Second District Supervisor Mark Ridley-Thomas & Los Angeles County Perinatal Mental Health Task Force,

A Project of Community Partners,

Invite You to

A Community Awareness Forum on

Maternal Depression

Wednesday, May 30, 2012
from 12-2 pm
at the Expo Center

Exposition Park
Administrative Offices East
700 Exposition Park Drive
Los Angeles , CA 90037

The forum will examine maternal depression and the need for all communities and sectors to address this important public health issue. Included will be a discussion of the signs and symptoms of Maternal Depression, its impact on families and communities, and ways to gather support and resources.

Speakers include:
Carla Velasco, PPD Survivor
Deborah Johnson Hayes, PsyD.
Carol Berkowitz, M.D.
Yolanda Becerra-Jones, President Of The LA County Commission For Women
Kimberly Wong, Esq. and PPD Survivor
Ellie Berkowitz Handler, Ph.D. and PPD Survivor

Refreshments will be served
Please RSVP to 323.315.0372 or info@maternalmentalhealthla.org
1 hour CME/CEUs provided (pending)

In Support of the Equal Rights Amendment

Date Submitted:	5/8/03
Resolution Author(s):	Dr. Eva Marie Mika, Cook County Commission on Women's Issues
Problem Statement:	The Equal Rights Amendment to the US Constitution has yet to be adopted.
Justification for NACW:	The NACW exists to work toward equality and justice for women. The Equal Rights Amendment is necessary to have a clear constitutional guarantee that sex will be considered a distinct classification, entitled to the same strict scrutiny courts reserve for race, religion, and origin.
Action(s) Recommended:	NACW urges any states that have not already done so, including the states of Illinois, Missouri, Florida, Oklahoma, and Virginia, to ratify the ERA so that it can be added to the US Constitution.

Whereas: Women were not included when the US Constitution and Bill of Rights were originally written in the 18th century.

Whereas: The 14th Amendment guarantees "equal protection" under the law, but was not intended by Congress when passed, nor interpreted consistently by the US Supreme Court, to include women.

Whereas: While great strides toward equality for women have been made in the last century, women are still not included in the US Constitution.

Whereas: Without a federal Equal Rights Amendment (ERA), women will be forced to continually monitor actions at town council meetings, sessions of state legislatures and the US Congress where a simple majority vote can overturn past won equalities for women or establish new injustices against women.

Whereas: The ERA was passed on March 22, 1972 by the required two-thirds vote of the House and Senate, and was then sent to the States for the stipulated ratification by three-fourths of the States.

Whereas: Only 35 of the required 38 states completed their ratification process within the Congressionally prescribed ratification time period.

Whereas: The 1992 ratification of the Madison Amendment, written by James Madison in 1789, established precedent for a longer ratification process for the ERA than originally prescribed.

Whereas: There is a renewed effort to get states that have not ratified the ERA to ratify the ERA.

Whereas: These states include Illinois, Missouri, Florida, Oklahoma, and Virginia.

Whereas: The NACW, as a nonpartisan membership organization of regional, county, and local Commissions urges state legislatures that have not already done so, to ratify the ERA.

Therefore, be it Resolved: that the NACW urges the members of the state legislatures who have not ratified the ERA, to ratify the ERA so that the women and girls in the US will have constitutionally-based equal protection under the law.

Further Resolved: that suitable copies of this resolution be transmitted to the President of the US, and each member of the US Congress, as well as the governors and legislative leaders of those states which have not ratified the ERA.

RENEW Los Angeles and the County of Los Angeles Commission for Women
Final Report

The County of Los Angeles Department of Public Health received a two year grant from the CDC through CPPW funding to address the obesity epidemic. This grant was called RENEW (Renew Environments for Nutrition, Exercise, and Wellness) Los Angeles County and the grant was intended to focus on environmental and policy change. There were several strategies funded under this grant including adopting vending machine policies, joint use policies and breastfeeding policies. The Los Angeles County Commission for Women worked closely with RENEW and the Breastfeeding Task Force of Greater Los Angeles to achieve the objectives related to breastfeeding. The Commission for Women opened up several doors which allowed RENEW to make significant progress with our goals and objectives. Below is a summary of the objectives and the progress that was made with the Commission's assistance.

Baby-Friendly Hospital Initiative

OBJECTIVE

Adopt and implement policies to support breastfeeding in three County hospitals.

RENEW LA and the Breastfeeding Task Force of Greater Los Angeles (BTFGLA) worked with the 3 County birthing hospitals to provide technical support, program management and team building activities to the maternity care staff to enhance the efforts already in place around the Baby-Friendly Hospital Initiative. These activities helped these hospitals focus on the final goal of becoming designated as a Baby-Friendly hospital. All three hospitals have been surveyed by Baby-Friendly USA. Olive-View was designated in June 2011. Harbor–UCLA and LAC+USC are pending designation.

WINS

- Olive View-UCLA Medical Center - designated 6/11
- Harbor-UCLA Medical Center - pending
- LAC+USC Medical Center - pending

At Harbor-UCLA, through the assistance of the Commission for Women we were able to schedule an appointment to meet with the new CEO, Delvecchio Finley, to discuss the Baby-Friendly initiative and gain his support for purchasing formula at his hospital. As of Nov 9, both Harbor-UCLA and LAC+USC are purchasing formula. The on-site Baby-Friendly assessment at Harbor was on February 13 and 14 and at LAC+USC on February 15 and 16. Mr. Finley was actively involved in our Baby-Friendly committee and in assuring that we were prepared for our assessment.

Workplace Lactation Accommodations

OBJECTIVE

Work with eight county departments, and two large employers to implement workplace lactation accommodation policies.

RENEW LA and BTFGLA worked closely with key players from the County of Los Angeles, City of Los Angeles and Kaiser to assist in adoption and implementation of workplace lactation

accommodation policies. Technical assistance consisted of help with drafting the policy, creation of web materials, breakroom poster, informational brochure for employees, training curriculum for HR and the development of the discount pump program at Kaiser.

WINS

- County of Los Angeles - Policy adopted 9/11 Revised version of policy anticipated to be adopted 3/12
- City of Los Angeles - Policy adopted 11/11
- Kaiser - Policy anticipated to be adopted 2/12

County of Los Angeles, Work-site Lactation Accommodation Program

We have made significant progress with the County of Los Angeles Lactation Accommodation Policy - PPG 705. Through the Commission for Women, we were able to schedule an appointment with the Director of Human Resources, Lisa Garrett. At that meeting, we were assigned to work with Linda Hopkins who helped to convene a workgroup to address this topic. On Oct 13, 2011, we met with Department of Human Resources, CEO and County Counsel to discuss the policy and implementation. It was concluded that the policy that was adopted in September of 2011 needed to be revised to be compliant with state and federal laws even though it had already been adopted and disseminated. RENEW provided revised language for this policy. A point person, Merce Gillo from the Department of Human Resources was designated to be in charge of the Lactation Program for the County. The Return-to-Work Coordinator in each department was designated as the person responsible for working with Supervisors to ensure that all mothers are accommodated.

- Oct 24, Oct 26, and Nov 1 - RENEW Provided a 15 minute training to approx 500 FMLA coordinators throughout the County on the basics of the policy and the resources that will soon be available. Once the policy is finalized and all implementation materials are completed and approved, an extensive training will be provided to a representative designated from each Department.

- Oct 27 - Provided a 15 minute training to approximately 70 Departmental Human Resource Managers on the basics of the policy and the resources that will soon be available.

- Oct 26 - We met with the website designer for DHR to map out what will be posted on the designated Lactation Accommodation Program webpage. This webpage will be housed on the County's website at dhr.lacounty.info, under Employee Benefits.

These are the items that will be on the page:

- Lactation Policy
- Brochure - Created by RENEW
- Powerpoint for supervisors with user notes

- Handout entitled “Preparing for Baby: How to maximize your benefits - Created by RENEW
- Breakroom poster - Created by RENEW

The resources section of the page will include:

- LA County Childcare
- MCAH
- EAP
- Choose Health LA
- Breastfeeding Task Force
- Womanshealth.gov
- WIC

RENEW is in the process of finalizing the above items.

We will also be posting a list of lactation room locations on the County intranet.

- On Oct 26, we also met with Victoria Pipkin-Lane, Director of Office of Workplace Programs to discuss creating a discount pump program for employees. Without a good pump, employees cannot successfully continue to pump long-term. By providing pumps at a discounted rate, more employees might be able to afford the high cost. Victoria seemed interested in the idea and asked RENEW to provide birth rate information for County employees to see how many people this program might potentially impact.

- We are hopeful that the revised policy will be adopted in March 2012 and that all materials will be posted on the DHR website by March as well.

- On January 18, 2012, we will be training Return-to-Work Coordinators at the Return-to-Work symposium about the policy and the procedure for accommodating mothers who desire to pump at work.

- On March 6, 2012, we will be hosting a train-the-trainer training for HR representatives from each department to train them how to manage lactation accommodation requests.

The Commission for Women has greatly assisted with the work on this grant. Their involvement will affect the decision to breastfeed for many women here in Los Angeles County.

This project was made possible by funding from the Centers for Disease Control and Prevention through the Los Angeles County Department of Public Health.

President's Activities for February and March 2012

Continued to Work on implementing the RENEW Lactation Accommodation policy and training for Los Angeles County Departments

Met with Dr. Antronette Yancey, Professor, Public Health, UCLA to discuss the Los Angeles County's Physical Activity Program and Nutrition Policy.

Advisor to the leadership of the Lennox Arts & Culture Committee's in District 2, attend monthly meeting

Attended "A Conversation with Los Angeles About Education" with Michelle Rhee the founder and CEO of Students First, a movement to transform public education. Kevin Johnson, Chair, California Mayors Education Roundtable and John Easy, LAUSD, Superintendent participated in the program. Event was hosted by Robert F. Kennedy School, formerly the Coconut Grove. RFK is a complex of six schools. School of Global Education, Ambassador school of Global Leadership, High School of the Arts,; New Open World Academy, UCLA/CS for the Visual Arts and Humanities,

Meeting with American Diabetes Association Board Member to discuss Diabetes issues in Los Angeles County

Attended lecture at the USC Roybal Institute on Aging given by Henry Cisneros, the former Secretary of HUD. Laura Trejo, Los Angeles Department of Aging was awarded the Community Partnership award.

Presenter at the Girls and Gangs Youth Achievement Awards

Presenter at the Junior League of Los Angeles's Boards and Commissions Institute meeting. Agreed to mentor a JL member. Met with JL member who is the director of development for LACMA.

Participated in the American Diabetes Association Roundtable. Presenters included: Richard Ross, Dr's Francine and Neal Kaufman, Dr. Fielding and Supervisor Yaroslavsky.

Attended the opening of the Salud Digna Community Clinic in Huntington Park. The clinic is interested in promoting bone health for women. They offer low-cost bone density screenings.

Meeting with Kaiser representative to discuss their support for the LACCW scholarship orientation program, the Lennox school district and the Girls and Gangs program.

Worked to secure sponsors and incentive items for the Woman of the Years luncheon, including L.A. Care; also assisted with program and emcee.

SaludDigna

La salud es para todos

In **2010 Salud Digna** helped **1.045.714** people with diagnostic services and glasses promoting timely prevention and detection of diseases.

SaludDigna

La salud es para todos

Mission:

Contribute through partnership with doctors, health professionals, employees and volunteers, to help people achieve a higher quality of life through the prevention and early detection of illnesses, offering our community diagnostic studies of the best quality at a very low price, being self sustainable in our operation

Vision:

Being a transparent institution with the highest standards of quality and efficiency, bringing the social model of Salud Digna to the maximum number of people in the world.

Values and Guidelines:

- Quality and kindness.
- Dignity and respect.
- Honesty and transparency.
- Co-responsibility and humbleness.

HARVARD | BUSINESS | SCHOOL

-

AUGUST 26, 2010

ALLEN GROSSMAN

REGINA GARCÍA CUÉLLAR

Salud Digna: Dignified health for everyone

"Don't tell me why not, tell me how"

— Jesus Vizcarra, Salud Digna's founder

Hugo Moreno, Salud Digna's CEO, was considering the organization's growth strategy for the next three to five years. The nongovernmental organization (NGO) provided diagnostic medical testing to the poor for illnesses, including diabetes and common forms of cancer (breast, cervical, uterine, prostate, and colon). Salud Digna was founded in 2003 in the northern Mexican city of Culiacan in the state of Sinaloa (see **Exhibits 1 and 2** for map and macroeconomic data on Mexico).

The objective of Salud Digna was to improve the quality of life for Mexico's low-income population through the prevention and early detection of illnesses. For the most part, the organization's target clients had no access or inefficient access to the types of services provided by Salud Digna. The organization's ultimate goal was to create a widespread culture of preventive health care in Mexico.

Salud Digna[1] charged a fee for all of its services, which was, on average, less than a third of that charged by private clinics. Fees accounted for 98% of Salud Digna's revenue, with only 2% of revenues coming from philanthropy. Since 2007, the organization's operations were financially self-sustaining, and since 2008, Salud Digna had opened new clinics almost exclusively using internally generated resources. (see **Exhibits 3 and 4** for the consolidated balance sheet and income statement).

In 2009, Salud Digna served 756,000 patients and performed 1.5 million diagnostic procedures. By 2010, Salud Digna had grown to 14 clinics serving 2,500 people per day in 12 cities. The target for 2010 was to serve one million patients and perform two million procedures, for 2016, Salud Digna wanted to attend 10 million patients (see **Exhibit 5**). Most of its services were offered in the state of Sinaloa, where Salud Digna had the majority of its clinics. In 2009, Sinaloa had the highest prenatal survival rate in the country. The organization was contributing to those results, having attended to 35,676 pregnant women out of a total of 45,049 births in the state.[2]

While the impact achieved by Salud Digna, in a relatively short amount of time, was meaningful, Moreno wanted to swiftly spread the results achieved in Sinaloa to the rest of the country. The unmet need in Mexico was great and Salud Digna wanted to reach many more people as soon as possible. To realize this objective, they had to rapidly increase the rate at which Salud Digna could open new clinics.

[1] Salud Digna means "dignified health" in Spanish.

[2] www.saluddigna.org and Consejo Nacional de la Población, www.conapo.org.mx.

That would require considerably more resources than the organization had previously been able to generate internally. Moreno pondered his options for scaling the impact of Salud Digna.

Origins of Salud Digna

Jesus Vizcarra, Salud Digna's founder, took over his family's cattle ranch in his native state of Sinaloa and built it into one of the largest meat producers and exporters in Mexico. During this period, Vizcarra also spent time on the social wellbeing of his region. In 1993, he was named patron of Culiacan's Civil Hospital which had a very dubious reputation in terms of the quality of its treatments. Under Vizcarra leadership, the hospital was rapidly transformed into one of the best in Culiacan, improving its morbidity rate to below the national average and raising its occupancy rate from 40 to 70%

This involvement in health-care provided Vizcarra with the insight that illness prevention and the consequent improvement in the population's overall health were key elements in helping low income people improve their quality of life and overcome poverty. He commented:

> My goal is to transform Mexico's current health culture to one of prevention. Mexican citizens, and in particular low-income people, tend to go to the doctor only when they have health problems. At that point, their situation is usually more complicated and it becomes increasingly difficult and expensive to address their needs. This often leads to catastrophic expenses for families, which can push them into extreme poverty. I want low-income Mexicans to have an active preventive care culture to avoid as many of these negative economic situations as possible. The only way to achieve my objective is to provide good quality preventive care at accessible prices.

In 2001, while Vizcarra campaigned for a seat in Congress, he created *Jornadas Medicas* or "medical work-days." Every two weeks he would go from town square to town square with volunteer doctors, using borrowed machines to provide free mammograms, ultrasound and lab work to any Mexican wanting these services. The program delivered approximately 1,000 studies per day. Vizcarra was so impressed with the demand for preventative services that he promised, should he win the seat for congress, to donate his salary to providing similar services to the poor. After being elected, he created his first clinic. Vizcarra commented:

> I called it the office of co-responsibility, because I wanted all of us to share responsibility. I wanted the people to feel responsible for their health, doctors to be responsible for providing high-quality health services, and we, as donors, to feel responsible for sustaining the office. From the beginning, we charged a minimal fee for every service provided. I believe that in order to appreciate a good or service it has to cost something—not much—but something.

The clinic, located on the main level of Vizcarra's office, became the first Salud Digna facility. Vizcarra asked his medical doctor friend, Humberto Gómez Campaña, to lead the new organization. Gómez Campaña remembered:

> I am an ophthalmologist and because of this I influenced Mr. Vizcarra in his choice of services. When we opened Salud Digna, knowing the importance of vision for a person's quality of life, I suggested to Mr. Vizcarra that we put an optical lab within the clinic. We gave eye exams for free, wrote prescriptions for clients and offered glasses at 30% of what patients would have to pay at any other place. The growth in demand was impressive!

In its first month of operation, Salud Digna performed four mammograms, sold 34 pairs of eyeglasses and completed 35 lab studies.

Reaching More Places

In 2005, a second clinic was opened in Mexicali. In 2006, Vizcarra´s son-in-law, Hugo Moreno, decided to open a Salud Digna clinic in Monterrey, the city in which he lived. As a first step, he visited Culiacán to learn about the organization's operations. Vizcarra immedialtely recognized Moreno's potential value to Salud Digna. Moreno's background as a civil engineer, his MBA from IPADE[3], as well as his experience as a commercial director of an investment firm could provide critical skills needed for Salud Digna's successful growth. Vizcarra asked Moreno to stay in Culican and become the general director of the organization. After agreeing to accept the role, Moreno participated in executive education programs in health care and nonprofit management at leading American universities. Nine months after becoming general director, Vizcarra promoted Moreno to CEO of Salud Digna.

Both Vizcarra and Moreno wanted Salud Digna to expand as rapidly as possible. To accomplish this objective, Moreno decided that his first priority would be to professionalize the institution. The systems and structures were basically patched together. Moreno strongly believed that to be effective, Salud Digna needed state of the art systems, including real-time information about every aspect of its operation. Moreno also recognized the need for building a strong management team. His goal was for Salud Digna to operate as effectively and efficiently as any firm in the for-profit sector and defy the often-held stereotype prevailing in Mexico that NGOs cannot be high performing.

In 2007, Salud Digna realized its first annual financial surplus. In 2008, Salud Digna opened the organization's first branches in other Sinaloan cities. In 2009, four additional clinics were added, while increasing the services provided at existing clinics, including pharmacies that sold generic medicines at cost (see **Exhibit 6** and **7**). All of the new locations were funded with resources internally generated from operations.

In early 2010, Salud Digna created an innovative partnership with the Gomez Mont family, friends of Vizcarra, to open its first clinic in Mexico City. The Gomez Mont family donated the capital required to open the clinic. Mariana Gomez Mont was appointed manager of *Mas Salud*[4], the name given to the Mexico City clinic. She commented: "We wanted to do something to help the Mexican population. We had the funds and the will but not the way. Our partnership with Salud Digna was a perfect match."

Mexico City seemed an ideal location for reaching Salud Digna's target population. However, the Mexico City clinic proved to be more of a challenge than expected. Residents of Mexico City had different habits from citizens in other parts of the country. Unlike the residents of Sinaloa, on weekdays people had no time to go to the clinic, traffic was bad and stress ran high. Additionally, the citizens of Mexico City had many more options for health and diagnostic care. With the help of Moreno and his management team, Gomez Mont adjusted to the new client behavioral patterns. Gomez Mont remained confident that in three months the clinic would begin to break even. She observed with gratification, "We already see the impact we are having that goes beyond the people we serve directly. Prices for services at our competitor clinics are dropping. Simi Labs, an operation owned by for-profit Farmacias Similares[5], located directly across from our clinic, started to give discounts that were not available at other Simi Labs in order to compete with us."

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[3] IPADE (Instituto Panamericano de Alta Dirección de Empresa www.ipade.mx) was one of Mexico's most recognized business schools. It was the first MBA program to be taught exclusively with the case method.

[4] Due to legal reasons, the clinic in Mexico City had to be opened with a different name. "Mas Salud" is Spanish for "more health."

[5] See: Michael Chu, Regina García Cuéllar, "Farmacias Similares: Private and Public Health Care for the Base of the Pyramid in Mexico," HBS No. 9-307-092 (Boston: Harvard Business School Publishing, Boston MA 2007) and www.farmaciasdesimilares.com.mx

Business Model

Salud Digna's mission was: "To contribute, with doctors, health professionals, employees and volunteers, to help people achieve a better quality of life delivering low-cost, high quality healthcare services to prevent and detect illness early, while being self-sustainable in our operation." Its target population was the low-income segment of society. However, as Moreno commented:

> We cannot screen the people that come into our clinics to determine their socio-economic status. It would increase our costs as well as the waiting time for our patients and distract us from our critical focus. However, I believe that most of the people that come to Salud Digna are low income. We provide something that is not being efficiently offered to them by their other health-care options—if they have any. If some who use the service are not poor, that does not bother me.

Salud Digna´s theory of change was that as early detection of illnesses increased, survival rates of the low-income population would also increase, while the cost of treating illnesses would decline. Moreno remarked, "In the United States, 89% of women receive mammograms and their survival rate for breast cancer is 84%. In Mexico, only 39% of women have mammograms and their survival rate for breast cancer is on the order of 40%. "

Salud Digna's activities incorporated five key objectives:

- To offer excellent service
- To sustain the quality of the health-care services
- To increase the number of patients seen daily
- To reduce and control costs
- To have an excellent working environment.

Salud Digna offered services in four main areas: laboratory tests, diagnostic tests, radiology screening, and optical exams. (see **Exhibit 8** for a complete list of services provided.)

Moreno perceived that the organization would compensate for the market failures of the Mexican public health-care system and private institutions. The organization filled the gap by providing faster, cheaper and more efficient services at every level of its operation. In reality, many of Salud Digna's patients had access to public health institutions, such as Mexican Institute of Social Security (IMSS) or *Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado (*ISSSTE[6]) where all diagnostic tests were done for free. (See **Apendix A** for a summary on the Mexican health-care system).

As evidence of their desire to work with existing institutions, Gómez Campaña observed, "In Culiacan, we have someone in charge of coordinating with IMSS and ISSSTE to help patients coordinate and work with social security to address any illnesses detected in studies done by Salud Digna. The coordinator tries to ensure that these patients receive timely and quality service at the public institutions. Moreover, if a patient does not have enough resources to pay for exams, we perform them for free and sometimes help them get financing for their treatment."

[6] IMSS was the Mexican Institute of Social Security or *Instituto Mexicano del Seguro Social* and ISSSTE was the Institute of Security and Social Services for State Workers or *Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado*. For a description refer to Appendix A.

A survey of patients at Salud Digna's Culiacan clinic revealed that 23% of their patients had social security and could receive services for free but nevertheless chose to pay for Salud Digna's services.[7][8] The survey also revealed that patients preferred Salud Digna over other options because they received appointments the same day, waited much less time than in state clinics, and test results were available online the same day the test was performed. (see **Exhibit 9** for delivery times of results).

When asked about other health-care options for their target population, Moreno commented:

> As social entrepreneurs we cannot see other health-care service providers as competitors. If someone else offers a service that is high quality and low cost, it is our community that benefits and that also fulfills our social mission. We are pleased that in the past year, there have been other for-profit institutions such as "Checate", "Simi Labs" and "Mi Salud" that have imitated Salud Digna´s model.[9]

The optical departments provided one of the most important services at Salud Digna. "Being able to see well improves quality of life and also job productivity," commented Cecilia Gonzalez, director of the optical lab in the Culiacan clinic. Gonzalez explained:

Many people who come to the optical lab did not previously wear glasses or wore glasses with the wrong prescription. People historically bought their glasses at large retail stores and paid for them with monthly installments. Typical waiting time for glasses was three to five days. At Salud Digna, we sell a pair of glasses for MX $160; the same pair costs around MX $580 in Coppel.[10] We sell approximately 300 pairs of glasses each day in this clinic and we perform the examination and have the glasses ready the same day. The waiting time for the eye exam is no more than 25 minutes.

Mammograms also had significant immediate impact on people's lives. In 2003, the clinic in Culiacan performed 10 to 12 mammograms per day. By 2010, the number averaged 60 mammograms per day. Salud Digna took particular care to follow up after an exam. Radiologist Margarita Barajas was the chief radiologist in the Culiacan clinic and was also a leading radiologist in the Culiacan medical community. She explained:

> When we see a bad result from a mammogram, we help the patient get an appointment with a good specialist and we make sure she is able to get timely treatment, no matter what her financial situation is.

She went on to state:

I want patients to spend no more than an hour for the whole mammogram study. In IMSS one of the main problems is that appointments are given for three months in advance. In Salud Digna we have a full time radiologist who interprets studies and enables us to give results the same day.

Salud Digna's charged clients enough to cover costs plus generate a margin. However, there was no fixed formula for determining margins, which varied a great deal from service to service. Instead, prices were set to be approximately one third the price charged by other clinics or hospitals for the same service.

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[7] The fraction of people without social security among the Mexican population was estimated to be between 44 and 62% (see **Appendix A**). However, this fraction could be larger for lower income people as they were more likely to be rural workers, unemployed, self-employed or in the informal sector.

[8] This percentage in other clinics was smaller. Source: company information.

[9] See www.misalud.com.mx for Mi Salud and www.analisisclinicosdeldoctorsimi.com.mx for Simi Labs.

[10] Coppel was one of the largest specialty retailers in Mexico. They sold furniture, electronics, clothing, and other consumer goods. Most sales were on credit and payable in weekly or monthly installments. www.coppel.com

The highest margins were in the optical labs, tomography and Magnetic Resonance Imaging (MRI) and the lowest were in mammograms (See **Exhibit 9** for a comparison of costs in Salud Digna and other institutions and **Exhibit 10** for comparative margins.)

Organizational Efficiency

Salud Digna status as an NGO with a clear social mission helped enable the organization to forge beneficial alliances. Suppliers were willing to sell material and machinery at below market prices and manufacturers donated a good bit of high quality equipment to the organization (see **Exhibit 11** for a comparison of the equipment at Salud Digna and its competitors**.**) One example was Salud Digna's relationship with Roche, a Swiss health-care company and leading producer of diagnostic medical equipment.[11] Roche both donated machinery to perform lab tests and sold equipment at deep discounts. Roche representative, Julio Alfonso Contreras recalled:

> In an alliance, we install machines and the lab has the obligation to buy all the material from us. To determine if a lab qualifies for an alliance, we analyze potential sales. When we were first approached by Salud Digna to participate in an alliance, they had previously been rejected by three companies. Salud Digna did not qualify in terms of existing or even expected sales volume. Nevertheless, given the social component of the project, I pitched it to my boss. I realized that my job security could very well have been on the line. Roche made an exception and formed the alliance with Salud Digna. We actually never foresaw the impact that the alliance would have on both parties. Of the 120 labs that I currently work with, Salud Digna is in the top 20, in terms of both the lab's quality and its sales volume. We now consider Salud Digna one of our key projects.

Salud Digna's custom of paying for material in less than 21 days, also contributed to its strong relationship with suppliers.

Another driver of success was the fact that Salud Digna clinics provided a range of health-care services in each of its location. Single locations did not typically offer, among other services, eye examinations, radiology services, and laboratory tests. Salud Digna would cross-sell it services by offering clients health packages. The most popular packages included one for women that provided bone densitometry, mammograms, breast ultrasounds, and pap smear tests; another was an adult check-up that provided a complete blood work-up, urinary analysis and cholesterol calculation; and finally, a pregnancy package that included an obstetric ultrasound, plus blood and urinary analysis. Within a package, the price per test was lower than if each test had been purchased separately. This bundling approach to marketing services not only increased revenues but encouraged patients to perform more tests, thereby enhancing a client's illness prevention. Packages were also efficient ways to help facilitate scheduling and reduce waiting time as patients could undergo one test while waiting for another.

Economies of scale contributed to Salud Digna's ability to offer services at low prices. Poignet Ayala, Salud Digna's supply manager, commented:

> I have been with Salud Digna for a short period of time, but through negotiations I have been able to significantly reduce supply costs. We have been able to get lower prices due to the volume of items we purchase and because suppliers want to have a business relationship with our organization. Salud Digna's low cost per study translates into low prices for people that need our services.

[11] See www.roche.com.mx.

Salud Digna's goal was to limit a patients waiting time for most tests to less than one half hour (see **Exhibit 12**). A sophisticated appointment/scheduling system efficiently distributed workloads and enabled doctors to see patients at their scheduled time. Despite this fact, 77% of the patients did not make appointments but walked in for services, which increased their waiting time.[12] By contrast, patients who visited public health institutions with an appointment waited an average of two hours. The lead-time for scheduling appointments was also much longer than at Salud Digna. For example, in the case of lab studies, IMSS gave appointments three to five days after a doctor's request, and for ultrasounds or x-rays there was a lead-time of seven to fifteen days. Patients described that in some cases an ultrasound appointment was given after a baby's due date. Gonzalez Pier, CFO of IMSS commented. "As in all large publicly-funded health care organizations, cost pressures lead to some sort of rationing that affects, for example, supply input and/or timeliness of service provision."

For maximum efficiency, services at Salud Digna were organized as an assembly line. While a doctor was with a patient, the next patient was being prepped by a nurse. During a patient's examination, the doctor dictated her observations to an assistant who would simultaneously input the information into a computer.

All wages in Salud Digna were aligned with productivity incentives. Managers received a base salary plus a percentage of their clinics' revenues. All other employees—from receptionists to doctors—were paid a weekly bonus if productivity reached a set of objectives. Doctors were paid per study performed. For example, a doctor received Mexican Peso (MX) MX $35[13] per mammogram and MX $35 per ultrasound. Mariano Chaidez, the general manager for the Culiacan clinic, explained:

> Doctors in public institutions are allowed to perform only one ultrasound every half hour. In a typical day, with a 7-hour shift, they complete 14 ultrasounds. At Salud Digna each doctor completes 50 in a comparable 7-hour period.

Each clinic had a general manager responsible for the overall operation of the unit. The manager supervised the staff and monitored the use of the clinic's consumables and equipment. He or she was also responsible for keeping close tabs on the clinic's patients' needs as a key source of information used for marketing and promotions. The manager tracked all performance indicators, such as waiting times and financial results. Each manager was supported by three area supervisors. Some managers were also in charge of satellite clinics. Satellite clinics had fewer services than the larger ones and depended on the large clinic for additional management. Satellite clinics sent lens work to larger clinics and referred patients to the larger clinics for studies that they did not provide (see **Exhibit 13** for a list of services provided in each clinic).

One threat to efficiency was the fact that the management team in 2010 was barely able to keep up with the workload. Chaidez said: "With the accelerated growth that we have seen, the operation is much more complicated. Hugo is overwhelmed! Even though I am not responsible for corporate managerial work, I sometimes help Hugo because the structure has not kept up with the workload." Moreno realized that if the number of clinics continued to grow at the same pace, the corporate structure would have to change to better accommodate management's responsibilities (see **Exhibit 14** for an organization chart of the company).

[12] Company information.

[13] The exchange rate was 12.6 Mexican pesos per dollar. Source: Banco de Mexico, www.banxico.org.mx, last viewed 6/17/2010.

Measurement

"Only that which can be measured can be improved" was Vizcarra´s mantra for his business as well as his public life. Salud Digna embedded a culture of measurement in its operations from its founding. Moreno commented:

> In Salud Digna we measure operations daily so we can keep track of our success. If we wait to analyze the monthly income statement or make decisions at the annual meeting (as we've seen other NGO colleagues do) we would be waiting too long. We cannot afford that! We must know immediately if some parts of our operations are not working as well as they should. That way we can respond to problems immediately.

All operations managers submitted a weekly report on a single sheet of paper to Moreno for different aspects of their operations. The sheet was divided into four quadrants in which staff described: (1) good things that happened during the week, (2) relevant issues that emerged during the week, (3) troubling things that occurred during the week, and (4) what was done to resolve these troubling conditions. "At the beginning, it was very easy to read weekly reports. We immediately followed-up on all the problems that appeared," stated Moreno. "Now I receive 80 reports each week![14] It is becoming almost impossible to read them all. Nevertheless, we try to give follow-up instructions for all the problems that are identified." Management had weekly and monthly meetings to follow up on these weekly reports and to discuss items of importance such as financial results and indicators. Every six months management had a meeting to discuss the period's financial results, compare market prices and results across clinics, and make new plans for expansion and growth.

To manage all of the information generated by Salud Digna, Salomé Nuñez, the IT manager, and his team had developed a web-based system to measure virtually every aspect of the operation. The system could track in real time what was happening in each clinic. Using a Personal Digital Assistant (PDA), managers could see how many studies had been done, patients had been seen, the waiting time for each study; the time spent performing a study, interpreting the results and presenting the results to patients. The system assigned red indicators to the items that were below preset objectives, so that managers could detect problems, determine what was causing them and correct them.

The IT team also created a Web based system called SisPrevention that kept information on every patient, including appointments, diagnostic results, medical records, and lenses supplied. The system also had information about each clinic. It contained the inventory of supplies and statistics such as the revenues per study, number and type of exams performed and waiting times for each service. The SisPrevention system could be accessed through any computer connected to the Internet and was thus available to management any time. Another important system was called the DataLab. The DataLab system was designed to reduce human error by creating a discreet barcode for every sample taken from a patient, which matched the patient to the work that would be done. The DataLab system enabled a large volume of patients to receive test results in three hours as the lab machines read the barcode and processed the work automatically, then posted the results for each patient online.

Marketing

Salud Digna's patients were the organizations most effective source of publicity. More than 60% of the people who used Salud Digna clinics, did so because satisfied patients recommended its services. In addition to word-of-mouth publicity, Salud Digna distributed flyers in each clinic's neighborhood. Radio

[14] Each clinic sent 5 reports plus one report from each area manager (Finance, Accounting, Operations, Medical director, IT, Quality, Laboratory, Purchases, Maintenance and Marketing).

and local newspapers were also used to promote services as well as to extol the virtues of preventive health measures (see **Exhibit 15**). As an NGO, Salud Digna was granted free radio air-time and space in newspapers through the NGO assistance institution (*Junta de Asistencia Privada*).

Salud Digna also had a pilot program underway that hired older adults to be promoters in their communities. They would extol the virtues of Salud Digna's services, as well as the importance of health prevention and early detection of illnesses. In addition to providing information orally, promoters handed out flyers and coupons to their local population that provided the location of the nearest clinic, pricing specials, and the range of services and packages offered. Every Monday, promoters met with the medical directors from each clinic to familiarize themselves with a range of relevant medical topics. In the first two months of the program, each promoter accounted for an average of 350 new patients.

Quality

From the beginning of Salud Digna, Vizcarra's dream was to have an institution with a level of quality comparable to any private hospital or clinic. In 2007, Salud Digna was recognized by PACAL[15] as one of the highest quality labs in Mexico.

Despite this recognition, Moreno wanted quality to continue to improve and decided that it was important to have someone on the leadership team who would focus exclusively on quality. In 2008, Tania Cardenas, an industrial engineer, who was completing a Masters Degree in Quality and Productivity from the Tecnológico de Monterrey, was hired. She commented:

> After graduating, I interviewed with many firms but I was impressed by this NGO that was so worried about quality. I always liked social work but I was not necessarily considering an NGO as my first job after school. However, Salud Digna's solid business model combined with the management's concern for quality and clear social focus attracted me to the organization.

Cardenas immediately set to work reviewing each step of every process, then documenting and measuring all of the clinics' services. Cardenas recalled: "When I entered Salud Digna most of the quality processes were in place and were done correctly but were not documented. My job was basically to standardize procedures across all clinics and to document quality." To accomplish this, Cardenas created checklists to insure that all procedures—from the greeting on the phone, to the design of the reception area, to the taking of a patient's information—were done in a similar way. Cardenas met with doctors to develop checklists on how medical procedures—such as ultrasounds, mammograms, and EKGs[16]—should be done and what elements had to be measured in every test. The checklists for all processes were compiled into a Salud Digna manual. All clinics, including new ones, had to adhere to these checklists. After creating the manual, Cardenas started auditing clinics to ensure that everything in the manual was being followed. Cardenas recalled:

> At the beginning there was a lot of resistance to the checklists. People were used to doing things the way they liked and they did not appreciate me coming into the clinics and telling them how things—such as how the reception area should be cleaned or what to look for in an ultrasound—should be done. I explained that my comments and critiquing were not personal; they portrayed how an ideal clinic should look and work. I told them that my comments pointed to things that needed to be improved, and that I wanted changes to be implemented for my next

[15] PACAL, Quality Assurance Program, was a Mexican certifying firm that evaluated Mexican labs in terms of quality. Each year it evaluated more than 2,500 public, private and not for profit Mexican labs. www.pacal.org last viewed 5/22/2010.

[16] Electrocardiogram.

visit. Despite the initial resistance, people came to understand the value of standardizing all processes and got to trust me.

Cardenas relied heavily on Salud Digna's workers for feedback about quality. She met with focus groups of eight to twelve workers from each clinic and discussed anything from complaints about some aspect of their work, to problems about how patients were treated, to approaches for improving operations. The workers' managers were not present at these meetings. Cardenas commented:

> Obviously we cannot take into account every suggestion or solve every problem, but workers feel heard, and we do try to follow up on all of their comments. When their suggestion cannot be implemented, we explain what impeded us from doing what they suggested. This has changed their attitude towards their job. Workers feel that they are an integral part of Salud Digna, and that is the case.

To gain knowledge from patients and improve service, Cardenas introduced randomized surveys that asked patients about their experience. Survey results were analyzed to detect areas of opportunity. Before Cardenas joined Salud Digna, suggestion boxes were used to measure client satisfaction and get feedback. However, only 1% of patients used the boxes, so the feedback from patients had been minimal.

Only top quality supplies and equipment were used in Salud Digna. For example, in the optical labs all equipment and lenses came from the French manufacturers Essilor and Augen.[17] Corrective lenses from these companies had a reputation for high definition and quality. Jorge Mendoza, director of the lens workshop in Culiacan, commented, "We used to use Chinese lenses but they were not top quality. We are so concerned with having top quality glasses that we prefer to use the French lenses."

Another approach to ensuring quality was remote monitoring through the IT system. Every machine in a clinic was connected through the web to a video and audio feed. Medical directors and managers could access in real time this remote monitoring system through any computer with Internet access. A doctor could monitor an ultrasound in any clinic as it was being performed. A director could even see what the nurse was writing during a procedure. This on-line capability helped insure that all procedures were done according to protocol and that patients received the highest level of service. In addition, all customer service calls were monitored to ensure quality. Moreno said:

> We are like the McDonalds of health. We have certain procedures and indicators that should be done in the same way for each exam. For example, in an obstetric ultrasound, we know the measures or indicators that have to be recorded. We can make sure that ultrasounds in Culiacan and Mexicali are done in exactly the same way because we can see what a doctor is doing in each clinic. In fact, we do periodic checks of exams in each clinic to make sure procedures and quality are the same across all of our clinics.

A collective commitment by employees to the organization's mission helped insure quality. Doctor Jose Rosario Leyva, who had worked in Salud Digna since its inception, said:

> I worked in the social security system all my life. When Salud Digna started, Dr. Gomez Campaña invited me to help him and I started working for Salud Digna mostly as a social service in my free time. Now that I am retired from the social security system, I work fulltime for Salud Digna. It is so gratifying for me to see how I can impact the lives of people who need my work. There is no comparison between my work here and at social security. Here, I often help people that had no access to high quality health services at prices they could afford.

[17] www.essilor.com/spip.php?lang=en and www.augen.com last viewed 21/6/2010

Human Resources

Salud Digna started with 11 people: 3 administrative and 8 medical staff that included doctors and nurses. By 2010, 362 people worked in Salud Digna clinics of which 7% were radiologists, 17% doctors, 15% nurses 9% managers. The rest were chemists, optometrists, receptionists, and other support staff.

Mariano Chaidez, the general manager for the Culiacan clinic, observed:

> The bulk of our current staff work here part-time. Doctors from public institutions use their Salud Digna earnings to supplement their pay and single moms can work flexible hours when their children are in school

The clinic manager was head of human resources for his clinic. Moreno commented: "When we interview someone for Salud Digna, we are looking for three main characteristics: that they care about people, are honest and effective, and believe in the mission. It is important that everyone associated with Salud Digna values their contribution to the mission through their work."

Moreno added, "When I interview someone for a manager's position I look first and foremost at their business background. If they do not know how to read a balance sheet I stop the interview immediately! I also ask them questions to see how much they identify with our social mission. Managers do not have to have any experience in NGOs or healthcare. To overcome any deficiency in these areas, each year we send our managers to professional development programs at American universities."

When a new worker started at Salud Digna, he or she first attended the Integral Training Program (ITP). In addition to receiving training in each operational area and how to use each technical tool, ITP introduced the mission and values of Salud Digna.

Governance

Salud Digna was guided by a board of trustees that was formed by Lucero Vizcarra[18] (who also served as president of the board), Dr. Humberto Gómez Campaña (secretary), Hugo Moreno (treasurer), Jesús Vizcarra, and Benjamín Sepúlveda. The board met once a year in April to analyze the annual income statement, performance results, and the overall financial condition of the organization.

Growth

Salud Digna measured growth along three dimensions, the increase in the number of clinics, studies or services provided in each clinic, and new studies and services offered by the organization.

For short-term growth, Moreno looked to open clinics in cities with more than 100,000 inhabitants that were relatively close to Salud Digna´s headquarters in Culiacán. Management had determined that for optimum efficiency clinics should be within a four-hour drive or less than a two-hour direct flight from Culiacán. This decision was informed by an unsuccessful expansion in 2008. Vizcarra decided to open a clinic in Vista Hermosa, a small city of 16,000 inhabitants near Vizcarras' family business.[19] He felt personally compelled to offer Salud Digna's services to Vista Hermosa´s population. "The Vista Hermosa clinic violated all the rules we had for opening new branches," Moreno recalled. "It was located in a small

[18] Jesus Vizcarra's is the daughter of Lucero Vizcarro who was married to Hugo Moreno.

[19] SuKarne was Vizcarra's family business. SuKarne was a vertically integrated meat company that was created in Culiacan in 1969. It consisted of cattle ranches, slaughter houses, meat processing facilities, and packing plants. Vista Hermosa was close to one of the company's largest cattle ranches. Source: www.sukarne.com.mx, last viewed 5/27/2010.

town, far away from Culiacán and with difficult access. We never reached our breakeven point, and we had to close in less than a year. It was a very valuable—yet costly—lesson!"

Salud Digna was planning to open 6 clinics in 2010, 7 clinics in 2011, and 12 in 2012. The investment needed to open a new clinic ranged from $65,000 to $450,000—depending upon the range of services provided in the clinic (see **Exhibit 16** for costs of services provided). Mammogram and tomography equipment were the most expensive and could only be installed in clinics at the upper end of the investment range.[20] Salud Digna based the decision on the size of the clinic on the potential size of the population it would serve. Salud Digna had two types of clinics: satellite and large. It planned to have a mix of 30% large clinics and 70% satellite clinics.

Satellite clinics could be opened in smaller cities (from 100,000 to 300,000 inhabitants) that were close to a large Salud Digna clinic. They depended on a large clinic for the lens workshop and other services such as mammography or tomography. Satellite clinics typically offered only lab, optometry and ultrasound services. Sometimes, they also offered EKGs and pap smear tests. Large clinics were opened in cities with populations over 300,000. Aceves commented "In 2008, we opened both the Mazatlan and Mochis clinics. In Mazatlan we opened a relatively large clinic and it took us five months to achieve breakeven. By contrast, in Mochis we opened a satellite clinic and by the second month we were realizing surpluses. We grew the Mochis clinic organically offering more services as the months passed and always in response to demand. We have had positive results since then."

Adhering to all short-term growth criteria, Salud Digna would be able to open clinics in Toluca, Tepic, Obregón, Monterrey, Guadalajara, Hermosillo, Ensenada and La Paz. Longer-term, Vizcarra had a vision to open clinics for the low-income Hispanic populations in the United States, beginning with California or Arizona. Chaidez commented: "The main difference between the number of clinics we would like to open and the number of clinics we are able to open is the money we have available."

Another area for growth was spreading services that existed in some of the larger clinics to the smaller ones. From 2009 to 2010, the number of new services provided had increased significantly. Clinics in Culiacán, Los Mochis, and Tijuana, Salud Digna brought in CT scans, EKGs, and pharmacy services. Moreno wanted to offer many of these services in more of the smaller clinics.

A third option for growth was providing new tests and services to meet the new or growing needs of Mexico's poor population. For example, obesity was becoming a common health problem. In fact, Mexico had the highest rate of obesity in children among OECD countries.[21] Further, obesity in children was highly correlated with socio-economic status, with low income Mexicans considerably overrepresented in this disease category. Another emerging health concern was diabetes. The Salud Digna clinics had detected an increase in diabetes through glucose exams, but they did not have a program to follow up on the patients who either had the disease or had a high probability of contracting it. To address these issues, Moreno was thinking of opening nutrition and stress-detection centers within the clinics. One more idea was to open a comprehensive prenatal health center where women could be treated from the beginning of pregnancy to the baby's birth.

A fourth possible option for growth was to open primary care clinics, as many competitors had done. Some in Salud Digna had their doubts. The primary health clinic would be staffed by a general

[20] Salud Digna offered MRI services although it did not have the MRI equipment in its clinics. Salud Digna had agreements with other clinics or institutions and referred its patients for MRIs.

[21] Encuesta Nacional de Salud, 2006, http://www.insp.mx/Portal/Centros/ciss/nls/boletines/PME_14.pdf, last viewed May 20th, 2010.

practitioner, and perhaps a pediatrician and gynecologist. The doctors could potentially examine patients and refer them for studies at Salud Digna. Aceves commented:

> One of the best things we have done is to limit our operation to what we know best: diagnostic and preventive care. If we begin to prescribe or to treat patients, we could become competitors to the doctors who refer patients to our clinics. Doctors would become much less likely to refer patients to us. Some of the clinics that imitated our model pursued these other options and did not do well. I believe in sticking to what we know best. Another risk could be to deviate from our prevention mission and become sort of an emergency facility where people come once they are already sick.

A last option for growth was to offer diagnostic services to public institutions. This was a huge market that was largely un-tapped by private institutions. In 2009 alone, the IMSS spent U.S. $441 million in diagnostic services and did 177 million diagnostic studies.[22] The public health institutions were overwhelmed and could not provide diagnostic studies in a timely fashion. Government institutions were beginning to outsource specialty services in areas such as dialysis. González Pier commented, "I think that in the future public health institutions will have to move in the direction of identifying the comparative advantages of private providers who can offer good quality services at a low cost when public provision has proved inefficient."

For-Profit or Not-

As part of a growth strategy, Moreno could not help but consider becoming a for-profit organization. For-profit organizations such as Farmacias Similares and Primedic,[23] both considerably larger than Salud Digna, had proven they could be successful in the same space. Moreno realized that for-profit capital markets could provide much more capital for Salud Digna's expansion. However, Moreno had his doubts.

Salud Digna had experimented with a for-profit model, establishing for-profit clinics in the state of Baja California. In April 2009, management decided to turn the clinics into NGOs due to the tax burdens they faced as for-profit organizations. "In 2008 we paid almost U.S. $150,000 in taxes; money that could have bought an ultrasound! In April 2009, we decided to change our status to a nonprofit, because our mission was social and in 2010, as of the end of April, we have paid only $9,000 in taxes.[24]" Alfonso Aceves, Salud Digna's accountant, explained: "Nobody wants to get rich from Salud Digna. Whatever our financial structure, we would use our surpluses to grow, improve our operations and help people providing health services. Therefore, it did not make sense to be a for-profit."

Moreno also believed that as a nonprofit, the organization would have greater focus on Salud Digna's social mission. He would not have to worry about shareholders pushing for profits.

There were however limitations to being a nonprofit. Under Mexican law, NGOs were restricted from providing services or selling to for-profit firms. Aceves explained:

> A for-profit firm can sell any assets or services to any other organization, for-profit or nonprofit. We have been approached by large corporations that want us to provide preventive care services.

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[22] Source: Instituto Mexicano del Seguro Social, IMSS, www.imss.gob.mx

[23] Refer to: Michael Chu, Regina García Cuéllar, "Farmacias Similares: Private and Public Health Care for the Base of the Pyramid in Mexico," HBS No. 9-307-092 (Boston: Harvard Business School Publishing, Boston MA 2007) and Richard Hamermesh and Lauren Marguiles, "Primedic –Providing Primary Care in Mexico," HBS No. 810-036 (Boston: Harvard Business School Publishing, Boston MA 2009).

[24] Even though by 2010 Salud Digna was a nonprofit firm, they paid taxes on its eye-glass shop and pharmacies.

> For example, they ask us to do check-ups for all their employees. If we were a for-profit firm this would be very profitable business. However, with our NGO status, we cannot get into these types of businesses. Our business with the public sector can only be through agreements where we provide a service and they give us a donation in exchange. We cannot participate in public tenders.

As a nonprofit, if Salug Digna needed external capital, it would need to attract philanthropy. In Mexico, the field of philanthropy was only recently emerging. There was little traditional philanthropic capital available for expansion. Most large donors had their own foundations that were geared to a particular cause favored by the donor.[25] On the other hand, Moreno had attracted social investors to sponsor the new clinic in Mexico City. Moreno pondered whether Salud Digna as a nonproift organization could mobilize enough philanthropy to achieve its maximum growth potential.

Challenges to Growth

It was assumed that the most significant constraint to growth was Salud Digna's financial resources. Moreno asserted that with internal resources they could open three to six small clinics or two to three large ones each year. He noted:

> Certainly, given present circumstances, we are not able to open enough clinics. If we truly want to make a difference in a country with such a high inequality of health and income we have to grow at a much more accelerated rate. In Mexico we could open more than 90 clinics. We estimate that to have a significant impact we should be attending five million people annually, which would imply having at least 70 clinics. Banco Compartamos[26] has beseeched us to become a for-profit firm in order to attract financial resources and expand rapidly enough to meaningfully achieve our social goal. While this is certainly attractive, my concern would be whether as a for-profit we can sustain our unrelenting focus on our social mission.

Looking back at the past four years, Moreno was very proud of Salud Digna's growth from 1 to 14 clinics. The organization had been transformed from one needing infusions of external resources to operate, to generating enough internal resources to open new clinics. Sauld Digna had changed from being an informal organization to becoming a professionally managed nonprofit. Still Moreno was not satisfied. Mexico's inequality in health access was appalling, and Moreno believed that Salud Digna had the potential to be a key player in reducing that gap. In the state of Sinaloa, Salud Digna was reaching almost half of the population. Moreno wanted to take the results achieved in Sinaloa to the rest of the country (see **Exhibit 17**).

Important questions lingered in his mind. Should Salud Digna become a for-profit organization where access to capital was much more assured? If Salud Digna remained a nonprofit, would philanthropy in Mexico provide enough capital for growth? Could rapid growth, whether as a for-profit or nonprofit, be achieved without losing Salud Digna's deep culture of serving the poor and its unrelenting social focus? Could he continue to attract enough professionals who both embraced the social mission and had the necessary skills? Should he work with the government to accelerate growth

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[25] Some of the largest foundations were Fundacion Televisa www.fundaciontelevisa.org geared towards education and health, Fundacion Telmex www.fundaciontelmex.org geared to education, health and human development, Fundacion Azteca www.fundacionazteca.org geared towards nutrition, Bimbo had Reforestemos Mexico geared towards sustainability www.reforestemosmexico.org, Fundacion Alfredo Harp www.fahh.com.mx geared towards promoting sports, archives and art, Fundacion Carlos Slim www.carlosslim.com.mx promotes art, culture and education among others.

[26] See: Michael Chu and Regina García Cuéllar, "Banco Compartamos: Life after the IPO," HBS No. 308-094 (Boston: Harvard Business School Publishing, 2008).

and cope with the inevitable frustrations of dealing with its bureaucracy? Should Salud Digna stay focused on its current services or enter into other areas that would improve the health of the Mexican population?

One thing he knew for certain, that whatever the decisions the leadership team made, he relished the inevitable challenges he and his team would face.

Exhibit 1 Mexico Map

Source: University of Texas Libraries, The University of Texas at Austin, www.lib.utexas.edu last viewed 5/6/2010.

Exhibit 2 Mexico's Macroeconomic Indicators

	2009	2010*
Population million [a]	111.2	112.5
Population growth (% change pa) [a]	1.1	1.1
% rural population [d]	76.5	
Recorded unemployment (%)[a]	5.7	5.9
GDP (bn US $) [a]	859.4	887.2
GDP (% real change pa) [a]	-7.1	3
GDP per head (at PPP) [a]	14,360	14,830
Consumer price inflation [a]	5.3	3.3
Exchange rate (pesos per dollar av) [a]	13.6	14.1
Lending interest rate % [a]	8.4	6.5
Workers' remittances (m US $) [a]	21,783	22,487
Gini coefficient [b]	51.6	
Population under US $1 per day % [c]	10	
Population under US $2 per day % [c]	26	
Share of income of lowest 20% [c]	3.8	
Share of income of top 20% [c]	59.1	
% of population below poverty line[c]	47.0	

Source: a) Economist Intelligence Unit, www.eiu.com last viewed 5/6/2010, b) Data for 2006. Source: Coneval www.coneval.gob.mx last viewed 5/7/2010 c) Data for 2008. Source: World Bank Indicators, www.worldbank.org last viewed 5/7/2010, d) INEGI www.inegi.gob.mx last viewed 14/7/07.

Exhibit 3 Consolidated Balance Sheet, dollars of December each year

	2006	2007	2008	2009	2010*
Assets					
Cash and cash equivalents	22,062	110,380	582,495	1,205,023	916,486
Fixed assets	69,096	345,516	1,386,804	2,128,850	2,407,691
Deferred assets	5,000	43,021	437,201	601,603	716,693
Total assets	96,159	498,917	2,406,501	3,935,477	4,040,870
Liabilities					
Accounts payable	132,030	84,464	1,338,417	1,600,679	1,260,841
Taxes payable	194	16,547	82,748	91,132	94,440
Total liabilities	132,224	101,011	1,421,165	1,691,811	1,355,282
Equity					
Equity	-	6,287	5,082	271,428	284,917
Earnings 2005	(30,016)	35,651	4,520	4,721	4,956
Earnings 2006	(13,182)	152,662	(33,036)	(34,507)	(36,222)
Earnings 2007	-	203,307	291,228	304,195	319,313
Earnings 2008	-	-	462,767	483,373	507,395
Earnings 2009	-	-	-	1,214,455	1,274,811
Earnings 2010	-	-	-	-	330,418
Contributions	7,133	-	254,775	-	-
Total equity	(36,065)	397,906	985,335	2,243,665	2,685,588
Liabilities + equity	96,159	498,917	2,406,501	3,935,477	4,040,870

* 2010 up until April 30th

Source: Company information

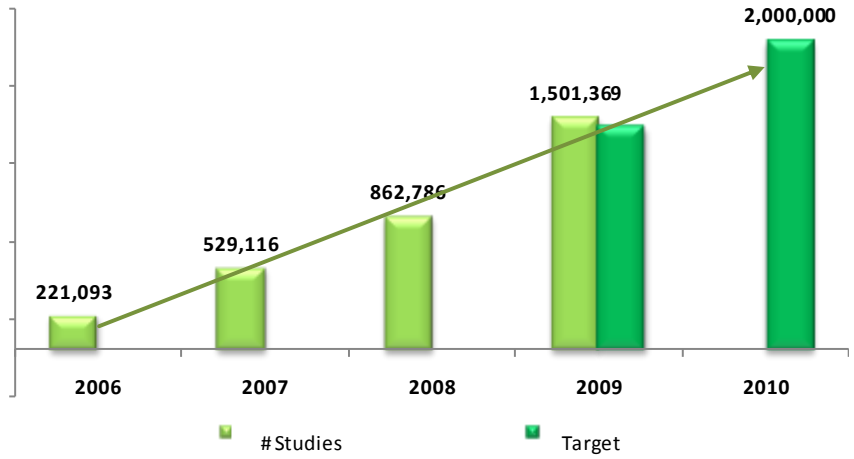
Exhibit 4 Consolidated Income Statement, dollars as of December each year

	2006	2007	2008	2009	2010*
# studies	228,225	522,301	851,315	1,486,874	619,124
Revenues	2,284,326	4,438,916	5,540,227	10,151,128	4,093,335
Revenues / study	10	8	7	7	7
Cost of goods sold	1,328,801	3,822,080	2,751,350	5,624,550	2,381,617
Cost of goods / study	6	7	3	4	4
Gross margin	955,525	616,836	2,788,877	4,526,579	1,711,718
Gross margin / study	4	1	3	3	3
Indirect cost	1,006,097	266,255	2,407,073	3,453,864	1,479,305
Indirect cost / study	4	1	3	2	2
Operating margin	(50,572)	350,581	381,804	1,072,715	232,412
Operating margin / study	(0)	1	0	1	0
Other income	9,759	9,719	80,963	325,967	208,459
Other expenses	-	-	-	184,227	107,677
Other income (expenses)	-	-	-	-	2,777
Earnings before taxes	(40,813)	360,299	462,767	1,214,455	330,418
Earnings before taxes / study	(0)	1	1	1	1
Taxes	-	-	66,910	37,406	5,382
Earnings	(40,813)	360,299	395,856	1,177,049	325,036
Earnings / study	(0)	1	0	1	1

* Data until April

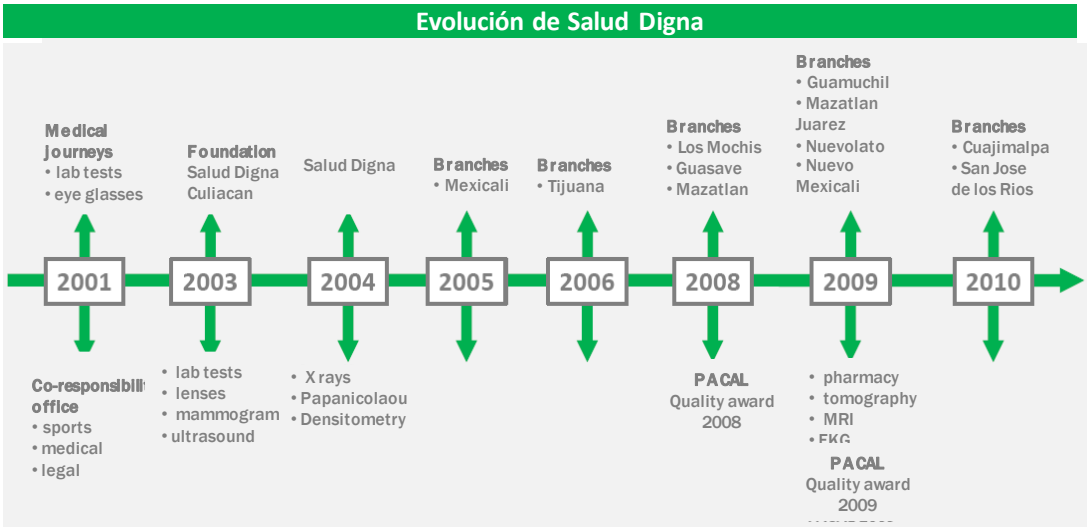
Source: Company information

Exhibit 5 Number of Studies Performed



Source: Company information

Exhibit 6 Salud Digna's Evolution



Source: Company information

Exhibit 7 Locations of Salud Digna´s Clinics

Source: Company information

Exhibit 8 Services Offered by Salud Digna

Breast Cancer	Cervical and Uterine Cancer	Prostate Cancer
▫ Mammography ▫ Breast Ultrasound ▫ Cancer antigen 15-3	▫ Papanicolaou ▫ Cancer antigen 125	▫ Prostate Ultrasound ▫ Prostate Antigen
Diabetes	**Hypertension**	**Quality of life**
▫ Glucose ▫ Glucosed Hemoglobin	▫ Urea ▫ Creatinine ▫ Uric Acid ▫ Cholesterol ▫ Triglyceride	▫ Bone Densitometry ▫ Eyesight exam ▫ Lenses
Pregnancy Control	**Other Tests**	**Other Tests**
▫ Obstetric ultrasound ▫ Pregnancy test ▫ Prenatal profile	▫ Serology ▫ Urinalysis ▫ Hematology ▫ Special tests	▫ X Rays ▫ Tomography ▫ MRI ▫ General Ultrasound

Source: Company information

Exhibit 9 Price Comparison: Salud Digna and Other Health-Care Institutions

Institution	Papanicolaou	Blood Chemistry	Hematic Biometrics	Pregnancy Test	Urinalysis
Salud Digna	$100.00	$80.00	$60.00	$55.00	$25.00
Delia Barraza	$300.00	$440.00	$100.00	$130.00	$80.00
Mi Salud	$280.00	$300.00	$100.00	$100.00	$45.00
Hospital Civil	$100.00	$210.00	$70.00	$80.00	$50.00
Hospital General	-	$480.00	$80.00	$135.00	$105.00
Laboratorio Lab	-	$490.00	$200.00	$150.00	$100.00

Institution	Ultrasound	Electrocardiogram	X-Rays	Mammography
Salud Digna	$70.00	$100.00	$100.00	$130.00
Mi Salud	$185.00	$280.00	$180.00	$220.00
Hospital Civil	$175.00	$120.00	$150.00	$300.00
México Americano	$450.00	-	$140.00	$460.00
Hospital General	$400.00	$265.00	$195.00	-
Hospital Angeles	$923.15	$672.00	$322.00	$466.00
Resomaz	$290.00	$150.00	$212.00	$290.00

Institution	Tomography Simple	Tomography Contrasted	Resonance Magnetic Simple	Resonance Magnetic Contrasted
Salud Digna	$800.00	$1,500.00	$3,300.00	$3,800.00
Mi Salud	$2,145.00	$3,145.00		
Hospital Civil	$1,500.00	$2,100.00	$4,400.00	$4,850.00
México Americano	$2,600.00	$3,090.00	$6,000.00	$6,850.00
Hospital General	$2,900.00	$3,500.00	$6,000.00	$6,600.00
Resomaz	$999.00	$1,999.00	$2,780.00	$3,780.00

Source: Company information

Exhibit 10 Gross margin by type of study

	Lab	Eye Glasses	Ultrasound	Mammograms	X Rays	Bone Densitometry	Papanicolau	Tomography	Electro cardiogram	MRI	Pharmacy	Flat foot
# Studies	933,628	127,773	259,981	34,109	50,098	33,453	38,562	1,215	7,896	138	31,542	21
Revenues	3,298,513	3,410,158	1,778,132	339,537	603,400	195,888	260,270	104,116	51,680	36,991	72,304	139
revenues/study	3.53	26.69	6.84	9.95	12.04	5.86	6.75	85.69	6.55	268.05	2.29	6.60
Costs of services	1,891,190	1,665,340	942,746	298,078	393,314	58,105	185,797	64,441	34,586	30,890	59,972	90
cost/study	2.03	13.03	3.63	8.74	7.85	1.74	4.82	53.04	4.38	223.84	1.90	4.28
Gross margin	1,407,323	1,744,818	835,386	41,459	210,086	137,783	74,473	39,675	17,094	6,101	12,332	49
margin/study	1.51	13.66	3.21	1.22	4.19	4.12	1.93	32.65	2.16	44.21	0.39	2.32

Source: Company information

Exhibit 11 Quality of Salud Digna's Equipment

Equipment	Salud Digna	Mi Salud	Dr. Simi	Chécate
X-Rays Developing Process	Digital developing process approved by FDA for mammography	Conventional Humid Developing Process	Does not offer x-rays service	Conventional Humid Developing Process
Laboratory	Automated	Automated	Manual	It does not have any equipment
Ultrasound	Doppler color	Without Doppler color	Without Doppler color	Without Doppler color

Source: Company information

Exhibit 12 Waiting Times and Results' Delivery Times

OBJECTIVE TIME TABLE		
Test (with appointment)	Waiting Time	Delivery of Results Time
Papanicolaou	30 min	4 días
Mammogram	30 min	45 min
Densitometry	30 min	Inmediato
EKG	20 min	1 día
Tomography	15 min	1 día
Resonance	15 min	1 día
X Rays	30 min	45 min
Ultrasound	30 min	Inmediato
Laboratories	15 min	4 horas
Glasses	15 min	45 min

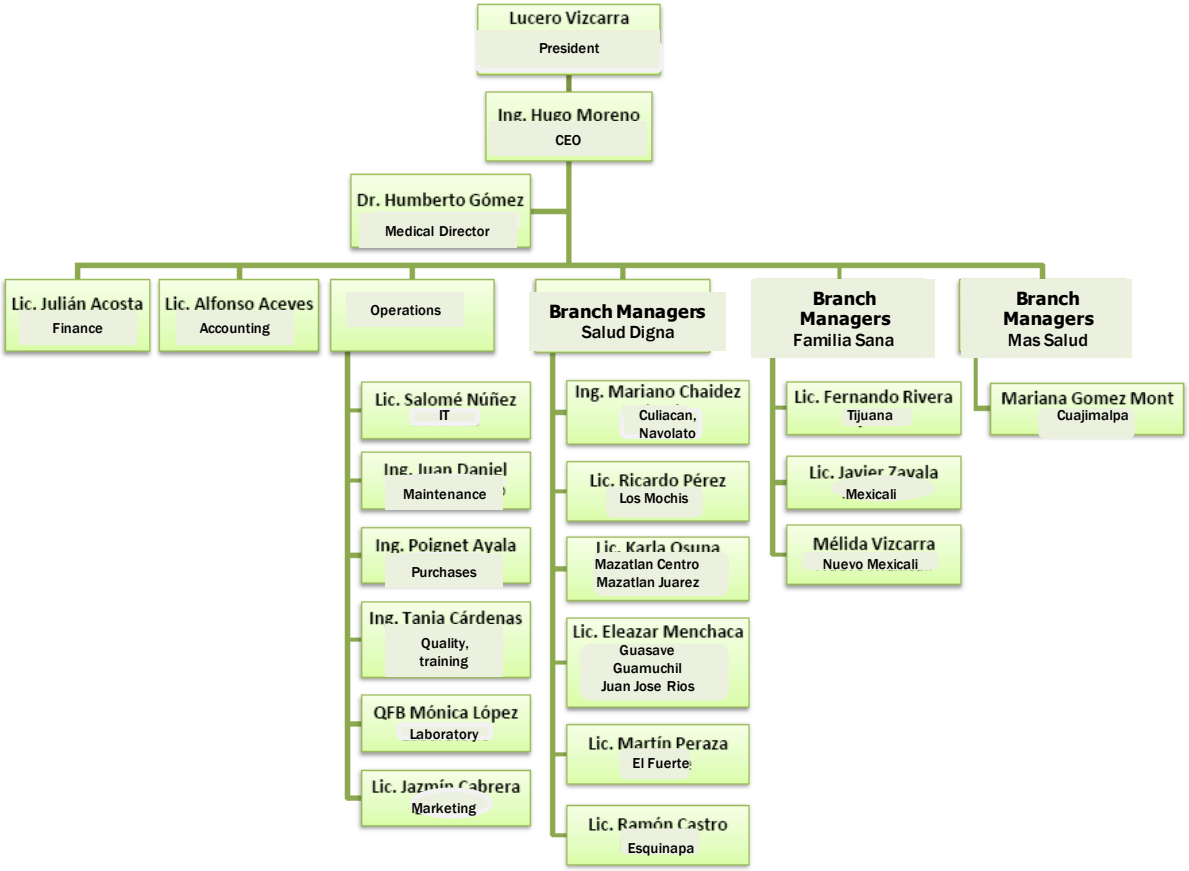
Source: Salud Digna, www.saluddigna.org.mx last viewed 5/22/2010.

Exhibit 13 Services Offered by Salud Digna

	Clinic	Lab Tests	Eye exam	Ultrasound	Mammogram	X Ray	CT	Bone Densitometer	Papanicolaou	EKG
1	Culiacan	✓	✓	✓	✓	✓	✓	✓	✓	✓
2	Mexicali	✓	✓	✓	✓			✓	✓	✓
3	Tijuana	✓	✓	✓	✓	✓		✓	✓	✓
4	Los Mochis	✓	✓	✓	✓	✓		✓	✓	✓
5	Mazatlán	✓	✓	✓	✓			✓	✓	✓
6	Guasave	✓	✓	✓	✓				✓	✓
7	Guamuchil	✓	✓	✓						✓
8	Mazatlán J	✓	✓	✓						✓
9	Navolato	✓	✓	✓						✓
10	Nuevo Mexicali	✓	✓	✓					✓	✓
11	El Fuerte	✓	✓	✓						
12	Escuinapa	✓	✓	✓						
13	México	✓	✓	✓					✓	✓
14	Juan José Rios	✓	✓	✓						

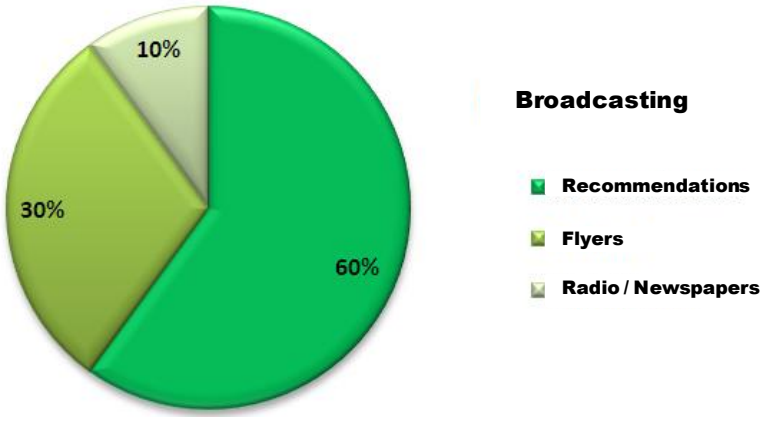
Source: Company information

Exhibit 14 Salud Digna Organization Chart



Source: Company information

Exhibit 15 Marketing Results: How Do Patients Come to Salud Digna?



Source: Company information

Exhibit 16 Cost per Service

EQUIPMENT*	UNIT COST	LARGE CLINIC (CULIACAN)		SATELITE CLINIC	
		QUANT.	TOTAL	QUANT.	TOTAL
ULTRASOUND	13,672	4	54,688	1	13,672
MAMMOGRAM	14,063	1	14,063		-
X RAY	23,438	2	46,875		-
PRITER AND DIGITAL**	35,156	1	35,156		-
TOMOGRAPHY	85,938	1	85,938		-
LENS WORKSHOP	21,094	1	21,094		-
LAB	7,813	1	7,813	1	7,813
OPTOMETRY	17,188	3	51,563	1	17,188
SMEAR TEST	2,734	1	2,734		-
EKG	1,172	1	1,172		-
DENSITOMETRY	10,156	1	10,156		-
COMPUTER EQUIPMENT	430	60	25,781	7	3,008
ENERGY SUB-STATION	5,078	4	20,313		-
SITE ADAPTATION			74,219		23,438
TOTAL			451,563		65,117

* Cost included machinery, area adaptation, training, and everything necessary to provide the service.

** To provide mammograms, X Rays and tomograhpy a digital and printer had to be bought.

Source: Company information.

Exhibit 17 Salud Digna's Market Share

City	State	Inhabitants	Registered patients	Participation rate
Tijuana	Baja California	1,440,549	297,028	**20.62%**
Mexicali		731,422	175,332	**23.97%**
Culiacán		609,722	410,937	**67.40%**
Mazatlán		355,043	76,581	**21.57%**
Mochis		233,670	107,447	**45.98%**
Guasave	Sinaloa	67,280	45,675	**67.89%**
Navolato		28,885	10,793	**37.37%**
Escuinapa		28,999	1,342	**4.63%**
Guamúchil		62,313	15,970	**25.63%**
El fuerte		12,004	2,191	**18.25%**
TOTAL		**3,569,888**	**1,143,296**	**32.03%**

Source: Company information

Appendix A: **Mexico's Health System**

The health-care system established in Mexico in 1943 remained in place in 2010. The health system consisted of two separate vertically integrated systems with no connections between them. On one side, a health insurance plan with integrated service providers, the Mexican Institute of Social Security (IMSS[27]), covered formal and salaried private sector workers and their families. Another similar social security system, the Institute of Security and Social Services for State Workers (ISSSTE[28]), covered federal public sector workers and their families. There were similar insurance institutions that covered public sector workers of the armed forces, the marine and workers of the national state oil company—SEDENA, SEMAR and PEMEX, respectively[29]—and public sector workers in each state of the country. Together, these social security institutions covered formal and salaried workers and their families, estimated to be between 38 and 56% of Mexico's total population.[30] Parallel to these insurance institutions, the Ministry of Health[31] (MoH) had centrally-controlled medical facilities in the various Mexican states that were run by the State governments. While open to all the population, these facilities were geared towards those who had no access to the social security institutions—e.g., the unemployed, self-employed, rural workers, non-salaried and informal workers. These medical facilities were funded by the government and supplemented by certain patient/user charges. However, even if everyone had access to health services in theory, some populations in rural remote areas did enjoy access to these resources in practice. Around 11% of the population had no access at all to public health care.[32]

In 2003, under Vicente Fox's presidency,[33] with Julio Frenk[34] as Minister of Health, Congress passed a health reform creating the System for the Social Protection of Health (SPSS).[35] The system was based on a new insurance plan for low income people: the Popular Health Insurance or *Seguro Popular* (SP). The SP was a voluntary insurance program aimed at covering those left uninsured by the current system. Premiums for the SP were progressive, with the first income quintile[36] exempted from payment (in return for adherence to certain preventive health practices). Premiums for paying customers were capped at 5% of family disposable income. The SP provided coverage for a vast number of primary care and hospital interventions (covering 95% of medical services demanded in Mexico) as well as laboratory tests and all medications. The care was given at MoH facilities; it was free at the point of service and covered the policy holder and his or her dependants. By 2009, the SP had 10.5 million families subsrcibed—35% of

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[27] *Instituto Mexicano del Seguro Social*

[28] *Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado*

[29] PEMEX is the National Oil Company or *Petróleos Mexicanos*, SEMAR is the Ministry of the Marine or *Secretaría de la Marina* and SEDENA is the Ministry of Defense or *Secretaría de la Defensa Nacional*.

[30] There were many discrepancies in the estimate of the population covered by social security. If one used the number provided by the 2005 census, the estimate of people covered was 32% in IMSS and 6% for ISSSTE giving a total of 38%. However, if one used the administrative data provided by the social security institutions the percentage increased to 56% (45% IMSS and 11% ISSSTE). The problem with the second estimate is that the number came from the number of people registered in the institutions and their dependents. There could be double counting of people covered as many dual-income couples were counted with their dependents twice and also, the family coefficients were estimated from averages. Source: IMSS report to Congress and Panagiota Panopoulou's interpretation of statistics.

[31] *Secretaría de Salud*

[32] IMSS, report to Congress, http://www.imss.gob.mx/NR/rdonlyres/CE906C18-D2CE-4B67-854D-1102CDC41E12/0/I.pdf last viewed 7/23/2010.

[33] President Vicente Fox served from 2000 to 2009.

[34] In 2009, Frenk was appointed Dean of Harvard's School of Public Health.

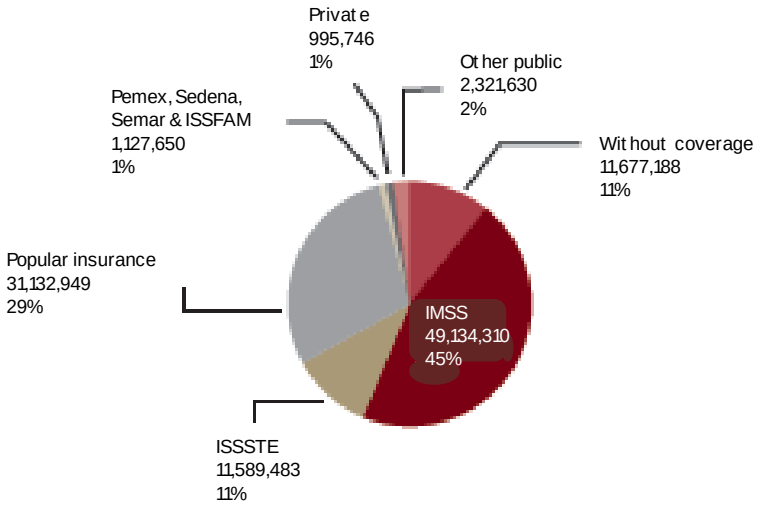
[35] *Sistema de Protección Social en Salud*

[36] The fifth (20%) of the population earning the lowest income.

them from rural communities—which represented 31.1 million people. Because 96.2% of families registered belonged to the lowest income quintile, premiums paid only covered 0.4% of the SP budget.[37]

The private healthcare system took all the overflow demand that was not serviced by the public system. Private insurance covered only 1% of Mexico's population and those insured were covered for a minimal number of procedures. In comparison, within other OECD[38] countries, about 70% of the population had some form of formal insurance coverage. High premiums were a significant barrier preventing most Mexicans from purchasing private health insurance.

Figure 1 Mexican population according to type of health coverage



Source: Instituo Mexicano del Servicio Social (IMSS), Report to Congrees, http://www.imss.gob.mx/NR/rdonlyres/CE906C18-D2CE-4B67-854D-1102CDC41E12/0/I.pdf last viewed 7/23/2010.

In aggregate, Mexico's overall spending on health care was low. During 2005 it spent 5.8% of its GDP on health, compared to an average of 9.0% for the OECD countries. Drilling down within health spending, Mexican public sector spending was also very low: only 45.5% of the total compared to an average of 72.5% in other OECD countries.[39]

Several characteristics of Mexico's health-care system raised issues of equity. The World Health Organization (WHO) ranked Mexico's overall health system 51 out of 191 countries yet it ranked Mexico's health system 144 in terms of its financial fairness.[40] One issue was the disproportionate share of public healthcare spending that went to the publicly insured population in relation to the uninsured: On a per capita coverage basis, the insured received 1.9 times more from the government than the uninsured. Moreover, as a group, the uninsured represented the lower income segments of society.

[37] Seguro Popular, Informe de Resultados 2009, www.seguropopular.gob.mx, last viewed 5/6/2010.

[38] Organization for Economic Co-Operation and Development is an international organization of developed countries that accept the principles of representative democracy and a free market economy. Mexico joined OECD in 1994. (Source: www.wikipedia.com.

[39] In 2005, the United States' health expenditures were 15.3% of GDP. Source: OECD Reviews of Health Systems: Mexico, OECD Publishing, France, 2005 and PRONAFIDE Programa Nacional para el Financiamiento del Desarrollo, www.bansefi.gob.mx last viewed 5/6/2010.

[40] Felicia Knaul, Héctor Arreola, Oscar Méndez and Martha Miranda, "*Preventing Impoverishment Promoting Equity and Preventing Households from Financial Crisis: Universal Health Insurance through Institutional Reform in Mexico*", Global Development Network meeting, San Petersburg Russia, January 2006.

As a result, much of the healthcare of the low-income population went through the private system. There, payments were out-of-pocket and not reimbursed. In total, as much as 58% of total health expenditures in Mexico were out-of-pocket expenses, above many other Latin American countries—including Brazil, Chile, Colombia, and Costa Rica.[41] These payments represented a higher fraction of disposable income for lower income families than for better-off families.

The distribution of healthcare across Mexican states was also imbalanced. Individuals in richer northern states were much better served than individuals in the poorer central or southern states. For example, between rich and poor states, distribution of doctors per capita differed by a factor of three and spending per uninsured individual differed by a factor of eight. Insurance coverage was regressive both across states and across income quintiles. For instance, in Chiapas and Oaxaca, two of the poorest states, only 25% and 31% of the households were insured, respectively, while the same figure was 70% in the more affluent northern states.[42] In the year 2000, more than 60% of the people in the highest income quintile were insured by the public health system compared to only 10% in the lowest quintile. In addition, the occurrence of health expenditures that had a catastrophic and impoverishing burden[43] on a family was more than four times as likely among the uninsured as it was among the insured.[44] Furthermore, within the lowest income quintile, 19% of families incurred catastrophic and impoverishing health expenditures, while only 2.9% of the highest income quintile had to bear catastrophic health expenditures, none of which was impoverishing. Among the poor, catastrophic or impoverishing health expenditures were mainly caused by spending on medicine (65.7%). Among the rich, hospitalization (51%) was the main cause of a catastrophic health expense.[45]

[41] A.C. Torres, F. Knaul, "*Determinantes del gasto de bolsillo en salud e implicaciones para el aseguramiento universal en México 1992-2000*", in Caleidoscopio de la Salud, Funsalud, 2003.

[42] OECD p.p. 68.

[43] Catastrophic health expenditures were defined as spending 30% or more of disposable income (total income less spending on basic needs such as food) on health. Impoverishing health expenditures were defined as falling below the poverty line or deepening the poverty level due to health expenditures.

[44] Felicia Knaul, Héctor Arreola, Oscar Méndez and Martha Miranda, "*Preventing Impoverishment Promoting Equity and Preventing Households from Financial Crisis: Universal Health Insurance through Institutional Reform in Mexico*", Global Development Network meeting, San Petersburg Russia, January 2006.

[45] G. Nigenda, E. Orozco and G. Olaiz, "*La importancia de los medicamentos en la operación del Seguro Popular de Salud*", in Caleidoscopio de la Salud, Fundación Mexicana para la Salud, 2003.