I knew IT was going to be its backbone. To assist physicians, promote and protect our service's quality, serve more and better, use cash and other resources more efficiently, and replicate our model—we had to start talking "bits and bytes."

I think we did well. The first in-house tool we developed was a system to confirm medical visits automatically through SMS and phone calls. Patient no-show rates dropped from 35% to 17%. Our second move was to create a dashboard to view real-time medical agenda occupancy rates, which in turn allowed us to reduce patient acquisition cost by 50%.

Phase 5: Expansion (December 2013 to January 2014)

Doors Turned into Tables

After three years to validate the concept, demand, and business model for dr.consulta, it was time to replicate our formula.

I used to consider myself a good investor in my previous life. Having switched sides, it is clear to me that an investor will never reach her full potential if she has never been in the skin of an entrepreneur, or operated a company. It may be no coincidence that all our investors are former entrepreneurs. We just did not get along with local VC funds managed by executives with an exclusively financial background, which are the majority in Brazil.

Since founding dr.consulta I have had the opportunity to talk to many types of investors based in São Paulo: family offices, venture capital funds, impact investing funds, wealthy individuals, and angels. Most came across as very formal and limited in their capacity to add value for our company. For cultural reasons, strong past volatility, and a lack of successful examples, I have a feeling that most VCs in Brazil are still "adapting."

A simple comic story sheds some light on the cultural issue. Until the end of 2013, I was based on the second floor of our first clinic. Our management team of four people had two tables, one shared with the call center team. The tables were actually just doors that we did not need, and adapted into tables. One day, associates from a local VC fund passed by our area and remarked to each other, "No way will their valuation will be xxxxxxx—they don't even have decent tables."

We weren't too poor for furniture; I just prioritized operational improvement. Several weeks later we received some folks from a prestigious U.S. consulting firm along with another group from a top U.S. university. We had a great session together, so I shared the table-door story. To my surprise, one of them commented:

> We had quite a different impression when we saw the tables. Jeff Bezos used to do the same, in the early days of Amazon.

Certainly, venture capital in Brazil is still a scarce resource. Many cite the lack of good projects, and while that is certainly true, I believe that most local investors have a very hard time separating lemons from peaches, or even understanding what venture capital is all about.

In Q3 2013 we raised a Series A from local former entrepreneurs, and during Q1 2014 we raised a Series B from two international VCs. (The GPs were former entrepreneurs, and their LPs were mainly entrepreneurs as well.)

Thanks to invaluable insights, pitch revisions, and words of wisdom from Kauffman Fellows

Clinics	5
Physicians	150
Medical Specialties	30
Support Staff	120
Annual Visits Growth Rate	129%
Annual Visits Capacity	603,750
Services	Medical Visits, Lab, Image, Ultrasound, Micro, Low-Complexity Surgery

Figure 7: dr.consulta Status in December 2014. Author's figure.

Matt Mochary and Phil Wickham, we got fully funded to open 20 clinics. We are ready to replicate the dr.consulta model throughout São Paulo.

During 2014, we performed 45,714 medical visits, plus another 84,286 lab tests, imaging exams, and low-complexity procedures.

Information Technology: Expansion

As of January 2015, we have 5 clinics, 150 physicians, 30 medical specialties, and 120 support staff (figure 7). Each clinic delivers 8,000 medical visits per month, for a total capacity of 44,000 per month—0.07% of the annual deficit we estimate for Brazil.

The uniqueness of our processes and culture posed an IT challenge larger than we had anticipated. The current IT systems available in Brazil are of no use to us, and even in the United States we have not found useful tools. We need tailored IT solutions to enable doctors, nurses, and managers to access real-time data and to facilitate any flow of information with the patient.

So, we have developed our own internal systems. We created the first fully automated online booking system in Brazil, to bring patients to us faster (how come something so simple has never been done before locally?), another fully automated system that allows patients to evaluate the quality of our medical and staffing service through a quantitative SMS grading system, a system for our chief physicians to have real-time access to their teams' productivity and quality grades, and one for the management team to have real-time information on financial and operational KPIs (key performance indicators). The only thing we were able to purchase is our new Enterprise Resource Planning (ERP) system, which we licensed from a large U.S. software company.

Looking ahead, I see us diving into big data and mobile in order to relate more and better with our current patients. I still cannot figure out how wearable technology will work financially for our patients, which makes me a bit anxious because that technology has tremendous potential to add more dignity and quality to their lives. Telemedicine is another great tool. It is still illegal in Brazil to perform medical visits using telemedicine, and the practical constraints are considerable, but I still believe it will become a relevant tool to bring high quality care to remote areas as well as to economically challenged urban areas.

The Future of dr.consulta

Four years ago, we began by testing a model for its capacity to generate impact in a huge market, and to be replicable, scalable, and profitable. The odds were against us, and yet today we have all these elements aligned.

Three hundred or more clinics in Brazil once seemed a distant dream. As more people shared it with me, however, it has become a vision on the visible horizon (figure 8). If we get there, we will perform 30 million medical visits per year, contributing to reduce the current access gap by almost 5% per year. That is something!

We are here to improve the quality of life for and to save the lives of a destitute majority.

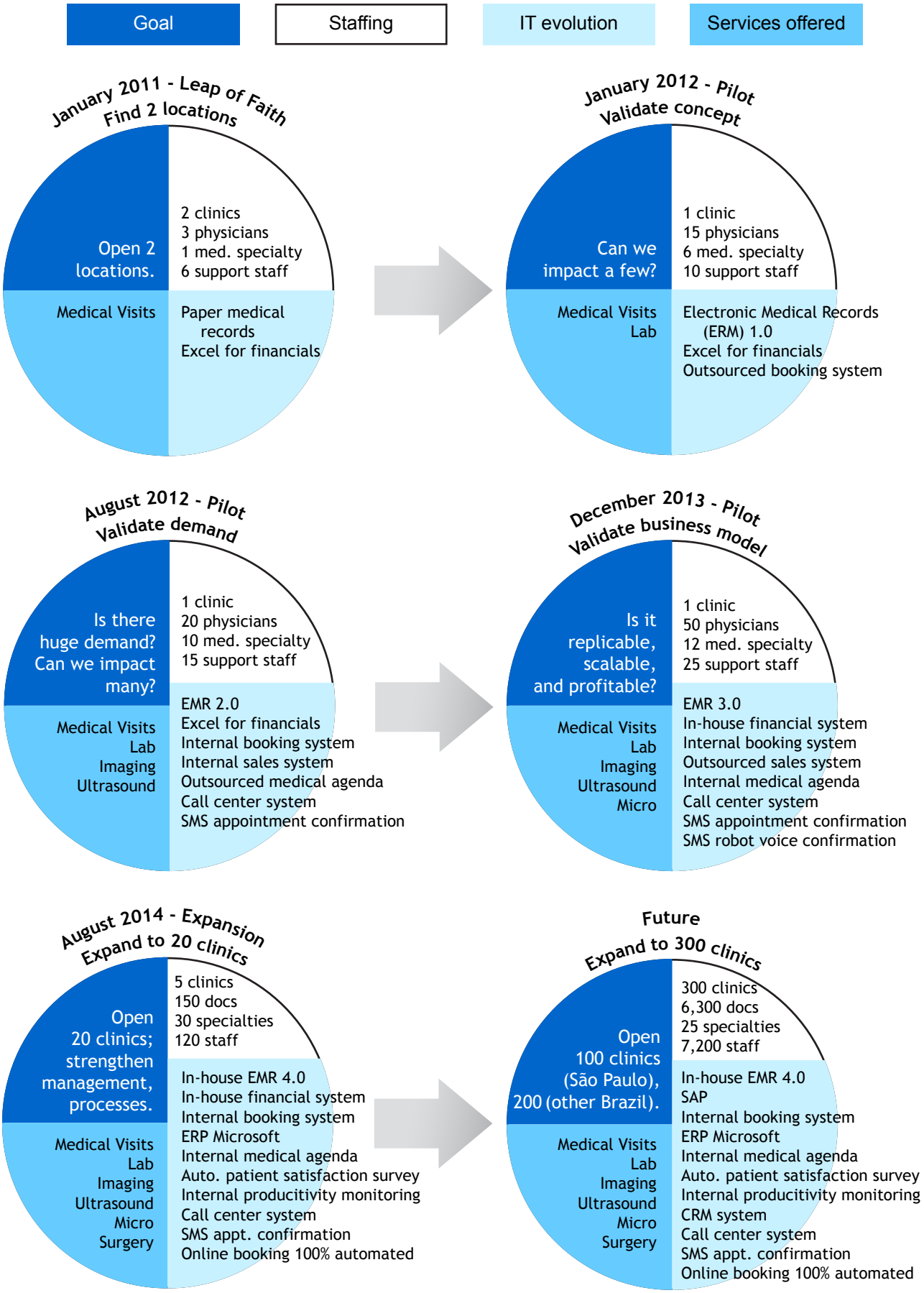

Figure 8. The Evolution of dr. consulta. Author's figure.

We are a vehicle for patients to meet doctors and take care of their health. However, we are no charity—we are pragmatic.

Population aging, the increase in chronic diseases, and low insurance plan penetration are the main drivers for increasing demand for our services. Our experience in the basic healthcare non-emergency market of outpatient clinics has shown us that demand is inelastic. If real income increases, more people will be able to access our affordable services. If unemployment rises, on the other hand, more people will lose their insurance plans and return to the public system—yet now they have a superior alternative.

In all, there are solid external perspectives and opportunities ahead of us. However, we have to keep up with our key internal challenges: people, IT, and cash flow. We will be as good as the people we have on board, including physicians and clinical staff, management, and partners and board members. It is all about people and processes, while IT will continue to play a central part on our journey, helping us leverage our assets. I believe that if we manage to keep on track, we will continue to attract smart capital to fund our vision to reboot basic health care in Brazil.

Thomaz Srougi

Thomaz is Founder and CEO of dr.consulta. Previously in Brazil, he co-founded the investment company Galicia with former Ambev senior partners. Prior to that, he launched a search fund that acquired and successfully led low-income homebuilder Tenda to IPO (TEND3.SA), and worked as a manager for Ambev (AB-Inbev). Thomaz holds a BA in business, an MBA, and an MPP from the University of Chicago, as well as a GMP from Harvard Business School. Kauffman Fellow Class 17.
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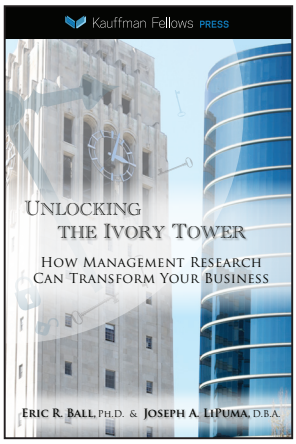

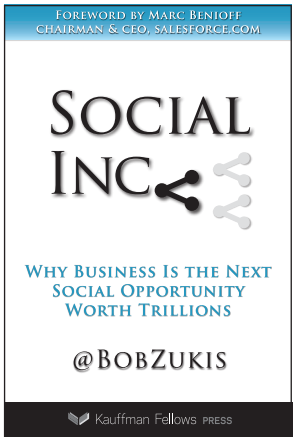

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