08 / CREATING VALUE

Aravind

The economics of wider access

How can a hospital widen access while funding dependable care?



Aravind Eye Hospital, Madurai, 2013. Photograph: Kannan shanmugam, Shanmugam studio, Kollam.
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A fictional capacity decision grounded in Aravind's published model connects paid services, subsidized access, operating discipline and patient outcomes.

A hypothetical eye-hospital leadership team | Model-based teaching scenario

35-45 minutes to prepare / 75 minutes to discuss
Original public-source teaching case • First member edition • 1 November 2026

PRINCIPLED BUSINESS IN PRACTICE

Introduction

About Principled Business

Principled Business (PB) is a nonprofit organization that brings together business leaders to advance capitalism through education, relationships and action. It helps founders, executives and investors understand free enterprise, apply its principles in their organizations, and explain the contribution business makes to people's lives.

The PB manifesto grounds capitalism in individual agency, private ownership and voluntary production and trade. These commitments take practical form in everyday business decisions.

Creating value

PB connects sustainable enterprise with creating value for others. Customers, workers and partners must have reasons to keep choosing the relationship.

Aravind's nonprofit model shows that enterprise economics can support value beyond distributions to shareholders. The case asks how a hospital can fund access while protecting quality and patient choice. A hypothetical capacity plan lets students examine the relationship between contribution, cross-subsidy and outcomes.

PB presents this case to make the principle usable in a real business decision. Your recommendation should connect the principle to a workable policy, account for the people affected, and identify evidence that could change your mind.

What you will learn

01 Connect a service's financial sustainability with its purpose and beneficiaries.

02 Calculate a feasible paid and subsidized service mix under explicit assumptions.

03 Set quality, access and financial conditions for expansion.

> **Apply it to your own business**
> Where does one activity fund another in your organization? What evidence shows that both groups receive value and that the funding relationship can endure?

Source: About Principled Business; Capitalists for Capitalism Manifesto, Section 2: Creating Value.

NOTES FOR STUDENTS AND TEACHERS

Using this case study

This packet includes the case, exhibits, worksheet, sources, answers and teaching notes. Allow 35-45 minutes to prepare and 75 minutes for discussion. Have a calculator or spreadsheet available.

Pages	What to use and when
4-8	Decision, evidence, exercise and alternatives. Read before discussion.
9	Decision worksheet. Complete before reading the answers.
10	Sources and reading notes. Check the evidence and its limits.
11-12	Worked answers, outcome and teaching plan. Read after deciding.

For students

Read once to identify the decision, then work through the exhibits. Separate historical facts from the invented classroom exercise. Use the case's decision boundary; write down assumptions when evidence is missing. Complete the calculation and worksheet on page 9. Be ready to defend your recommendation and the strongest objection to it.

For individual study, decide before turning to pages 11-12. Compare your reasoning with the worked analysis and write a short reflection on what you would change. Choose one action to try in your own organization.

For teachers and discussion leaders

Read the full packet and timed plan before teaching. Assign pages 1-10 first and reveal the final two pages after students commit to a choice. Record the alternatives, evidence and disagreements on the board.

Treat clinical quality and informed patient choice as requirements, not variables students can cut to balance the model. This is an operating and finance discussion, not guidance on medical treatment.

> **How to assess the work**
> Look for a clear choice, accurate analysis, stated assumptions, attention to affected people, a fair objection, and an implementation plan with an owner and review point. Assess reasoning rather than agreement with the historical decision.

HYPOTHETICAL EXPANSION • PUBLISHED OPERATING MODEL

The decision

Aravind began in 1976 under Dr. G. Venkataswamy and developed a nonprofit, self-supporting approach to eye care. Its published account describes serving paying patients alongside people receiving free or subsidized care. The model makes operating economics part of the access mission. [V1]

Now consider a fictional hospital planning a monthly service unit with capacity for 1,000 comparable procedures. Leaders can reserve different shares for paying and fully subsidized patients. They must fund the unit, meet demand and protect the same clinical quality standard for every patient. The plan and all quantities are invented.

A choice about access and sustainability

Choose a service mix and an expansion rule. A high share of paying patients might generate funds for future growth. A larger subsidized share might meet more immediate unmet need but require additional funding. Neither result can be judged from procedure counts alone.

The leadership team needs to know whether patients can reach the service, understand their options, receive appropriate care and complete follow-up. A nominally free service can remain inaccessible if travel, information or lost work time prevent people from using it.

> **Scenario boundary**
> This is not a reported Aravind expansion. Clinical suitability and safety are assumed to be assessed by qualified professionals. Students may not weaken those requirements to improve the financial result.

THE BUSINESS LOGIC

Value has to be delivered

The patient’s complete experience

Patients value an appropriate outcome, understandable choices, respectful treatment and a service they can realistically access. Price is one part of that experience. Outreach can help connect need with care, but screening activity is not the same as a completed treatment or an improved outcome.

A surplus has a purpose

A nonprofit still needs to cover costs, maintain equipment, develop staff and absorb setbacks. A surplus can fund those needs and future access. The relevant question is how resources advance the institution’s purpose while preserving the trust of people who pay and people who receive support.

Cross-subsidy needs clear arithmetic

Revenue from a paying service first covers its own variable costs. Only the remaining contribution is available for common fixed costs and subsidized activity. Counting the entire fee as available support would overstate the model’s capacity to serve additional patients.

The financial plan also depends on real demand and real capacity. Empty reserved paid slots cannot fund occupied subsidized slots. More scheduled procedures do not create useful capacity if they overload staff, compromise follow-up or exceed safe operating limits.

> **A balanced decision**
> Choose a plan that can fund the promised service under stated assumptions, then test whether the service creates the intended patient value. Financial feasibility is necessary; it is not sufficient.

EXHIBIT 1 • SOURCE EVIDENCE AND PB QUESTIONS

The operating model

Published feature	Management question
Nonprofit and self-supporting purpose. [V1]	What surplus is needed to maintain and expand the service?
Paying and subsidized care within the model. [V1]	What contribution can one activity reliably provide to another?
Outreach as part of patient care. [V2-V3]	Where do patients drop out between awareness, access and follow-up?
Quality work within service delivery. [V2]	Which outcome measures must remain acceptable as volume changes?

Before approving expansion

Ask for evidence about demand by patient group, waiting times, safe staffing, follow-up completion and quality outcomes. Identify the capacity constraint rather than assuming it is always the operating room. Travel support or better scheduling might unlock existing capacity more effectively than a new facility.

What should remain equal?

Explain the distinction between optional amenities and clinical quality. If the funding model offers different service packages, patients should understand the difference and be able to make an informed choice. Do not assume that a lower price permits a lower standard of clinically necessary care.

> **The exercise’s limit**
> The model treats procedures as comparable units for arithmetic. Real services differ in complexity, resource use and clinical suitability; an actual plan must account for that mix.

EXHIBIT 2 • INVENTED CLASSROOM EXERCISE

A feasible service mix

Use Indian rupees (INR). The unit has capacity for 1,000 comparable procedures per month. A paying patient pays INR 6,000. Variable cost is INR 2,000 for every procedure, regardless of payment status. A fully subsidized patient pays zero. Monthly fixed operating cost is INR 1.2 million.

Plan	Paying procedures	Fully subsidized procedures
A	700	300
B	600	400
C	500	500

Assume all reserved slots fill, all patients are clinically eligible, and quality meets the same required standard. Ignore capital expenditure, financing, tax and depreciation. No donation or external grant funds a shortfall. The access goal is at least 400 fully subsidized procedures per month.

01 Calculate each plan’s monthly operating surplus or deficit. Which plans meet both the funding and access conditions?

02 At full capacity, what is the minimum whole number of paying procedures needed to break even?

03 If the fee falls to INR 5,500, recalculate the minimum paying volume and test plan B.

04 What happens to plan B if only 500 paid slots fill while 400 subsidized procedures are still delivered?

> **Quality is a condition**
> Do not reduce necessary care or staffing to make the arithmetic work. Revise the service mix, funding, timing or other defensible operating assumptions.

ALTERNATIVES • IMPLEMENTATION • ASSIGNMENT

Fund the promise of access

Approach	What it protects	What it puts at risk
More paid capacity	Financial headroom and future investment.	The immediate access goal if subsidized slots shrink.
A balanced mix	A specified access commitment with a financial buffer.	Reliance on enough paying demand at the assumed price.
More subsidized capacity	More immediate access for people unable to pay.	Sustainability unless a credible funding source covers the gap.

Your assignment

01 Choose a service mix and state the financial and access commitments together.

02 Specify evidence needed to verify demand and safe capacity.

03 Design a dashboard with financial, access and patient-outcome measures.

04 Set a trigger for pausing or revising expansion and explain how patients will be protected.

Distinguish a temporary funded deficit from an unsupported ongoing promise. If you propose donations or a different price, identify that as a new assumption and show what must be secured before relying on it.

> **The decision to defend**
> Explain why your proposal creates value for paying patients, subsidized patients, staff and the institution that must continue serving them.

WORKSHEET • COMPLETE BEFORE READING THE TEACHING NOTES

Your decision

Write as the decision-maker. Use the historical evidence and the classroom model for their stated purposes. A recommendation needs a boundary, an owner and a test.

My recommendation and the principle it puts into practice

The calculation or evidence that matters most; its main limitation

Who bears the risk, and how their choice or voice is protected

The strongest objection and my response

First action, accountable owner, review date and stop/change trigger

EVIDENCE • METHOD • LIMITS

Sources and reading notes

A hypothetical expansion decision informed by Aravind's published operating model. The capacity, prices, costs and alternatives are invented. No actual investment decision, patient case or internal hospital budget is reported.

V1 Aravind Eye Care System, Our Story

Institutional history, nonprofit purpose and self-supporting delivery model.

Open source document →

V2 Aravind, Annual Activity Report 2024-2025: Patient Care

Published account of patient services, outreach and quality work; contextual evidence only.

Open source document →

V3 Aravind, Community Outreach training

The organization's approach to local needs, community partners and outreach planning.

Open source document →

How to read the evidence

These sources describe Aravind's model and activities; they do not validate the fictional unit economics. An institution's account of quality should be examined alongside appropriate outcome evidence. This case makes no clinical recommendation.

All quantities in the classroom exercise are invented unless explicitly identified as historical. The models omit factors deliberately for discussion; they are not company forecasts. Photographs are documentary context, with dates and licenses on the cover.

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TEACHING NOTES • READ AFTER COMPLETING THE DECISION

Worked analysis

Monthly operating result

Plan	Revenue	Variable cost	Surplus / deficit
A	INR 4.2m	INR 2.0m	INR 1.0m
B	INR 3.6m	INR 2.0m	INR 0.4m
C	INR 3.0m	INR 2.0m	−INR 0.2m

Subtract the INR 1.2m fixed cost as well as variable cost. B alone meets both the stated access goal and nonnegative operating result. A is financially feasible but serves fewer than 400 subsidized patients; C needs additional funding or a revised plan.

Break-even and downside

At full capacity, revenue must cover INR 3.2m. At INR 6,000 per paid procedure, 3,200,000 ÷ 6,000 = 533.33, so at least 534 paid procedures are required. At INR 5,500, the minimum is 582. Plan B at that price earns INR 3.3m and retains INR 0.1m surplus.

With only 500 paid and 400 subsidized procedures, revenue is INR 3.0m, variable cost is INR 1.8m and fixed cost is INR 1.2m: the result is exactly break-even. Do not charge variable cost for the 100 empty slots in this model.

A responsible approval

B is a feasible starting plan under the assumptions, not a demonstrated real-world optimum. Verify paid demand, patient access, staffing and outcomes before expanding. The modest downside buffer makes monitoring and a pre-agreed response especially important.

> **Key error to avoid**
> Procedure volume is an activity measure. It cannot establish appropriate care, equitable access or an improved patient outcome on its own.

TEACHING NOTES • READ AFTER COMPLETING THE DECISION

Outcome and teaching plan

A model to test, not a reported decision

Aravind's published history and activity reports document an enduring service model and continuing outreach. They do not report an outcome for this hypothetical unit. Use the debrief to test whether the proposed plan can deliver its access promise without weakening quality or financial sustainability. [V1-V3]

A 75-minute discussion

Minutes	Facilitation plan
0-10	Choose a service mix and define what success means.
10-25	Map patient value, access barriers and funding flows.
25-40	Calculate all plans and both downside tests.
40-55	Design a dashboard and a responsible expansion gate.
55-65	Discuss the limits of applying a simplified model to real care.
65-75	Identify another cross-subsidy whose economics and outcomes need joint review.

> **Closing question**
> What would show that a financially sustainable service is also creating the human value it exists to provide?

Assess the decision at its stated boundary. Later success cannot prove the original choice was sound; later failure cannot, by itself, prove it was unreasonable.