Equitable Healthcare Access to the Poor

Monograph (Vol I)

6 March 2018
L V Prasad Eye Institute
Hyderabad

Dr. G. N. Rao
Mr. M. P. Vasimalai
Dr. G. Chandra Sekhar
Ms. Anshu Bhargava
Dr. Shobha Mocherla
Prof. Prakash Satyavageeswaran
Prof. D. V. R. Seshadri

Acknowledgements

An effort of this nature does not happen without the support and involvement of a multitude of people. The authors named are the people directly involved in the creation of the Monograph. The authors gratefully acknowledge the support of the staff from the L. V. Prasad Eye Institute (LVPEI), DHAN Foundation, and the Indian School of Business, who were instrumental in the planning and conduct of the meeting on the 6th of March 2018, which is the basis for the current Monograph. Specifically, the authors would like to acknowledge the support of Dr Sreedevi Yadavalli, Sreedevi Penmetcha, Vijaya Perumal, Mahaveer Jain of LVPEI. The authors also acknowledge the efforts of A D Chitralekha in editing and polishing the document. Finally, the authors thank all the participants of the meeting for their thoughtful comments and discussions, which forms the basis of the present document.

Table of Contents

Prologue 2

Chapter 1: Equity in Health Care – a Paradox? 4

Chapter 2: Trained Workforce, an Integral/key Ingredient 7

Poor training and need for skill building 7

People and Skill Gap..... 8

Unwillingness to go to the rural areas 11

Chapter 3: Task Shifting, an Answer to Sustainability 14

Chapter 4: We Participate; the Community Owns 19

Chapter 5: Working with the Government; Issues and Work-arounds 23

Chapter 6: Learning Hub, the Ultimate Convergence 26

Epilogue 30

List of Participants 33

Prologue

India ranks among the top countries in the world with the largest private sector healthcare practice. It is also among the most populous countries in the world. Yet, ironically, India ranks 145th among 195 countries in terms of quality and accessibility of health care, behind its neighbours viz., China, Bangladesh, Sri Lanka and Bhutan, according to a Lancet study. The study further emphasized "the urgent need to improve both access to and quality of health care across service areas and for all populations; otherwise, health systems could face widening gaps between the health services they provide, and the disease burden experienced by local communities."

Hence, an acute need was felt for dialogues between established and upcoming healthcare institutions spanning various healthcare specialties, to provide access to health care for all, irrespective of the patient's capacity to pay. It was also felt that health care is not an isolated factor contributing to human well-being. Its immediate connection to livelihood and education of the next generation is apparent. Thus, the germ of an idea was born to get like-minded organizations to form a network to create synergies.

This resulted in a meeting of about forty individuals representing ten organizations in health care, education and livelihood on 6 March 2018.

LV Prasad Eye Institute (LVPEI) and Aravind Eye Care System (AECS) have demonstrated the potential for rolling out equitable access on a massive scale in one important aspect of health care, viz., eye care. In a similar manner, DHAN Foundation has, on a pan-India scale, done so for livelihood. Several organizations including LVPEI, DHAN Foundation, Fernandez Hospital, Ameya Life, Doctors for Seva, NanoHealth, SIICP (Smiles International Institute of Colo-Proctology), ISB (Indian School of Business), and IIM (Indian Institute of Management) Udaipur were present in the initial meeting on 6th March 2018, hosted at LV Prasad Eye Institute, Hyderabad.

The basic objective of this meeting was to explore the potential for creating a forum for mutual learning and ideation to create synergies and take up these ideas for implementation, through the stages of pilots and subsequent scale-up. The deliberations during this meeting, wherein potential for such a network was realized, led to the formation of The Equitable Healthcare Access (EHA) Consortium

EHA is a Consortium of socially sensitive healthcare providers, organizations involved in fostering livelihood for the poor, and education institutions targeting the poor, from across the country, who can through networking and resource sharing, come up with new and improved models for providing access to health care, livelihood and education to the poor. Hopefully such a model will provide inspiration for similar experimentation in different parts of the world, especially in the developing world.

Chapter 1: Equity in Health Care- a Paradox?

Some of the participants at the meeting, having delved deeply into successful models for equitable eye care such as those seen at Aravind Eye Care and LVPEI felt that the time was opportune to find ways of creating similar models in other healthcare specialties such as cardiac, neuro, oncology, orthopaedics, etc. While there were a few existing models for these other specialties, many have not scaled to the level to which Aravind and LVPEI have grown. One of the important ingredients for a stable society is equitable access to high quality health care for all, which was the primary reason to organize this meeting. The tone for the meeting was set by Dr. G.N. Rao's (Founder, LVPEI) comments on LVPEI's journey.

Dr. G.N. Rao, Chairman of LVPEI, set the tone for discussions by referring to the Economist article on the missing Indian middle class. The bottom 50% of India is similar to the destitute parts of Africa as per the article. Interestingly, there did not seem to be enough financial resources to cross-subsidize the free treatment for the poor through charging higher amounts from the rich, given that only 1% of Indians earn more than Rs. 100,000 (UDS 1400) per month. Looking at this picture, he questioned if we could create a system where health care is made accessible to all the different groups of people. This would include the upper 1%, the next 9% comprising the middle class, the 40% comprising the lower middle class, and finally the bottom 50%. In absolute numbers, the last two sets of people are huge, each accounting for several hundreds of millions of people.

He emphasized that when we talk about equitable care, it is not just giving some care to everybody. It is equitable only if we give the same kind of care to everybody, without any discrimination. So, the principle, equitable health care means equitable access to health care irrespective of paying capacity, without compromising quality.

Interestingly, he pointed out that LVPEI has been unknowingly addressing this issue in some sense for the last 30 years. He reflected that when LVPEI began to see the poor quality of care in the rural areas, it entered into these areas creating a model where the quality it would provide in those areas would be the same as that of the urban areas. It started with a simple

premise: to reconcile excellence with equity. The choice of obtaining treatment as a paying versus non-paying patient \Vas made by the patients themselves. People were largely honest and people who could pay, did pay. He highlighted that there had been some exploitation by a small fraction of patients, but LVPEI found that it was not significant.

He was told multiple times by people that such a model was not possible. However, LVPEI persisted and has now proved to the world that indeed this model is eminently possible!

Dr. G.N. Rao stressed on the fact that the facilities and doctors had to be the same for all patients, irrespective of their paying capacity. When he talked of quality of health care, it had to be quality, equity, and excellence, with the right kind of workforce.

While he warned that India is soon going to have a convergence of the diseases of the past with those of the present -given that we are # 1 in TB, leprosy and are going to be # 1 in cancer, diabetes, and cardiac problems, every segment of health care needs to evolve a model for providing equitable care to all people.

He thus maintained that what LVPEI had done in a very small way, in a very small segment of health care, could be replicated, and perhaps be improved and implemented in other areas of health care.

Mr. Ratan Jalan, Founder & Principal Consultant, Medium Healthcare Consulting, pointed out that everyone in healthcare business, ironically, claims to be world class. Even small clinics in small towns tout their world-class status. What we really need, he emphasized, is 'India class' hospitals, which incorporate cost effective innovations suitable for Indian circumstances and conditions, and not 'world-class hospitals'.

Prof. D. V. R. Seshadri, faculty at ISB, strongly agreed, maintaining that doctors and hospitals in small towns have shifted the focus to profits.

Dr. Taraprasad Das, Vice Chairman, LVPEI, pointed out that the village-level need for medical care is different from that of the urban areas. Creating the right eco-system to generate synergies for the participating organizations is the next logical step. While there is a strong need for paramedics training, community ownership would make a big difference. There is a need for inclusive partnership at all levels. As demonstrated by LVPEI in the context of eye care, getting the vision technician at the village-level to multi-task (i.e., develop other complementary skills) may be the key to equitable healthcare access. He wondered if such healthcare providers for other ailments could learn t]·om this experience and replicate it in their own specialty areas.

Chapter 2: Trained Workforce, an Integral/ Key Ingredient

Dr. G.N. Rao stressed on the need for creating a well-trained and motivated workforce. LVPEI had developed the talent in-house by looking at its needs, as the talent needed for such models to be launched in a sustainable manner is not readily available.

Dr. N. S. D. Prasad Rao, Founder & CEO, Ameya Life suggested that this need could be bridged by adopting the 'Virtual hospital' as a concept.

In response, Dr. G.N. Rao was emphatic when he stated that he did not believe machines could replace humans. He maintained that there should always be a human element. Only when we combine artificial intelligence with natural intelligence would we get the best results. He rather challenged members to point to any global example where telemedicine has replaced a large segment of clinical work. It could only facilitate to some degree, but one still needed people.

Poor training and need for skill building

Dr. G.N. Rao further talked about the poor quality of education across all healthcare cadres in the country. In addition, the numbers of healthcare professionals that are coming out of the country's education system are grossly insufficient across various levels, in comparison to the country's need. LVPEI gets nurses who have never stepped into a hospital during their training. They have a basic science degree. In many of the nursing institutions, their nursing training is done in a classroom! Seldom do they get to see a 'real' patient. The focus of even the statutory bodies, he declared, is only on certification and not on developing competencies of the professionals.

The problem in our country Dr. Taraprasad Das remarked, is the obsession with certification, where youth are focused on getting degrees rather than learning new skills or gaining knowledge. People do not value competence, which is a serious problem. Instead, more emphasis is given to obtaining a certification from

some institution or another. There is need for policy makers to recognize competence-based education and to promote people based on competence and not merely based on certificates.

At LVPEI, common people who join as trainees or employees from various parts of the country upgrade their skills by doing technical courses, nursing courses, etc. Well-charted-out career paths are outlined for them. LVPEI focuses on developing competencies at every level, wherein people get promoted and are given opportunities to grow based on demonstrated competence. This is a big difference compared to what we generally find in the society which is more focused on certification.

Mr. Vasimalai, Executive Director, DHAN Foundation, found this observation very insightful. He shared information about how DHAN runs People Academy, which trains community leaders using competence building programmes for hundreds of batches of people leaders. The Tata DHAN Academy (now called 'The DHAN Academy') trains select youngsters in a two-year MBA programme to work in the development sector. Placements for these people is good. Several of the graduating students are recruited into DHAN. So much so, he revealed that when DHAN Academy was considering UGC recognition, it was told that given the track-record and the work being done by DHAN Academy, UGC recognition is not needed for the Academy, since the outcomes are already excellent.

Dr. G.N. Rao added that LVPEI was also tempted to become a deemed university. However, several former vice-chancellors of universities warned that becoming a deemed university would be the beginning of the end of competence building at LVPEI and the idea was dropped.

People and Skill Gaps

Dr. Santosh Kumar Kraleti, Senior Health Advisor to Doctors for Seva and Founder and Executive Director, Dhaatri Mothers Milk Bank, talked about the challenges in bridging the gap between the large numbers of trained people required and the availability of skilled manpower. There are thousands of volunteers for example in their organization who are unpaid part-time or unpaid full-time volunteers or full-time workers with modest remuneration.

They are not well-trained but have their hearts in the right place. As a way of addressing this skill gap, one could experiment with cross-training of volunteers, so that they are able to work on multiple themes. The other big challenge is to bring the heart (and humane approach) into care-giving in a typical person who has only skills. According to him, Teach for India (TFI) has a good model that Doctors for Seva is trying to emulate.

Mr. Vasimalai seconded Dr. Kraleti, saying that TFI does have a well-structured fellowship programme. He also talked about SBI, which also has a fellowship programme, wherein young, idealistic graduates are inducted and given opportunities to work in the rural arena. After a year or two, they may choose to continue to work in the development sector or go back into the mainstream. Many of these inductees are deputed by SBI to work in the various DHAN projects. What is needed, he emphasized, is structuring and positioning of the specific programmes suitably to be successful. Immersion programmes help trainees get connected with the poor people, especially in the rural areas. Often, these programmes affect the trainees in a deep way and open their eyes and hearts to a world of alternative career options.

Mr. Vasimalai went on to declare that the NGO sector cumulatively 1s a very large employer, although most people do not know of this fact, since the sector is quite fragmented. Furthermore, the NGO sector develops people across the board and creates large numbers of grassroot leaders. Thus, there is scope to do a lot of innovative work in this sector.

Dr. G.N. Rao stated that the TFI-model however does not work among doctors because social service is not part of what is taught in medical colleges. There are no alternative models presented to the medical college students other than the fact that doctors are meant for private practice or for working in corporate hospitals. Those are the role models presented to the students. The discussion is often only on how a doctor can make more money. Ironically, we are more likely to get doctors from abroad to work in rural India than to get Indian doctors to go to rural areas voluntarily for work, he rued, and emphasized the need to sensitize students of medical schools to the realities of the 'other India.' This is related to the broad subject of public policy and public health that is generally absent as a subject in medical colleges. He talked about the LVPEI model of 3H (hands, head, and heart), wherein, LVPEI seeks to impart the right service attitude among its doctors and fellows (who pursue super-specialty education at LVPEI).

He expressed, "We believe that hands with no head and heart are useless. For a good doctor, all the three are essential for providing compassionate care."

Mr. Vasimalai agreed that identifying the right kind of people was the key. DHAN Foundation has 400 professionals. It is in reality a Human Resource organization where people (i.e., members of the community that DHAN serves) are the owners. He maintained that motivated people with the right attitude are available in the society to do the kind of work that DHAN does. He expressed the need to dive very deep into the pool of potential candidates to choose the right ones. Taking the example of DHAN, he pointed out that there would be 2 to 3 people out of a potential pool of 100 candidates, who would be the right fit culturally for DHAN. The challenge is to find them. The search cost would be high, but at the end of the day, the whole effort is worthwhile. These recruits need to be then groomed rigorously into the culture of the organization. The search process is the key. For the MBA programme in development, some 200 to 300 professional colleges are visited to enthuse students to join the MBA programme after their graduation. After all this effort, 10 to 12 students finally decide to join the programme. It is still worth all the effort, Mr. Vasimalai said, as each of these people, on graduating, make a huge difference in the country, simply based on the value that they create in the society through their work. According to him, "If you make your professionals motivated to do extraordinary work in the society and they really are shown a future where they can make a difference, they take ownership of their work. The development professionals tend to stay back and bring more people into the DHAN fold. This has been our experience".

Dr. Raja Narayanan, Consultant Ophthalmologist, LVPE seconded Mr. Vasimalai saying that at LVPEI too, they have a comprehensive ophthalmology fellowship. Therein, doctors work in the rural secondary centres and become eligible for their specialty posting, which serves as a career plan and is valued highly. He reasoned that just trying to force people into rural areas would not work. The government does not provide visibility of future careers for doctors going in for rural postings during their early careers. That is the challenge for doctors passing out of government medical colleges. At LVPEI, this problem has been effectively addressed by showing the fellows a medium to long-term career path of progression.

Unwillingness to go to the rural areas

One of the problems, brought up by Dr. Kraleti, was the dearth of doctors and trained personnel in the rural areas, common across all healthcare specialties.

Mr. Ratan Jalan wondered as to how ITC and HUL (two large MNCs that are sought after by fresh graduates) get MBAs from IIMs to go to really far-flung areas such as Saharanpur or Bareilly. Possibly, they promise a bright future through a career progression plan, which is clearly charted out upfront and communicated individually to these '. Clearly, the institution needs to look after its staff, and only then the staff will look after the institution.

Dr. G.N. Rao revealed that this approach was tried at LVPEI but was not successful. Promises of future faculty position, higher salary, etc. as future rewards for rural postings were given but these did not work.

Dr. Veda Prakash Gowda, Orthopaedic surgeon with CARE Hospitals, Hyderabad and the President of SAKSHAM for the state of Telangana categorized doctors into 5 types: (1) Self-motivated and committed doctors, which is about 1%. These are people who will work on their own in the rural areas. They do not need any extrinsic motivation. (2) 60% of doctors who are eager to work in rural as long as reasonable facilities are available for them and their families well-being and their career growth is ensured; (3) Doctors for whom going to the rural areas is the only option available. However, their motivation would be low. (4) Doctors who will go to rural areas only due to government mandate. (5) Those doctors who will not go to the poor, rural hinterland, as they are focused on maximizing their wealth by serving the upper strata of the society.

He expressed that it is important to identify for each doctor, into which of the above five groups he/she fits into, work only with the first two of these groups and provide them with what they need, in order to facilitate them to look at the opportunities and advantages of working with a broader mindset of serving patients from a wide spectrum of the socio-economic strata, including the rural and the poor.

Dr. Raja Narayanan spoke about the need for an enabling system to reduce sources of friction for doctors doing their rural stints. He ref1ected that there was little clarity on health policy even in places where you would expect such clarity, such as in the concerned government departments. There are many hindrances such as inability to move doctors to a different state in India without their needing to re-do their rural stint. As a result, healthcare models that work well in one state do not meet as much success when they are replicated in other states.

Dr. Somasheila Murthy, Consultant Ophthalmologist LVPEI brought out the fact that, generally, the patients who have health-related problems are referred to the next level of LVP}Ts famed pyramid model of healthcare delivery (starting from vision centres to secondary to te11iary hospitals and finally to the Centre of Excellence at the Hyderabad campus). At the same time, there is need to go downstream, as it is not necessary for all patients to come to the Centre of Excellence (for example, to attend to refractive error correction). This will help decongest the higher-level hospitals of the healthcare pyramid. Keeping this in view, at LVPEL specialists from tertiary hospitals periodically visit secondary hospitals to provide high-end care to cater to those patients who cannot come to the tertiary hospitals or to the Centre of Excellence at Hyderabad. This approach helps to decongest the tertiary hospitals and the Centre of Excellence.

Dr. Pramod, Director at Fernandez Hospital, reasoned that it is important to understand health problems in totality, understand what can be addressed by physician assistants, and what needs to be escalated to physicians, even if it means lower bottom-line for the healthcare provider.

Mr. Ramam Atmakuri, Vice Chairman, LVPEI ref1ected about ho\v amazed he was that a 'Baahubali' movie poster or a 'Coke' reaches the remotest place in India, but not health education! This requires concerted efforts, he opined. "Can we leverage all the great practices like what DHAN Foundation has done and go back to the segment of population we want to serve? The opportunity exists. We just need to decide whether to spend our time on a skilled person such as a doctor without his heart in the right place convincing him to work with us in the social space, or whether we spend our time on people with a heart, and then spend a little more time on them, building the requisite skills? The opportunity to work in the social space is huge as we have seen at LVPEL"

He then pointed out that each of the organizations in the meeting (such as DHAN, LVPEI and Fernandez Hospitals) were individually touching the lives of hundreds of thousands of people each year. If these socially conscious organizations came together to work in a networked manner, leveraging possible synergies, much more exciting opportunities would open up!

Dr. Parameshwara Munikrishna, Founder, Smiles International Institute of Colo-Proctology (SIICP), admitted that he thought a bigger group was needed to do impactful work on a large scale, but after hearing Mr. Ramam Atmakuri, he now felt confident that a small group of passionate people could bring about large change. He expressed his belief that educated people have the responsibility to help others who are less fortunate. An inter-disciplinary approach is needed to address the multitude of problems facing the healthcare sector in the country where, for example, LVPEI model could be emulated to bring changes in SIICP.

Mr. R. Rajapandian, Chief Executive in Sustainable Healthcare Advancement (SUHAM) Trust, the healthcare initiative of DHAN Foundation summarized this part of the discussion: "For doing good work, money is never a constraint. The vital ingredients are the 3Ps – principle, process, practice. Building technical capacity at grassroots level is important for delivery of high quality service in any domain."

Chapter 3: Task Shifting, an Answer to Sustainability

While Dr. G.N. Rao declared that non-availability of quality human resources was the biggest hindrance, he revealed the need to upskill select, potentially high calibre local people to address the first level of diagnosis and treatment, until living conditions in rural areas improve to attract higher skilled professionals including doctors to be based there.

The need to efficiently use expensive human resources was stressed. For example, Dr. G.N. Rao suggested that using an ophthalmologist for refraction is an overkill. Hence, at LVPEI, this is done by a separate cadre of trained professionals, viz., optometrists. He felt that such efficient deployment of human resources is possible in every specialization of health care.

He suggested that local youth with education up to 12th standard (i.e., Intermediate) could be trained and shown a career path that would enable them to grow within the support system needed in rural areas. Being from the same rural area where they would eventually be posted after their training, would also address the issue of possible attrition.

Dr. Parameshwara Munikrishna added that while earlier there was less availability of manpower in PHCs (Primary Health Centres) across rural areas, due to the increased supply of doctors, the PHCs and clinics have trained doctors even in rural areas. He said that this was the case in Karnataka. According to him, availability of doctors is more of demand-supply mismatch issue.

Dr. G. Chandra Sekhar, Vice Chairman and the Director of Kallam Anji Reddy Campus, Hyderabad, LVPEI, interestingly pointed out that there was a need to segment the disease / work so that only the core work is done by the doctors and the rest is done by trained technicians / physician assistants. For example, in Ophthalmology, we need to segment the conditions that need primary care that may not require a specialized ophthalmologist and can be taken care of by either a trained technician or an MBBS doctor. This would be useful since the number of people who will have relatively less complex disease profiles would be much larger than those that would require tertiary or advanced tertiary care. Thus, segmenting the disease into primary, secondary and tertiary care of treatment is important.

Moreover, the challenge is the intellectual satisfaction that a medical professional is looking for while providing care and treating the most complex disease. If one changed that paradigm, that it is the human life one wants to impact more rather than just treating the most complicated disease, it would be more rewarding for highly trained medical professionals. Dr. Chandra Sekhar sadly noted that such kind of a mindset is something that is missing.

Dr. Evita Fernandez, Managing Director and Senior Consultant Obstetrician at Fernandez Hospital, Hyderabad corroborated this view point in her own field of Obstetrics. Considering that in India, there are approximately 22 million births every year, certainly doctors are not needed for 85% of these births. Rather, there is a need for well-trained professional midwives, who are cost effective. A programme for professional midwifery also generates not just employment but self-esteem for these nurses, who may choose to get into this career path.

This poses a challenge; however, as there is low acceptance of professional midwives among obstetricians as they feel that this encroaches into their domain. However, professional midwifery can be mandated by policy changes. This is another example of what can be done to de bottleneck the resource constraints in the context of obstetricians, she remarked.

Big hospitals, which are now overcrowded with low risk mothers, could benefit if these mothers are looked after by professional midwives. Overcrowding will reduce and maternal mortality will decrease. This is important for the future well-being of the nation, Dr. Evita emphasized. The growing epidemic in C-sections even when this procedure is unwarranted has long-term effect on future generations, including altered immunity levels of children, resulting in increased risk of asthma, obesity and other chronic diseases as compared to kids born through the normal delivery. With clinically unnecessary C-sections numbers growing, we are producing a generation that is not going to be healthy.

Dr. Raja Narayanan maintained that there must be a change in the doctors' mindset that they are not required for most of the healthcare problems in this country. In the developed nations, there is acceptance of paramedics for handling many of the tasks relating to health care. The policy in India is to try and push doctors to rural areas, whereas, raising the bar for training of paramedics could make a big difference.

Mr. Rajapandian stressed on the need to change the policy and allow common diseases to be treated by paramedics. In his experience, training the community health workers has helped in screening patients at the first level. As an example, he cited the screening for breast cancer and cervical cancer done by DHAN community health workers, thereby reducing the burden on doctors as well as on overcrowded hospitals. A forum such as Equitable Healthcare Access Consortium could provide the necessary advocacy that could bring about necessary changes in the government policies, going forward.

Mr. Kasinadh Lakkaraju, a software consultant and the National General Secretary of SAKSHAM shared his experience that a significant part of the population is not willing to take up screening services that are offered in rural areas. It may help if Ayurveda / AYUSH (Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homeopathy) were integrated into the basket of offerings to the patients in these areas for better acceptance.

Dr. Prashant Garg, Consultant Ophthalmologist and Director KVC, Vijayawada, LVPEI stated that health for all is not restricted to only disease treatment. Health promotion is equally important, he reiterated, quoting the World Health Organization, which about 10 years earlier recognized the concept of task shifting as an important strategy to address the issue of health care in low resource countries such as India. Task shifting allows higher proportion of tasks to be done by less qualified or specifically qualified people. Moreover, screening for diseases relevant to rural areas, rather than those pertaining to urban areas, is important. He felt, that the EHA Consortium should look at the diseases that are relevant to the rural areas and launch initiatives that foster task shifting for the identified diseases. Similar to what LVPEI has done for eye health, there would be diseases relevant for the rural areas that can be mapped, and one can work towards the goal of addressing those diseases, he remarked.

Dr. Santosh Kumar Kraleti added a new dimension stressing on the need to demystify health care. People generally think that health care is possible only in hospitals; outside hospitals no health care would be possible. Hence, demystification of each and every component in the healthcare value chain is very important. This process starts at home, he emphasized. In India, only 37% of infants are given early breast feeding (within the first one hour of birth) and only 65% of babies get 6 months of continuous breast feeding. Health care starts with

early breast feeding Both these aspects (early breast feeding and continuous breast feeding during the first six months) are vital for the health of the child. He cited the example of SAKSHAM, which has been working on a very innovative concept called MARA, Mother as Rehabilitation Activist, where volunteer mothers become the hub and the therapist for the child.

Dr. G.N. Rao agreed that policy makers, professionals and the public must be educated, and they need to work together to bring about the change that Dr. Santosh Kumar Kraleti talked about.

Mr. Manish Ranjan, Co-founder and CEO of NanoHealth suggested that adoption of technology, such as tablet computers, is helping ASHA (Accredited Social Health Activist) workers and other community level workers today. In the last four years, while working on a model that is also based on the health workers known as Saathis (a network of local community health workers), who are like ASHAs and ANMs (Auxiliary Nurse Midwife), there were doubts expressed on the scalability of the solution. This was especially true in their training and ensuring the consistency of the care provided by them. Then, it was realized that providing a tablet computer ensured that protocols are complied with. This led to the installation of a decision support system to enable the users to have better experience.

Dr. Parameshwara Munikrishna added that over the last 3 years, SIICP has trained about 150 colo-rectal nurses, who go to every house and talk to the respective families. Surprisingly, out of every hundred families screened, it was found that about 30 people were found to be suffering from colo-rectal symptoms. They were brought by the colo-rectal nurses to the hospitals in Karnataka. In his view, to address the problem of health care in the rural areas, it was essential for the provider to go door to door and have paramedics screen the people. What was true in colo-rectal practice would also be true in other healthcare specialties, according to him.

Dr. Rajeev R. Pappuru, Consultant Ophthalmologist, LVPEI wondered if a multipurpose health worker could possibly focus on identifying a few of the common diseases among the targeted rural population for better results. Mr. Ratan Jalan commented that the problem that comes up for such workers and their acceptance is that the doctors feel threatened. This creates friction between the healthcare workers and the doctors. Unless a solution to this issue is found, progress on this front may continue to be slow. Dr. Rajeev Pappuru felt that if the

roles are clearly defined, one can overcome this perception of threat in the minds of the doctors. Dr. Prashant Garg added that the identity and competence of these workers needs to be clearly communicated to the community at large for better acceptance by all stakeholders. If this is done, the physician community will begin to understand that when low-skill tasks are shifted to the health workers, it makes their life easier.

However, Mr. Vasimalai raised a question about the number of competent healthcare workers who are currently available to address the issue, suggesting that the number of people that we have at present are simply inadequate compared to the numbers that are needed. Hence, it is important to carefully identify people from the rural settings, train them effectively and shift tasks. Self-motivated people who will go to distant rural areas on their own, especially from cities and towns are few. It is best to select local people and train them. This is the sustainable model that DHAN has used.

Mr. Ratan Jalan agreed that one needs to look at the problem from a holistic perspective. Task shifting is the key to take quality health care to the masses to address multiple healthcare ailments of the rural people.

Mr. Ramam Atmakuri summarized saying that the issue is all about economics. For example, when LVPEI conducted the vision technician training programme for students from rural areas who had completed their high school, they were very happy and motivated to be posted back to their own villages after the training. Their income could provide them with a decent livelihood in their villages. This worked because there is a need locally for good quality primary care and because the care providers trained by the institute also came from that area.

Chapter 4: We Participate; the Community Owns

Mr. Vasimalai shared his broad philosophy at DHAN at the meeting: 'We participate; the community owns.' This is important, and very different from the more commonly known community participation, he stressed. He reasoned that, "Whenever we talk about scaling up, the impact perspective is important." For instance, wherever LVPEI has scaled up its operations through expansion of its footprint, patients have been able to experience the impact. That is the key. The need of the hour is to understand the outcomes, focus on what will result in those outcomes and finally assess how the work is perceived by the community. In DHAN, when families come forward and declare that they are out of poverty, that is the impact that comes straight from the beneficiaries' experience.

This takes time, he revealed, perhaps a decade of painstaking work to show the impact. There are no quick fix solutions, contrary to what many people think.

When the community feels the impact, then there is a pull effect: others in the community too want such solutions to the multitude of their problems. In this process, the community becomes empowered and the whole process self-sustaining.

Dr. G.N. Rao expressed that when trust is the foundation for the relationship between the community and the organization working with the community, there is an outpouring of support from the community. Hence, credibility is the key. Health care and education is done best with community involvement.

Prof. D. V. R. Seshadri pointed out that in several meetings of DHAN that he had attended, he witnessed the spectacle of several people voluntarily coming forward and declaring to the audience that they have now come out of poverty and are doing well in their lives due to the interventions of DHAN. He wondered if this idea could be adopted in health care. Poor people who have received good treatment free of cost (or at costs much below the market rates) from the healthcare provider could come forward and talk about their experience in getting good health care at affordable prices. These could be video recorded and put on a suitable website. In this way, they would become ambassadors of the healthcare provider, which would get good buy-in from the community that is being served. "Could we leverage

that sort of a word-of-mouth of beneficiaries. for example, of Dr. Prasad Rao 's, or Dr. Parameshwara Munikrishna's, or Dr. Evita Fernandez's institution? People who have been through DHAN 's livelihood programme, benefitted from it, found value, collectively built a platform that is self-perpetuating with phenomenal energy, has resulted in the creation of a group of leaders at the grassroots that continually grows the footprint of their respective local organizations. This is one of the major reasons for DHAN to be able to achieve its mission"

Dr. G.N. Rao quoted McKinsey Global Institute's new metric for societal well-being called 'empowerment index,' saying DHAN has done better than just pulling these people out of poverty. They have pulled people into the realm of empowerment.

Mr. Vasimalai explained that Rural, Urban, Coastal and Tribal are the four broad domains where DHAN works its offerings and models are different for each of these domains. For each theme that DHAN works on, which is chosen with a lot of care to ensure relevance to the respective domain, DHAN does progressive scaling up through several rounds of pilots. This process could take as many as ten years for the theme to mature, after which it becomes self-sustaining, fuelled by the energy of the community. "There could be lessons from this approach to the context of health care."

Prof. D. V. R. Seshadri agreed that the strength of DHAN comes from the community. Other organizations, he proposed, need to take a page out of this book in their own context.

Mr. Kasinadh Lakkaraju, spoke about people who have dedicated their lives for the community. In SAAKSHAM. Dr. Sukumar Kare, a social worker for the last 30 years in Andhra Pradesh and a shining example of such dedication, was a gold medallist in his medical studies and now goes across the country doing good work in the realm of health care for the poor. Having examples such as these helps others to get motivated to work for the community. An attitude of service and a motivation not to run after material gains in today's competitive world is needed for doctors to emulate his example.

Dr. Sukumar Kare stated that Dr. Rao, who left behind a very successful practice abroad and started a world-class institution in India, is his primary motivation for a lot of doctors including for himself. Today's youth are positive and motivated. They are enthusiastic, he believes. However, the problem is that they need role models and people who can guide them, mentor them and channelize their energies. In SAKSHAM. grassroots-level people help in channelizing the energies of the youth and in motivating them to do service. In Pune district for example, through the work of Saksham, deaf and mute children were identified and provided intervention, helping them get back to normal lives and be effective contributors in the mainstream society. About 150 children have been reached in this manner till date. He felt that today there are enough well-motivated volunteers with the right attitude who are coming forward to help in this work. Yet, he admitted, there is a need felt for people to channelize the energies of the volunteers and to motivate them.

Mr. Vasimalai enquired as to what then stops Dr. Kare from getting professionals to further to Mission of SAKSHAM. Dr. Sukumar Kare replied that there are professionals, but not in adequate numbers. The situation varies in different states across the country.

Dr. Beula Christy, Head & Consultant, Dr. PRK Prasad Centre for Rehabilitation of Blind and Visually Impaired at LVPEI, reflected on how corporate employee mindset that has been largely prevalent in the society, with youngsters wanting to get good jobs and carry on their lives comfortably, is now changing. Many of these people, despite having high pressure jobs, want to contribute to society in a meaningful way. At LVPEI, there are 850 active volunteers, who spend an average of 3 hours per week helping in rehabilitation work despite having hectic jobs during the weekdays. She pointed out that it is very important to figure out w ays to involve them in the various service-oriented activities and channelize their energies.

Dr. Santosh Kumar Kraleti maintained that community participation is the key. as demonstrated by DHAN. Training volunteers is also something where a lot can be learnt from LVPEI's Rehabilitation programme and to some extent in the Vision Guardian programme. Mr. Ramam Atmakuri agreed, citing examples from his experience, where LVPEI has been able to foster community ownership of the initiatives launched.

Dr. Raja Narayanan provided an interesting outlook on how high visibility individuals could be engaged to talk about healthcare behaviours, such as for example, a diabetic actor talking about how he grappled with the problem and how he changed his behaviour to overcome the health condition of diabetes. He added that screening programmes could integrate screenings from multiple specialties. It would also be useful to provide some incentives for the field-level healthcare workers, such as recognition, etc.

Dr. Rangana of Medium Healthcare Consulting, Hyderabad stated that leadership is the key and perseverance in moving towards the mission is important. Finally, community support is crucial for sustainability.

According to Dr. Pramod, lack of reach is a problem in health care that must be addressed. Community needs to take ownership. It is important to understand the health problems in totality, understand what can be addressed by physician assistants, and what needs to be escalated to physicians, even if it means lower bottom lines for the healthcare provider. The Kangaroo Mother Care (KMC) system introduced by Fernandez Hospital is one such example that has made a difference in mother and child care.

Dr. G.N. Rao concluded the discussion on this insightful theme by elaborating on an incident at the Vijayawada airport, where he chanced to meet an old acquaintance who envied him for becoming richer with each passing day. Dr. G.N. Rao was taken by surprise and asked why the acquaintance thought that this was the case. The acquaintance clarified that everyday lakhs of people were giving Dr. G.N. Rao blessings and thereby making him richer with each passing day. This underscores the crying need and the importance of finding ways to take health care to the masses.

Chapter 5: Working with the Government; Issues and Work-arounds

Dr. Evita Fernandez came up with one major problem faced in health care and that is one of corruption at every level while dealing with the government. Given the large volume of births that occur in public hospitals, she cited how Fernandez Hospital thought of training midwives in large numbers in a large and very busy government hospital, to inculcate the compassion, providing dignity to patients irrespective of their socio-economic backgrounds, being sensitive to their needs for privacy and to reduce resorting to needless C-sections for delivery of babies. To achieve scale, they started working with the government but faced corruption at every turn. "When a baby is born, the infant is given to the mother only when she pays a bribe of a few hundred rupees. The same is the case at every stage of mother and child care in a typical government hospital. This is overwhelming." She rued that while they thought of working with the government given the huge outreach it has, corruption at every level now forces them to reconsider if they should just go with a parallel system and create another rural hospital instead.

Mr. Vasimalai threw light on how DHAN works with the government using the concept of a 'revolving fund'. The work goes on from this fund and the government approved fund comes later. The delays in obtaining funds from the government are inevitable, especially since DHAN has a policy of not paying any bribes. However, this workaround has been useful in ensuring that the works go on smoothly and does not wait for want of funds. In some areas that require government interface, DHAN Foundation (the central organization of DHAN Collective) steps in to facilitate the process. However, wherever possible, a committee that is drawn from the local community deals with the local government. Once the community takes the lead, corruption generally recedes into the background, as an empowered community can get the government to pay heed to its legitimate grievances and demands.

Mr. Rajapandian added that in the last 14 years, DHAN has worked very closely with 150 government PHCs, ensuring service availability to people. There are steering committees for

PHCs, which include community members. The community rates these PHCs based on several important parameters such as service, accessibility, etc. The community takes ownership and demands performance from these governmental organizations. The community members do not blame and complain; instead, they are fully involved in the functioning of the government system. "It does not take care of all problems, but it is a good start."

Dr. Prasad Rao seconded Dr. Evita Fernandez, saying that while they work with the Telangana government, conducting screening at over 300 social welfare, tribal welfare and minority welfare schools reaching about a million children, the reimbursement from the government for conducting these screening camps is disbursed very late. Consequently, his organization has to cross-subsidize the screening done at these schools with the income obtained from conducting such camps at private schools. This puts tremendous pressure on managing working capital. However, Dr. Prasad Rao maintained that not all governments are corrupt. Many governments, like that of Maharashtra, are proactive. This augurs well for the future, given that every government has pressure to show results.

Dr. Santosh Kumar Kraleti suggested PPP (Public-Private Partnership) as a solution, given his experience in large-scale programmes with government hospitals, where even simple recommendations like having soaps, tissues, etc., did not get implemented because of corruption.

Corruption boils down to leadership, Dr. Parameshwara Munikrishna declared. In their Medical College's department of OBGN (Obstetrics & Gynaecology), they plugged corruption, because of the excellent department head in the medical college. She rooted out corruption completely, and this corruption-free culture continues to this day.

Dr. G.N. Rao maintained that it is important to ensure sustainability of the healthcare provider without need for government subsidy. In this manner, dependence on the government can be minimized or brought down to zero. For example, in cataract surgery though there is a scheme to obtain government subsidy, it is not that easy to avail it. Consequently, at LVPEI, the focus has been on ensuring sustainability of the operations

without any dependence on the government subsidy. In his v1ew, if and when the subsidy from the government is received, it should be treated as a bonus and as an extra source of funding. He reiterated this point: "One should not depend on it."

Mr. Vasimalai revealed that DHAN has faced corruption while dealing with the government. To handle this. it keeps friendly relations with (upright) bureaucrats. Some good bureaucrats have helped resolve various issues. In some cases, work-arounds are explored, such as keeping a revolving fund (as described earlier) so that the work does not stop. "We may need to go a hundred times to the government department to get the money due to us from the government. This requires extreme patience. At DHAN we have learnt to be very patient in dealing with the government. On a broader note, each organization needs a strategy to deal with the government."

Dr. Beula Christy commented that, sadly, corruption is present in government departments even for obtaining disability certification for the differently abled people such as the blind people. For someone with vision impairment to avail government benefits, it is necessary to obtain a certificate of disability from the government. Even to get this certificate, it takes immense effort and often one must deal with corrupt officials.

Dr. Sukumar Kare agreed with Mr. Vasimalai on the need to have a revolving fund while working with the government. Many of the policy makers, he maintained, are also sensitized to the challenge of providing quality health care to the masses. The corruption that is being experienced as described above in the context of several organizations and their dealings with the government occurs more at the working level in the government and not at the top, at least in the context of providing health care for the poor.

Dr. Merle Fernandes, Consultant Ophthalmologist and Director GMRV campus, Visakhapatnam, LVPEI summarized that "It is best never to bend and instead be persistent, because some day the money that is due to you from the government has got to be eventually disbursed to you!"

Chapter6: Learning Hub, the Ultimate Convergence

Mr. Vasimalai expressed the need for a learning hub as an outcome of the consortium, where all could learn from each other's experiences. For a think tank to really make an impact, each issue should be discussed further; and well-documented action plans need to be put into action.

Mr. Kasinadh Lakkaraju was glad to see that there were many people working towards the same goals and agreed with Mr. Vasimalai regarding the need for this kind of meeting once every three months.

Mr. Manish Ranjan, agreeing with Mr. Vasimalai, found patience to be the key success factor in working with the weaker socio-economic strata. It is in this segment that it is possible to create large-scale impact. Once the community witnesses this impact, there would be enough number of volunteers who would put their heart into this kind of work to make it a success.

Dr. Beula Christy offered to integrate the rehabilitation work at LVPEI with the work of many of the other organizations represented in the meeting, as a way of collaborating to create synergies.

Dr. Prashant Garg added that eye banking and school healthcare screening programmes are areas where LVPEI may be able to participate.

Dr. Evita Fernandez felt that a lot could be learnt from the LVPEI pyramid model. For her, rural immersion, community involvement and the need to set up a revolving fund to work with government were key takeaways.

Mr. Vasimalai, having been on a campus tour of LVPEI's KAR campus in the morning, observed that there were a lot of poor people who came to LVPEI for treatment. Consequently, he felt the need to simultaneously start working with these poor people intensively on the livelihood front in order to alleviate their poverty. There may be scope for DHAN to work closely with LVPEI on this front.

Dr. G.N. Rao was intrigued by the way Mr. Vasimalai had been taking notes on what ideas could be implemented programme-wise, and what could be included in the teaching curriculum. He remarked that this was something everyone should emulate. He offered to facilitate the opening of a DHAN counter for the non-paying people in a few of the primary/ secondary centres at LVPEI, as a pilot, to work on poverty alleviation for this group of patients. He also proposed pilots with SIICP in the realm of colo-rectal care, wherein SIICP could work on detecting and curing colo-rectal problems that some of LVPEI's poor patients may be suffering from.

Dr. Srinivas Goud Bulkapuram, Associate Director and Co-Founder of Dhaatri Mothers Milk Bank stressed on the need for a more collaborative approach. Frequent interactions to discuss the progress were essential to maintain the momentum of the consortium.

Prof. D. V. R. Seshadri concluded the meeting by declaring perseverance as the key. He stressed on the need to scale up only after learning from implementation of pilot projects. The founders of healthcare organizations that work with the poorer sections of the society need to have a hands-on approach to design and develop and implement a sustainable business model. Preserving the culture is critical. Hiring the right talent is impm1ant, and one should not succumb to hiring people because of pressure from various quarters, including political pressure.

If work that is being done is good, money will follow. Even the poorest of the poor will contribute resources, as demonstrated by DHAN. It is important to create knowledge and to gain visibility as a thought leader in the chosen field, as both DHAN and LVPEI have shown. Tremendous focus on induction training is essential to get the right orientation for those who have newly joined the organization.

In this context, Dr. Sudha Murthy, Head of the Department at Basavatarakam Indo American Cancer Hospital and Research Institute, Hyderabad, added a new dimension to the discussion of investing in research similar to that of LVPEI to bring down costs. She believed that all hospitals or any medical fraternity, doctors or otherwise, should get into it and it should be part of the medical curriculum, if possible.

Prof. Seshadri continued that organizational culture needs to be reinforced continually. To keep costs low, it may not be a good idea to focus on long-term retention of all employees, as this would increase costs and make the model unsustainable. Instead, even those who move on to other lucrative jobs become ambassadors of the organization that moulded them in their initial years. This has been demonstrated both at LVPEI and Aravind Eyecare Systems (AECS), another internationally acclaimed eyecare provider. There is no need for every organization to change the world and fix all problems. It is vital to stay focused. There is no need to work with doctors and other care givers who are focused on money; there are many others who have their heart in the right place and it makes sense to get them on board. It is important to insulate one's organization from the government to the extent possible. It is essential for the top management of these organizations to have a laser-like focus on sustainability and focus on research and training to position the organization as a thought-leader. DHAN and LVPEI have demonstrated the efficacy of such an approach. Credibility is the key to success. It is important to know when to say 'no' to donors so that the original mission of the organization is not compromised.

Dr. G. Chandra Sekhar put forth livelihood, education and health as the three pillars of stability in a society He proposed looking up to DHAN for their grass-roots-level work. There is a need to identify what are the skills required to roll out an equitable healthcare access model and understand what needs to be done to take this initiative forward. This is where community ownership is important and DHAN has demonstrated ho\v this can be done to perfection.

He suggested that at the level of the secondary hospital, attracting talent and retaining them would continue to be a challenge. In his view, it is important to be a good human being first and then a good doctor. We should have a focused immersion programme for the specialists to sensitize them to the realities of the rural hinterland. The problems regarding health care and poverty are similar. In health care, the patient centricity is largely missing in the country. In addition, having a good plan for working capital will be the key to ensuring sustainability of the healthcare organization that works for the larger societal good.

Mr. Ratan Jalan expressed a need to address the deficit of trust in health care. Optimism, hope and objectivity must be brought back into health care.

Prof. D. V. R. Seshadri concluded the session by suggesting the creation of an Internet-based group or forum of all the participants, with potential to add more organizations going forward.

The meeting ended with a vote of thanks by Dr. Prashant Garg.

Epilogue

The first meeting, the Think Tank organized at Hyderabad to address the vital issue of equitable access to health care on 6 March 2018, has rapidly evolved into the Equitable Healthcare Access Consortium, comprising several institutions that are involved in healthcare, livelihood and education, across the country.

Participating organizations agreed to pool field-level resources, thereby generating new synergies and getting better efficiencies. Discussions subsequent to the first meeting resulted in agreements on cross-pollination through immersion programme for specialist doctors and agreements between institutions to work in a holistic manner on inclusive partnerships, with the organizations opening up their locations and facilities to each other for providing their respective equitable healthcare solutions in the last few months.

The EHA Consortium is currently organized as an informal forum and is not yet a separately registered legal entity. Individuals working on this consortium, drawn from various member organizations, volunteer their time to keep the consortium running.

The website for the consortium was launched in April (www.ehaconsortium.org) and blogs on thoughts and articles related to health care have made the site come alive.

Through networking and sharing resources, the EHA Consortium has already spawned pilot projects in the areas of school health, women & child development, eye banking, eye care support, colo-rectal care, and livelihood opportunities. Updates are now available on the website, facilitating easy access and dissemination.

With the pilot programmes up and running and with numerous organizations signing up in the consortium since the first meeting, there are clear signs that many institutions consider equitable access to health care an important and urgent need for the country. There is also willingness to do something about it.

The second meeting of the consortium is scheduled to be held on the 7th and 8th of July, hosted by DHAN Foundation, Madurai. The immediate agenda for 2018-19 would be to consolidate the progress made till date to facilitate actionable

conversations among responsible healthcare providers. It is also expected that based on the progress being made, more members will be attracted to join the Consortium. Going by the current interest levels of organisations to be part of the consortium. it is expected that the number of institutional members would reach 100 by the middle of 2019.

List of Participants

Organization	Participants
Ameya Life	Dr. Prasad Rao
DHAN Foundation	Mr. M.P. Vasimalai Mr. Rajapandian Mr. Sadasiva
Doctors for Seva	Dr. Santhosh Kumar Kraleti Dr. Srinivas Goud Bulkapuram
Fernandez Hospital	Dr. Evita Fernandez Dr. Pramod Dr. Nuzhat Aziz
LVPEI	Dr. G.N. Rao Dr. G. Chandra Sekhar Dr. T.P. Das Mr. A. Ramam Dr. Beula Christi Dr. Raja Narayanan Dr. Merle Fernandes Dr. Rajeev Pappuru Dr. Prashant Garg Dr. Somasheila Murthy
NanoHealth	Mr. Manish Ranjan
SAKSHAM	Dr. Veda Prakash Gowda Mr. Kasinaadh Lakkaraju Dr. Sukumar Kare
Smile International Institute of Colo Proctology	Dr. C. Parameshwara
Arogyamarg	Dr. Sudha Murthy Mr. Rajiv Reddy
Medium Healthcare Consulting	Mr. Ratan Jalan Dr. Rangana Sharma Mr. Indraneel Chatterjee
ISB	Prof. D.V.R. Seshadri Mr. Ashish Galande Mr. Prakash Satyavageeswaran Ms. Swati Sisodia
Individual Capacity	Mr. Srikanth Malladi Mrs. Pratibha Rao Mrs. Prema Denduluri