"They were not looking for freebies": Jayanth Bhuvaraghan on price points, the value of field experience and how compelling data can get governments on board

Ambika Samarthya-Howard
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Ambika Samarthya-Howard: Can you talk a little bit about your experience with eyeglasses and what models you specifically work with?

Jayanth Bhuvaraghan: My experience with eyeglasses, especially Ophthalmic lens business has been quite long, over 25 years, in different geographies, employing different business models. I started off by setting up the subsidiary for Essilor in India. I was the first employee; right time, right place. It grew very well and then I created businesses in the Middle East, East African countries, before moving to Singapore and Southeast Asia. That was all setting up businesses in different countries for Ophthalmic lenses

Ambika Samarthya-Howard: What was the name of the business? And when you say that you set up businesses for eyeglasses, what do you mean by that?

Jayanth Bhuvaraghan: Essilor International. Essilor was the largest Ophthalmic lens company in the world. In 2018 it merged with Luxottica, the largest frame manufacturer, to create a world leader in Eyeglasses. At Essilor, we sold Ophthalmic lenses, prescription lenses and progressive lenses to the opticians and eye hospitals. It was primarily market creation driven by the market needs and market-priced.

I was setting up and running Essilor subsidiaries around the emerging markets primarily in Asia and Africa regions, starting green field companies and also by doing acquisitions, joint ventures, partnerships with local partners. We were primarily creating new markets and consumers in these emerging markets.

While we were doing all of this, my experiments with going to places where there was no access started around 2004/2005. Around that time, we were already working with hospitals like Aravind Eye Hospital and Sankara Nethralaya in India who are pioneers in the world in the area of cataract surgery. And my question was, "Why can't we dispense eyeglasses through the cataract camps? What do we need to do to help this?" It was something they considered, so we started experimenting with these hospitals. They had the infrastructure to screen people for cataract, and we helped in adding the refractive error component to it. Then, we gave away or sold eyeglasses to the patients in these camps

Certain things came out very clearly in those initial stages; there was a real problem of access. Most of the rural consumers were living on a daily income, so if they needed to get glasses, they had to travel forty to fifty kilometers, which can take anything between three to four hours one-way in rural areas. Also, normally, they don't go alone; two of them go together. So after coming back to get the glasses, they would have lost four days of income for getting a pair of glasses. Because of this their eyeglasses needs were never met.

Ambika Samarthya-Howard: How did you figure out these types of details about the access and transportation? Did it happen through a study?

Jayanth Bhuvaraghan: Field experience by seeing it happen in front of your eyes and working with partners to do that. There was no study that was done. There have been studies done here and there, but it was actually real life experience in the field. The message was loud and clear that there were access issues there.


Second thing that came out – which was pleasantly surprising to me – was that people were willing to pay. They were willing to pay what they could afford to pay, and they were not looking for freebies. The people in the villages and small towns where we went were willing to pay for the products; they had their own aspirations as consumers. They wanted choices, they wanted colors, they wanted shapes, and they wanted good service; typically what any consumer would look for.


Those messages came loud and clear from the market. The understanding at that time was that people were poor and had nothing so anything will work including hand-me-downs and used spectacles. That was the view from the developed world, in general, but it was so wrong. People

had a willingness to pay. So access and intention to pay, these two things came out as clear learnings in those early days.

 At that point, we already started romancing with technology where we had a collaboration with Sankara Nethralaya and Indian Space Satellite Research Organization [ISRO] who gave us bandwidth on the satellite link with an antenna in a van. We used that to travel to villages near Bangalore and far away to do teleophthalmology. They would see an ophthalmologist virtually and get their eye examinations done.

 At that point, we were sending another van along with the tele ophthalmology van… a mobile optical shop that sold glasses and gave glasses to those who couldn't afford to pay. This was in the early days, like 2006/2007. We were already trying to do teleophthalmology with this hospital in Chennai. That was my initiation into this field of reaching out to people who had no access.

Ambika Samarthya-Howard: Can you talk a bit more about how the mobile optical operations worked?

Jayanth Bhuvaraghan: [The initiative started about 15 years ago]. Here's a video on that. [It} gives you the whole story about how it works with pictures, etc.

Ambika Samarthya-Howard: Yeah, that would be great. And how much did that scale?

 **Jayanth Bhuvaraghan:** It did not scale. So, that was another point. It did not scale for a simple reason – a van has limitations as to how much distance it can cover and what it can do. If you had to reach millions of people, you probably needed hundreds of thousands of vans. So, from being an eyecare operator or a hospital, you became a fleet operator. To manage a fleet of vans and things is a different proposition.

 Most importantly the capital expenditure and the cost to serve was very high. It was very resource heavy. While it was effective when it was there, the cost to serve was high and not financially sustainable.

Another message which came in very clearly was that you needed a permanent access point. We could go to a particular village, but the van could only be there for a day or two, then it moves to other places. We would not go back to the village for a year or two, so there was no follow up for people who needed further interventions. You needed a permanent access point.

So those were problems with the van. It was a good idea, but it did not have the potential to scale. In fact, there's a case study from HEC Paris where they wrote about this whole thing back in 2007/2008.

Around 2010/2011, I joined the executive board – the "Comex" as the French call it. The new Chairman/CEO saw that we were doing well in terms of profitability, but we were not addressing the whole market. Surprisingly, there was no study to estimate the size of the refractive error problem and the number of people who are corrected and uncorrected.

So, we commissioned BCG [Boston Consulting Group] to do a study for us in 2012; at that point of time, they came back with a number which said that the total market is around 4.5 billion people. Two billion are corrected through opticians, ophthalmologists, and other networks while there are 2.5 billion people in the world who have uncorrected refractive error, which meant that one-third of the world had visual impairment because they didn't have access.

Around that time, Kevin Frick from Johns Hopkins had done a study on the economic impact of poor vision. He came up with the financial equivalent of productivity losses in the world due to poor vision… $225 billion every year. Everything was falling in place. The size was huge and there was a big economic impact, and we had the solutions. We knew what needed to be done, so why couldn't we solve the problem?

That's when we created a new function, which I took charge of as the Chief Mission Officer. My mandate was to reach out to the people who are uncorrected and find ways to provide them eyeglasses. Early on, we were very clear – I was very clear – that philanthropy was not a solution to solve the problem of one-third of the world. We needed business solutions to solve this problem, or at best, a hybrid of philanthropy and business solutions.

 We went back to the drawing board to build business models and find products that could serve people, not quite at the base of the pyramid, but the lower part of the pyramid. Our estimate was that out of the 2.5 billion, probably about 800 million people were living below the poverty line. That's below $2 a day. They would need philanthropic support, but the large majority of them could still buy their products provided it was made available to them at an affordable price and at a place they could easily access. That was my theory of change, and I started working on that.

 We set up an inclusive business arm in 2013 and set up the "BoP [Base of Pyramid] Innovation Lab," which was supported by the Economic Development Board of Singapore, the government of Singapore. They supported us by taking 50% of the cost of operations of the BoP innovation lab in the initial years.

 We also set up an advocacy and awareness creation arm. Simultaneously to address the 800 million people living below the poverty line we set up foundations around the World to give them free eyeglasses. It was a comprehensive plan addressing all segments of the society.

 We were quickly able to come up with products that people could afford to buy. I had a very simple rule of thumb about the cost of the product, and this is true anywhere in the world whether you are in New York, California, Bangalore, or in a village near Chennai, the cost of eyeglasses is and should be anywhere between three to four days of your income. If you earn $2 [a day], we should be able to give you products for $6 to $8. Keeping this in mind, we needed to develop products that could be sold for less than $10.

Ambika Samarthya-Howard: How did you come up with that rule? Why three days and not two days or six days?

 **Jayanth Bhuvaraghan:** This was again, [based on] field experience. We knew what people were willing to pay. There were also internal studies we did on our own. There was nothing published, but we tested different price points. We've seen what their willingness to pay was and how much people were spending on other products.

Then there was the question of solving the access issue. We said that we needed an outlet for [every] population of around 25,000 [people]. This was another number that we picked up based on the markets that we were working in, which had large, densely populated populations. Access should take less than an hour, preferably thirty minutes, to come to the shop and go back. Looking at all of this, we said we needed to create outlets to do that.

 We started in India, which was a hotbed for all the creativity and innovation in the BoP Markets where there was a lot of work happening on skill-building. I had a friend running a skill-building organization who helped us create a course for opticians and refractionists. We started with a first batch of ten people [who were] young, very motivated guys.

That worked very well. We did a training program for about two months, and they became quite good at the job. We took that a step further and helped them go to their villages and start their own outlets to become entrepreneurs in their own way. Again, that worked, so we scaled the program. This program is called Eye Mitra. Mitra is the Sanskrit word for "friend."

That scaled up very well and solved the need for a fixed access point. We were creating startups, employment and livelihood. With this program, we would train them for six to eight weeks, then give them a grant for 25,000 rupees to go back [to their villages] to start an outlet. We would also train them on the business skills they needed to become successful entrepreneurs.

Today, we've got over 10,000 of them in India. We've also expanded that to Indonesia and China. In Kenya, it's called Eye Rafiki because 'rafiki' in Kenyan means "friend." It's not the same exact model, but variants of it have been adapted to the [local] situations.

Around the same time, McKinsey helped us to do a study to create a road map as to what it takes to eliminate poor vision from the world in one generation. And what will it cost? We launched that roadmap in 2018 on the side of UNGA in New York. That roadmap shows that you can solve this problem by 2050; that every single person could have access to eyeglasses. It shows that the industry or whole sector would need to invest about $14 billion over the next 20 to 25 years into three to four buckets.*

 One is innovation, which will be front-loaded, and that's about $2 billion or so. A big chunk of it is about awareness, because that is something which is missing. Then, creating access points, which is the Eye Mitras [model of] reading glasses access points, and advocacy. The calculation showed us that we need to create a million outlets over the next 25 to 30 years. Out of that, 600,000 of them should be purely reading glasses related while 400,000 should be full-service [outlets] that do all the other refractions. It was a fairly comprehensive report, a roadmap to see where we need to go and what we need to communicate to stakeholders.

Ambika Samarthya-Howard: What happened after that?

Jayanth Bhuvaraghan: Luxottica and Essilor merged in 2018 and created the largest end to end eyewear company [in the world]. I retired from the company in 2021. Since then, I have continued my passion for eye health acceleration as an independent consultant and Senior Advisor, and also by being part of the board of directors of different organizations like EYElliance and RestoringVision. I am also a Global Ambassador for the Vision Catalyst Fund and an Emeritus trustee of the India Vision Institute.

 I am a firm believer that spurring new tech innovations will help us democratize eye health and solve the problem of access and scale. To this end, I am encouraging and mentoring tech start ups that work in this space. I am greatly excited by the possibility of doing refraction on mobile phones and using big data, AI [artificial intelligence] and ML [machine learning] in this area.

Another area of interest is knowledge building and sharing. A question that has come up is whether people are actually wearing the glasses long after we give them and are they finding them beneficial. There hasn't been any big studies done on whether [these programs] work, don't work, or what happens after.

** This estimate includes all vision issues and is not limited to presbyopia*

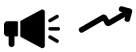
We did a big intervention in a district near Bangalore in South India where we covered every single person in the village with glasses. So I'm now trying to do a dipstick study to go back after two years to check whether the glasses are being worn, what price they paid, etc. to give some idea about whether this intervention worked or not, as well as to check what other things came out of it.

If some interesting insights come out of it, I'll do another detailed one which will be more quantitative, but right now, I'm just doing it on a very small scale. That's one of the things I'm doing on my own. Another thing is that I'm also searching for new business models; I'm incubating some new ideas.

 I am incubating a project in Coonoor, South India. It's a hilly area with many tea plantations with a population of over 800,000 people. We are trying to figure out how to reach all these people and find new ways to distribute reading glasses. There's a local Rotary Club that does amazing work there and an eye hospital also doing some brilliant work, but they do it independently. We are trying to connect the two, and also have a person who would work with them to create sustainable access points where we can distribute reading glasses. We can then sell reading glasses there so that we can be financially sustainable in the long term. Once we find workable solutions, the idea is to share it globally and replicate it wherever possible.

My interest lies in incubating new ideas more from this perspective. That's what keeps me busy nowadays.

Ambika Samarthya-Howard: I have a couple of follow-up questions for you. In the McKinsey report, you mentioned awareness and advocacy. What is the difference between awareness and advocacy in the eyeglass context?

 **Jayanth Bhuvaraghan:** In our context, the way I see it… Advocacy is primarily working with the government and policy makers to create awareness amongst them about the need and the huge ROI [return on investment] that the countries will derive by focussing on eye care. While awareness is all about educating the consumers about the importance of eye exams and wearing eyeglasses when needed. Both are important stakeholders who need to be reached.

While effective creative local communications will help us reach the end consumers, for the governments we need to show them compelling studies and data to back up our claims.

Ambika Samarthya-Howard: Can you talk a little bit about demand generation? A lot of what you've been talking about is more of the supply side and the access side, and I hear what you're saying about people willing to pay, but it feels like in a lot of places in the world, people might be more concerned with other more urgent healthcare matters. I know demand generation comes up a lot, so I was wondering how you've seen it or tackled it?

Jayanth Bhuvaraghan: That's very true, actually, because people don't realize that they've got poor eyesight. Since it's a gradual drop in power, they tend to learn to cope and live with it, and they just treat it as a matter of aging.

That's not only in the emerging countries. It happens everywhere in the world. I have seen it even with a lot of my friends. They would gather at a dimly lit restaurant and be embarrassed to be looking at the menu for a longtime. People may think they're looking at the prices and deciding what to order, in reality they just can't read because they have a simple near vision problem that can be corrected with a simple pair of reading glasses.

The added complication about loss of vision is that it is gradual and painless. In contrast, If you had a toothache, within twenty-four hours, you would run to a dentist to get it fixed. Because of the nature of this problem eye care tends to get neglected. This has been a historical problem.

 Consumers need to be educated on the importance of eye care and the huge impact it can bring in their lives. The industry needs to do more in explaining the value proposition that eye care brings to consumers.

There have been a few things that have been tried globally. In India, Amitabh Bachchan lent his name and supported a campaign to encourage people to go to optical shops to get their eye tests. This had a tremendous impact and the eye exams boomed during the campaign because they could connect with his message and trusted him. There have been other campaigns with celebrity endorsements that helped in terms of creating awareness.

There could be other ways of doing it through digital platforms and things like that. It's a big thing. In fact, of the $14 billion, if I'm not wrong, I think over $6 billion is earmarked for awareness and advocacy.

Ambika Samarthya-Howard: Have you seen anything not work in terms of the demand generation?

Jayanth Bhuvaraghan: There are probably a few mistakes which we did that we can learn from and rework on. So the Eye Mitras, although there are about 10,000 of them, not all of them are successful. About 20-30% of them are very successful while some of them are kind of meandering their way and others are not successful at all. It's got to do with various things.

 You need a certain level of entrepreneurship from the person who's running the shop to make the business work. It's not provided just like that. When creating a new market, you also need to create those things. Those skills are not very easy to find. If they're [driven to create a

successful business], they'll probably end up doing other things than selling eyewear at 200 rupees. There's a [limited] availability of talent.

In Brazil, there was an already existing model in the Favelas where consumer product companies sell their products door-to-door and offer installments. We thought it was a natural fit for us because these guys have access to the Favelas and already have an existing commercial relationship with the families. But it did not work. Because again, the skills required for selling a consumer product and the skills required for selling eyecare are different. We had to stop it.

What I'm going to tell you now will probably surprise you – the pharmacy model did not work for us in many parts of the emerging markets in the world. Even the petrol stations model did not work in many parts of the world, which we tried.

  We tried the pharmacy model in Medan, Indonesia and in China. We tried working on this model through the pharmaceutical distributors who had the supply chain and relationships with the pharmacies. We had specially designed and attractive displays put up in the pharmacies.The distributor salesmen were trained to sell readers. But it didn't work.

 Some of the reasons for that was pharmacies are a very high and quick turnover kind of a business. Lots of people come to buy medicine and go off, and they probably didn't find eyeglasses that attractive at that stage. When we put reading glasses in these outlets, even if it was high traffic, at best we sold about ten glasses in a month. It was nothing compared to [the business] they could do every hour or every day; there wasn't enough motivation for them to do it. There could also be other reasons, but it also didn't work very well in China. There needs to be more work done in this area.

Ambika Samarthya-Howard: I can see why the pharmacy model doesn't work, but I don't understand why the petrol station model doesn't work, because it feels so convenient.

 **Jayanth Bhuvaraghan:** We tried the petrol station model in East Africa, including putting up a few kiosks where one could buy it there, but you've got to imagine in countries where people are typically on their two-wheelers, they're interested in just going to get their two liters of petrol, paying on the spot, and moving on. Most of them pay the cash to the attendant and don't even go inside the petrol station.

These models work in continental Europe; I've seen it in France, Germany, etc. It works very well. But I cannot think of a place in developing countries where it has worked. Even in Singapore [where I live], pharmacies are hit-or-miss. I don't think all of them have reading glasses.

I think we need to actually be in the field to understand where [people] actually go, what they need, and what the business economics are to find a model suitable for that area. There's no cookie cutter approach possible where you just pick one model and scale that around the model, or even three models. We should have a menu of models which have worked and not worked with all the learnings, but ultimately, each city or village has to look at that menu and come up with an adaptive model for what makes sense for them.

Ambika Samarthya-Howard: And what do you think about community health workers?

 **Jayanth Bhuvaraghan:** That works very well in countries where such networks exist. For instance, EYElliance has demonstrated the success of this model in Liberia. The definition of success here is effective and smart connection across all stakeholders and also ensuring that eyeglasses are properly integrated in their program. Now the next step is to take this model and the learnings to other countries.

It's also being tried through different models, like in Bangladesh and a few other countries, not exactly through community health workers but through other networks that reach the last mile like Grameen network in Bangladesh and the ASHA [Accredited Social Health Activist] workers in India. But I believe more work needs to be done in this area.

Ambika Samarthya-Howard: I'm actually going to Bangladesh in a few weeks to look at the project VisionSpring has right now.

 **Jayanth Bhuvaraghan:** A unique collective action by major stakeholders led by VisionSpring was conceived by all of us many years back. At that time, I was still in Essilor, which is also part of it. I've not been following the latest there, but you can look at that when you go there and check with the different stakeholders.

Ambika Samarthya-Howard: I know India is the area where early adopters often are, where there is more uptake a lot of the times. But it seems that this is much more difficult in other parts of the world. What factors are at play?

Jayanth Bhuvaraghan: Yeah, and even in India, it varies from region to region. And in any case, India is the largest market in one country. And then India historically has a lot of innovations in rural penetration and marketing through other companies like Unilever and Procter & Gamble, and things like that. And then there's interest.

Well, I think in most of the other countries too there is a lot of exciting work happening and I am confident to see big success in the area of access creation and impact. We need to create effective business models adapted to each country.

Ambika Samarthya-Howard: That makes so much sense. Well, this was really a lot of insights. Thank you so much for taking the time to talk to me.

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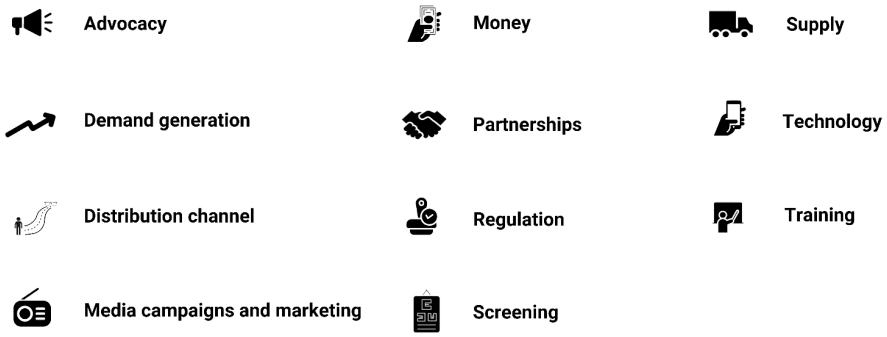

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** This interview has been edited and condensed.*