Meeting Record Notes

3rd Quarter Meeting of the Equitable Healthcare Access Consortium

Held on Saturday & Sunday, 17th & 18th November 2018

at People Tree Hospitals, Bangalore

Version 3 dated 26st November 2018

Compiled by:

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1. Action Items relating to pilots

- Dr. Roja suggested a pilot with Dr. Pavitra for training of Global Hospitals trainee nurses on reproductive health.
- DHAN and Sankalp to pilot a screening training to prevent mother to child thalassemia.
- Saksham will work with DHAN on training community workers on disability and other areas.
- DHAN will partner with Fernandez Hospital to train community worker on mid-wifery.
- SIICP will partner with Aurolab who will study and manufacture at low costs locally, the videorectoscope, which is a diagnosis equipment used in coloproctology. Currently this equipment is imported from Italy at very high costs.
- SSISM to provide a report on primary illness (disease pattern) based on the survey they have already conducted. Basis the results, the health needs can be identified and the consortium can look at how a couple of pilots can be undertaken in MP.
- SSISM is open to partnering with other members to include skill training to specifically have students ready for recruitment by member organizations for specialized roles.
- Dr. Pavitra and Dr. Sharad to provide support in identifying health needs and providing associated training for both DHAN community workers and SSISM students.
- EHAC team to provide a template to all pilots for capturing the inputs as well as outcomes.

2. Participating Organization and Members

Organization	Participants
Action Research and Training for Health (ARTH)	Dr. Sharad Iyengar
Ameya Life	Dr. N. S. D. Prasad Rao
Aravind Eye Care Systems (AECS)	Dr. Devendra Tayade
Arogyamarg Healthcare Diagnostics	Mr. Rajesh Reddy
Basic Health Care Services	Dr Pavitra Mohan
DHAN Foundation	Mr. R. Rajapandian Ms. G. Palaneeswari
Doctors for Seva	Dr Santhosh Kumar Kraleti
Fernandez Hospital	Dr. Tejaswini Basavarj
Global Hospital & Research Centre	Dr. Roja Tumma
Indian Institute of Management - Udaipur (IIMU)	Prof. Prakash Satyavageeswaran
Indian School of Business (ISB) - Hyderabad	Prof. D.V.R. Seshadri
Kauvery Hospital	Dr. S. Vijayabaskaran Ms. J. P. J. Bindhu
L V Prasad Eye Institute (LVPEI)	Dr. G. Chandra Sekhar Dr. G. N. Rao Ms. Anshu Bhargava
Narayana Health	Dr. Thimappa Hegde Dr. Kiran M
People Tree Hospitals	Dr. Chandrasekar C. Dr. Jyothi Dr. Nagendra Ms. Hema Shanbhag
Sankalp India Foundation	Mr. Lalith Parmar Mr. Rakesh Dhanya

Sant Singaji Institute of Science and Management (SSISM)	Mr. Pranjal Dubey Mr. Prashant Sharma
Smiles International Institute of Colo-Proctology	Dr. Parameshwara Munikrishna
Samadrushti Kshamata Vikas Evam Anusandhan Mandal (SAKSHAM)	Mr. Kasinadh Lakkaraju
Swami Vivekananda Youth Movement	Dr. G S Kumar
Vikram Hospital	Dr. Rajesh B. Iyer
Observers: **Individual** **Individual** **Indian School of Business (ISB) - Hyderabad** **Gunam Hospital** **KREA**	 Ms. Vidhya Srinivasan Ms. Rajashree Kallapur Ms. Swati Sisodiya Dr. Senthil Mr. Pravin Shekar

3. Agenda

17th November 2018 - Saturday

Time	Agenda	Presenter/Chair

9.20 AM	Assemble at the auditorium at People Tree Hospital	
9.30 AM to 9.35 AM	Welcome address	Dr. Chandrasekar
9.35 AM to 10.00 AM	Setting the agenda and talk about the core team and the rationale behind it and introduce the members	DVR
10.00AM to 11.00 AM	Primary Heath Care - Focus Area for EHAC	Dr. Iyengar and Dr. Pavitra
11.00 AM TO 11.30 AM	Discussion on Focus area - Rural vs Urban poor	Rajapandian
11.30 AM to 11.50 AM	Tea Break and Networking (Cafeteria) - Group photograph of the EHAC will be taken here	
11.50 AM to 1.15 PM	New Pilots discussion keeping the new focus area as theme	Dr. GCS
1.15 PM to 2.00 PM	Lunch at "The Terrace" on the 4th floor	
2.00 PM to 2.30 PM	Pilot Update - SIICP and DHAN with Video presentation on Responsible Healthcare	Dr. Parmesh
2.30 PM to 4.00 PM	Updates for live pilots sion on pilots that are dormant	SPOC's from collaborating orgs.
4.00 PM to 4.20 PM	Tea Break and Networking (Cafeteria)	
4.20 PM to 4.50 PM	Presentation of the Vision, Mission, Values for EHAC and formal adoption by members	Dr. GCS/DVR
4.50 PM to 5.30 PM	Session on' IORA' case study followed by Q and A	DVR
5.30 PM to 5.50 PM	Themes on way forward for the Consortium received from ISB Assignment	Prakash
5.50 PM to 6.00 PM	Wrap up	Dr. Rajesh
6.00 PM to 6.30 PM	Presentation on People Tree Hospitals followed by campus tour	Dr. Chandrasekar

18th November 2018 - Sunday

Time	Agenda	Presenter/Chair
8.15 AM to 9.15 AM	Breakfast meeting of the Core Team in the conference room	Core Team Members

9.20 AM	Assemble at the auditorium at People Tree Hospital	All Other Members
9.30 AM to 10.00 AM	'Equitable Healthcare for all' - Patient Experiences (Experiences of patients' core relatives followed by discussion)	Dr. Rajesh Iyer Rajashree
10.00 AM to 10.45 AM	Legal Entity Formation with Q and A	Sridhar
10.45 AM to 11.00 AM	Tea Break and Networking (Cafeteria)	
11.00 AM to 11.15 AM	Divide breakout sessions into 6 groups of 6 people each to discuss - 1. Membership Criteria; governance, operating processes, etc. 2. Equitable Healthcare for those who cannot afford to pay for healthcare (including initiatives such as Example: primary healthcare) 3.Equitable Healthcare for those who can afford to pay but still get shoddy treatment (such as those who pay and still do not get good quality healthcare) One / two core team members will be tagged to each group as the chairs for that group	Core Team Members
11.15 AM to 11.45 AM	Internal group discussions on assigned topics	
11.45 AM to 12.30 PM	Groups to merge into one on each topic and prepare final presentations.	
12.30 PM to 1.00 PM	Group 1 Presentation with Q and A session by members At the end of these sessions, we should have clarity and consensus	Dr. GNR
1.00 PM to 1.45 PM	Lunch at "The Terrace" on the 4th floor	
1.45 PM to 2.15 PM	Group 2 Presentation with Q and A session by members	Dr. GNR
2.15 PM to 3.00 PM	Group 3 Presentation with Q and A session by members	Dr. GNR
3.00 PM to 4.00 PM	Next meeting - where/ when/ broad agenda - Open Discussion	Dr. GNR
4.00 PM to 4.15 PM	Vote of Thanks	Pranjal
4.15 PM	Tea and Disperse	

4. Day One Proceedings

4.1. Welcome by Dr. Chandrasekhar

Dr. Chandrasekhar of People Tree Hospitals warmly welcomed the members and shared that the mission of EHAC is very much similar to that of People Tree Hospitals. He also provided an overview of the agenda for the next two days of the meeting.

4.2. Setting the Context

DVR introduced the members and organizations present in the meeting. He also introduced the core group members as well as the idea behind forming the core group. The current core group shall have a duration of 3 years and subsequently 1/3rd of the members will be replaced with new members every year.

DVR discussed the agenda, providing the context for each session. He also stated that the purpose of the consortium is to be action oriented rather than just discuss problems and theories.

4.3. Primary Health Care – Focus Area for EHAC

Dr. GC from LVPEI provided two case-lets highlighting the need to tackle the problems at the grassroots level. He emphasized that primary care is the need of the hour in India, whether it is in the urban area or in the rural area. He then invited Dr. Sharad and Dr. Pavitra to share their experience on primary healthcare.

Dr. Sharad focused his presentation on the role of technology and innovation in primary health care. There are few facilities in the rural areas. In addition, there are unfilled vacancies. There are also difficulties in ensuring protocols. In this context, the gap is filled by 'Bangali doctors' or quacks, which provide high dose medication to give quick relief. This is done at high prices.

On the other hand, there is also the problem of over-medicalization – a form of populist medicine which is not restricted to the interior areas but is more prevalent in the cities. "Inappropriately excessive use of medical resources for the delivery of health care, often to safeguard unrealistic standards of quality". Over-medicalization significantly reduces access and increases costs, especially of primary care. Irrational over-medicalization is used to impress patients & families and earn more money, in the private sector. Where regulation is poor, over-medicalized hospital care coexists with quack cures in rural and slum areas

In view of the above two extremes, the recommended path is to de-medicalize primary care and develop a strategy to enhance access to healthcare services. "Systematic measures undertaken by a health system, to optimize the use of scarce or expensive medical resources".. De-medicalizing primary health care offers a promising approach for improving access and reducing inequity. This can be achieved through task shifting, screening checklists in local languages and graphics, portable and user-friendly packaging, and technologies that help make diagnosis by non-doctors for certain conditions easy and reliable. All this needs to be linked to good referral systems.

Deficiencies in primary care have led to scope creep in secondary care. Secondary care takes over primary care at higher costs and potentially higher risks, primarily due to greater interventions.

In summary, the technology needs to fit the problem and not the other way around. The equity of access has to be looked at from a political perspective of who benefits from the current system.

Dr. Pavitra focused on the opportunities and challenges of delivering comprehensive primary health care. He started with case-lets that highlighted the dynamic nature of medical needs. An individual or a family would have different medical needs. So, any programmatic approach that address one need or the other does not take care of the other medical needs. Dr. Pavitra also highlighted some key facts about primary healthcare including this being about prevention rather than only cure, and the need for high quality care provided by professionals.

Primary healthcare is comprehensive in both horizontal (all conditions, covering entire life-cycle, and providing preventive, promoting and curative care), as well as vertical manner (primary, secondary and tertiary level).

The key barriers to delivery of primary healthcare are physical access, reliance on physicians who don't turn up and / or over-reliance on community workers. The non-availability of health professionals in rural areas can be tackled by providing adequate training in general disease conditions in rural settings, and by taking care of compensation and training needs of healthcare professionals who need not be doctors. Another barrier is the mismatch between the need in the locality and the healthcare being provided. Hence it is important to study the disease profile of the local area.

In terms of opportunity, Government has committed 70% of all healthcare allocation to primary healthcare. There is a ramp up of number of trained professionals coming out of colleges, including trained doctors. However, there are also uncertainties in terms of how the changes in policies affect the health service providers.

EHA Consortium could come up with appropriate models of healthcare for urban and rural areas, using the expertise of its member organizations to inform and train people.

Dr. GC closed the session by urging the members to look at what verticals could be looked at based on the expertise of EHAC member organizations and use those insights to work on relevant models.

4.4. Variations Between Rural and Urban Poor

Mr. Rajapandian (Raja) spoke on multiple contexts, including rural, tribal and urban. There are three aspects that are relevant based on DHAN's experience that need to be understood. The first is the dependence on quacks in rural areas. The second is the accessibility in terms of finances as well as physical distance. There is also social distances and taboos. These are the important

issues in rural areas. In urban areas, the disease profile that exists is different than the rural context. For example, in urban areas cancers, CVDs (cardio vascular diseases), and diabetes are more prominent. However, in the rural areas, malnutrition is a major problem. Similarly, from a infrastructure and healthcare professionals availability perspective, disproportionately large resources (of both varieties) are located in urban areas despite the population being more in rural areas.

The rural healthcare is dominated by government infrastructure and services. However, even from the government service providers, referrals are done to private hospitals for secondary and tertiary care in the urban areas. Creating linkages with hospitals in order to provide affordable access is key and this is one of the areas that DHAN has been working on. Another important component is the use of technology. Finally, the question is 'What kind of offering can be provided at their doorstep for the community members who really are not in a position to afford the services offered by the private players?'

DVR raised a question on how can public secondary and tertiary hospitals be incentivized to provide free but good quality services? Raja talked about the government policy that provides incentives under insurance schemes for hospitals. Basically, for any procedure done, the government hospital also gets insurance payout just as a private hospital would. This translates to more financial resources for public hospitals to hire more doctors and improve infrastructure.

Dr. Rajesh inquired about the penetration of mobile phones in rural and remote areas. Raja stated that about 40% of population have access to smartphones and another 40% of the population have access to the regular feature phones. Dr. Sharad talked about need for facilitators in helping patients understand and access care in secondary and tertiary hospitals. Raja talked about the role of DHAN facilitators in referring to patients to primary health centers (PHCs). However, where the PHC or secondary / tertiary government hospitals are not able provide timely solutions, the facilitator refers to partner hospitals or other hospitals attested by the community.

Group Photo and Tea Break

4.5. New Pilots Discussion

Dr. Roja shared that Global Hospitals' objective is to provide healthcare for all. In addition, they have mobile clinics that cover over 90 villages. They have also selected and trained community members, each of who service a few villages and identify diseases that need referral to secondary or tertiary hospitals. In order to address malnourishment, they also provide free food for children. Pregnant women are provided Iron, Folic Acid and Calcium tablets. Near the mobile van, during camps, messages and support for alcohol de-addiction are provided. The work is supported by various charitable foundations as well as through government insurance schemes, making the services free for the villagers. Global Hospitals is also moving into tertiary level care soon.

Dr. GC invited members to suggest interventions that can be potentially provided at the field level through the large workforce of DHAN, LVEPI and AECS. Basically, can we use existing human resources to provide additional services through one-time training?

Dr. Sharad suggested that we need to be aware of certain aspects relating to primary healthcare. There is need for two-way linkages – one for development organizations to help establish PHCs (Primary Health Centers) at the ground level and the other to establish linkages to secondary hospitals. The idea is to have a host of PHCs that are easy to access and link these up to the next levels (secondary and tertiary levels) to handle referrals.

DVR requested for a working definition of primary, secondary, and tertiary care. He also asked whether there is a need for one person at the primary healthcare level for addressing each diseas type, as that would make it very difficult to action. Dr. Pavitra suggested that we could look at research to identify the top 10 diseases in a local area and focus on those disease conditions. First level of care is self-care, home care, primary care and other similar forms of care, including the care provided by a general physician. All of this would be part of primary care. Any further procedure that needs specialist and/ or invasive procedures would come under the ambit of secondary care. Tertiary care would require super-specialization and more sophisticated equipment.

Exhibit-1 provides working definitions for the three types of care (primary, secondary and tertiary).

Vidhya talked about the work done by Lions and Rotary clubs at various levels. While there is much work done, it is not systematic or institutionalized. She suggested that what we need is the equivalent of Doctors without Borders (Médecins Sans Frontiers). She also referred to 'Ekam', which works on reducing MMR and IMR. They work by making sure that equipment in the care giving centers are in working condition and by bringing clarity across the system on whom to contact for what issues / problems.

Dr. Santhosh talked about the problem of different sectors understanding 'PHC' differently. For example, within the government, maternal and child health as well as communicable diseases are classified as coming under the ambit of PHC.

Dr. Kiran shared the experience of Naryana Hrudayala in setting up a network of health information centres for collecting health data and digitizing this information, which is then used to provide advice by accessing a centralized database. He suggested that such a network can be setup by EHAC and services offered on a paid basis.

Dr. Kumar suggested that the verticals of care are a continuum and the divide between primary / secondary / tertiary is not sharp.

Dr. Nagendra talked about a PHC model in Kerala, Kutumbam, which is self-sustaining. This network of primary care is connected to the next level of hospital care (secondary care) through

tele-medicine. Dr. Tejasvini from Fernandez Hospital shared the experience of FH in training nurses on mid-wifery, which has resulted in 10% reduction in C-Section deliveries.

Dr. Pavitra provided some pointers to move the discussion forward on various models:

(1) Any effective healthcare model should cover both preventative and curative services.

(2) Such a model cannot replace people with technology; however, technology can be a useful supplement.

(3) Sustainability of these models should be thought through carefully, since the reality is that poor people may not have resources to pay for the services. Hence the need for alternative ways to fund such systems.

Dr. Roja suggested a pilot with Dr. Pavitra for training of Global Hospitals trainee nurses on reproductive health.

Dr. Sharad also reiterated the need to pick pilots that are geographically proximate to the partners. The goal of self-sustainability cannot be a precondition for many of the models that are implemented for the poor, as they simply do not have any means to pay for the services.

Lalit (Sankalp) would be happy to launch a pilot with Dr. Pavitra, Dr. Sharad, and with DHAN to provide prevention of Thalassemia in children, leveraging their large experience. Sankalp can be at the back-end for treatment, while the frontline organization can help at diagnostics. While Dr. Sharad reverted that screening for Thalassemia is generally not done at the ground level for everyone, Raja said that DHAN would be interested in participating with Sankalp for this kind of screening support.

Dr. Santhosh suggested that in addition to Sankalp, other organizations can also partner with DHAN to have multiple training programs for the community workers to enhance their capacity to offer the first line of diagnosis at a limited number of centres. He also suggested that DHAN could partner with Fernandez Hospital for mid-wifery training. Dr. Sharad added that Skill India program could be leveraged so that people who are trained can be placed in the private or public sectors.

Dr. GC emphasized that while there is possibility for multiple such trainings, it is important that there is visibility of what are the greatest disease burdens at each PHC's local area, so that training and support for these initiatives can be very focused.

Anshu suggested that primary healthcare has to be delivered at the community level. This can result in a structured model of healthcare, much like LVPEI's pyramid model. Pranjal stated that based on survey done by the students of SSISM, there has been identification of common disease conditions in the areas surrounding Sandalpur (Madhya Pradesh) where his college is located. They were now looking for partnerships to create capacity at community level to address these diseases. Pranjal invited members to partner with his institution (Sant Singaji Institute of Science and Management) to provide relevant training to his students, who could then work at the

community level to provide the first level of healthcare. These training programs would enhance the employability of the youngsters who were getting trained. Additionally, member organizations could recruit the trained persons.

Dr. GC requested Dr. Pavitra and Dr. Sharad to help enhance understanding of primary care in the various projects that are being taken up between member organizations. This could be done for instance, by training the field level workers of DHAN as well as hand-picked students of SSISM, who would then roll-out the community-level programs for education and first level of diagnosis. These programs will necessarily have to be customized to the local needs including relevant local disease profiles.

Dr. Devendra suggested that to increase awareness in the community, camps could be organized involving past patients.

DVR summarized the discussion by clarifying the three pilots that evolved during the discussion. He suggested that for each of the training programs undergone by the community workers / students, a EHAC-tagged certificate could be awarded, which would serve as a motivational tool.

Dr. Sharad offered help for any member organization that is interested in working in the areas of sex and reproduction at the community level.

Lunch Break

DVR introduced Dr. Thimappa Hegde, who offered his best wishes for the EHA Consortium.

4.6. Pilot Update- SIICP & DHAN

Dr. Paramesh introduced the work done by SIICP and stated that the idea of training large numbers of field-level care givers and the concept of community healthcare was learnt from the EHAC members. In addition, based on understanding of the model of LVPEI and AECS, SIICP now has a cross-subsidization model in colo-rectal care.

Dr. Paramesh also provided background of the poor awareness of colo-rectal diseases as well as the low attention paid by doctors to treat these conditions. He also discussed the problems that women face in villages due to lack of access to toilets. He discussed the plan of hub and spoke model with Accredited Social Health Activists (ASHA) workers and Auxilary nurse midwife (ANMs).

Dr. Paramesh discussed the role of collaborations in helping move everyone forward. He pointed to proposed research study with IIM Udaipur.

4.7. Update of Pilots

Kauvery Hospitals updated on its pilots with DHAN and Sankalp. The partnership with Sankalp has an MOU and has resulted in a day care center being set up in Trichy for Thalassemia. In a similar manner, the MOU with DHAN has been signed and Kauvery will conduct health awareness camps in some of the areas covered by DHAN. There will be two camps conducted per month and will cover 10,000 households over two years. While it was not part of the MOU, going forward, Kauvery will incorporate training of community workers. Sankalp Foundation found that Chennai had good infrastructure for care of Thalassemia patients. The partnership with Kauvery has resulted in day care centre in other cities, with training also having been provided to doctors and paramedics. Going forward, the centres will also investigate other hemoglobin disorders. Kauvery hospitals were also appreciative of the strong database maintained by Sankalp.

People Tree Hospitals partnership with DHAN has resulted in MOUs with DHAN as well as with Suham hospitals (Part of DHAN Collective). As part of the partnership, health camps were conducted covering over 900 people with 16 surgeries being conducted for free. In addition, health awareness session for women health covered over 450 members in three sessions. Cervical cancer screening was conducted with a nominal fee of Rs.50 being charged. 67 members were screened. The partnership also resulted in conducting one session on basic life support skills for DHAN Self Help Group (SHG) members. Dr. Chandrasekhar stated that he is keen to ensure that every member of DHAN is trained on basic life support skills. The partnership between LVPEI and People Tree hospitals has not yet started as it was dependent on the recruitment of an Ophthalmologist by People Tree Hospitals. This will be taken forward in the coming quarter.

Dr. Sharad noted that in addition to number of camps and number of people covered, it is important to document what was detected for each patient and what was done in each of these cases. He also said that it is useful to do some costing on the time and resources deployed by each partner. Arnaz added that EHAC can provide a template for tracking the same. Dr. Pavitra also pointed out that we need to measure the outcomes.

Dr. Sharad also noted that one-off surgeries such as cataract operations are easier to do as part of camps, rather than care that needed multiple visits over a protracted period of time. This maybe the reason for success of LVPEI. However, when the need is not one-shot, but something like diabetes that required recurring care, it cannot work through camps. Secondary care, whereby the poor patient has to travel long distances to reach the secondary care center cannot address such chronic conditions. Primary health capacity that is provided closer to the home of the patient has to be built to take care of such problems.

Rajapandian discussed the remaining pilots. First with AECS, there has been existing partnership. Over 100 camps are conducted every year with about 250 participants per camp. With LVEPI 1658 patients were covered in two camps, with 350+ people provided with free interventions including free spectacles provided to those who need these, as well as free surgeries for some of them.

Lalit and Dr. Roja discussed the Sankalp and Global Hospitals partnership for Thalassemia day care centre. The centre is child-friendly and is fully operational. Sankalp has provided comprehensive package and it is expected that there will be about 50 children by end of the year who will be able to avail continuing treatment. Dr. Roja stated that they run a major blood bank in the region. Hence, setting up the Thalassemia centre was easy.

Dr. Roja also talked about the idea she got from SIICP about using a questionnaire to reach out to people and understanding whether they have colo-rectal diseases. Using this, Global Hospitals is now able to unearth and address colo-rectal diseases in the community and provide suitable counselling.

DVR requested Dr. GC to provide a broad introduction to the LVEPI and AECS model, as some of the participants requested that this would be needed to understand the reasons for founding of EHAC, which draws inspiration from these two world-renowned organizations.

The discussion of plans for dormant pilot projects was initiated by Dr. Santhosh from Saksham. The partnership with Sankalp has not moved forward due to various reasons, largely internal to his organization, owing to other preoccupations.. Dr. Santhosh promised to take this up with more emphasis internally and reconnect with Sankalp. With regard to another partnership that Saksham had initiated with Fernandez Hospital (relating to lactational counsellor course), the training program needs to be actioned. The main road block has been that the next rung of leadership in both institutions need to take this forward (after the top leadership of the two organizations agreed to take it forward). He promised that going forward, the partners will push their respective internal teams to take this pilot forward. The third partnership was with LVEPI and relates to capacity building of Saksham's eye banks. In this case too, there has been a gap in follow up. Finally, Dr. Santhosh requested for dropping the pilot with Vikram Hospitals, as it was not getting much traction.

Anshu stated that the problem could be that once the top leadership has agreed on pilots, the intent may not be translated completely within respective organizations. She suggested the Consortium could play a role in pushing the intent down into the two partner organizations, to action the intent.

LVPEI and DHAN foundation pilot on livelihood opportunity will be taken up for decision by both organizations through discussion on next steps.

Remaining announced pilots have been dropped.

Tea Break

4.8. Presentation of Vision, Mission, and Values of EHAC and Formal Adoption

DVR started the session with an introduction to Jim Collin's approach to defining core purpose, core values, BHAG and Vivid Description, which together constitute an organisation's vision. He explained that the purpose, values, BHAG (also referred to as Mission) and vivid description for EHAC that has been circulated to the members has been derived from this framework. The basic versions were based on the outcomes of the 2nd meeting of the EHA Consortium and have been iterated among the core committee members.

The core purpose was discussed and adopted as such.

In the values section, there were questions raised on whether we should specifically include indigenous medical systems, especially in the wellness area. Another concern raised was in terms of respect of patient rights not being included in the values. It was clarified that we do not mention any system of medicine specifically and thus there is no need to emphasize indigenous systems. The current vision did not forbid indigenous healthcare systems from being part of EHAC's agenda. It was pointed out that the values reflect what the members believe in. Since the vision was evolving, it was felt that the same could be revisited after an year, if felt necessary to tweak it.

While the members broadly agreed on the purpose, values, BHAG and vivid description, it was felt that there could be some nuances added. To facilitate this, Arnaz would email the presentation to all members. They could revert with suggestions in track changes mode / comments.

4.9. Iora Model Discussion

DVR gave a brief introduction to Iora and its founder and set the context on healthcare industry in the USA. This was followed by showing two videos on Iora.

The discussion around Iora model brought out the need for relooking at who can prescribe medication, and importance of task shifting as well as health coaches in the communities. The other factor that is common in the two contexts is the need to have localized and contextualized models. Dr. Pavitra also emphasized on the need to consider the costs involved in healthcare,

since going forward, when health insurance picks up in the country, higher costs would mean higher premiums for the insured. Hence it was important to keep costs under check.

Prakash brought out the role of ASHAs and ANMs as 'health coaches' and suggested that the Consortium can look at the role of such people in the public and private health care systems.

4.10. ISB Assignment Feedback

Prakash highlighted four key areas of feedback provided by the ISB students from the healthcare course. These included launching courses to educate all stakeholders in healthcare on various aspects that the consortium considers important; formation of a legal entity in order to have systems, processes and clarity on way forward; options for financing the consortium, and finally leveraging existing educational institutions. He also requested Arnaz to share the full presentation with the members for their perusal.

4.11. First Day Wrap-up

Dr. Rajesh provided a succinct and insightful wrap-up summarizing the proceedings of the day.

This was followed by a presentation by Dr. Chandrasekhar on People Tree Hospitals.

End of Day 1 Sessions

5. Day Two Proceedings

Day 2 started with Core Team meeting. Minutes of this meeting would be shared separately.

5.1. Patient Experiences

DVR shared two case-lets of patients being given improper care or not being given any care.

Mrs. Rajashree Kallapur shared her experiences of admitting her father in a corporate hospital in Pune. It started with an arm pain but went into complications. In addition to improper health care, there was complete lack of empathy. She also talked about the higher mortality rate within India due to drug resistant bacteria, especially with greater number of hospital infections. She referred to the Checklist Manifesto by Dr. Atul Gawande.

She recommended that there should be CCTVs in the ICUs similar to what was practiced in the US. What is urgently needed is better relationship between doctor and patients / relatives. Can we have hospices for elderly people? Can we have more empathy from the healthcare system? We should also have audits of hospitals.

She closed her talk by stating that the lack of empathy by the providers as well as the uncertainty and information black-out caused more distress to her and her siblings than her father's death per se.

Dr. Rajesh stated that Behavior and Attitude matter a lot in health care; it is not just about Knowledge and Skills. The death rate in ICUs in India is double that of the western world. He also shared examples of medical cases where there was medical negligence.

Dr. Nag shared his experience with Dr. Dimitry, head of healthcare at Google. Dr. Dimitry said that with AI, doctors can get back to being doctors – provide empathy, compassion and care.

Dr. Devendra shared that a similar patient story of negligence in the US at John Hopkins that caused death of a child led to significant patient safety changes in hospitals in the US.

5.2. Legal Entity Formation

Bangalore-based Chartered Accountant (CA) with many years of experience, Mr. L. Sridhar discussed three options. The first and second are Section 25 Company and Society respectively. After explaining the pros and cons of these forms, he suggested that EHA Consortium should be registered as a Trust. Additionally, the Trust must registered with the Income Tax Dept for tax exemption.

Mr. Sridhar explained in detail how the Trust would be formed and operated. He also stated that that we should get 80G and tax exemption for donations. In addition, we could register under FCRA for foreign contributions. He answered clarificatory questions from the members.

Tea Break

5.3. Breakout Sessions and Presentations

The members were formed into three groups, each looking at one of three areas. After small group discussions, each group made its presentations as detailed below.

5.3.1. Group 1 – Organization Structure, Membership and Processes

The group discussed the option of continuing as an unregistered entity versus registering as a Trust. The Consortium decided to proceed with the formation of the Trust. It was decided that a Trust would be formed with 6 Trustees – Dr. Nag, Dr. Evita, Pranjal, DVR, Dr. Sharad / Dr. Pavitra and Vasi, representing various streams that are relevant to the consortium.

A draft Trust deed would be made by Mr. Sridhar and circulated for comments and approval. The operating guidelines would be created jointly by Arnaz and Prakash.

The membership will be by invitation, based on recommendation of existing members. The Executive Group consisting of Arnaz, Prakash, Dr. Nag and DVR can decide on the membership applications received. The group also decided that there must be well-articulated criteria based on inactivity by members (such as not attending three meetings in a row) for removing members.

Lunch Break

5.3.2. Group 2 – Equitable Healthcare Access for People who cannot Afford

The group suggested understanding and mapping the different models of healthcare in the country and then trying to see what role EHA Consortium can play in these models. In addition, the group suggested enabling linkages between various vertical levels of healthcare (primary, secondary and tertiary). The group also suggested mapping the various models of cross-subsidy in healthcare. There could also be scope for members to work closely with various Government schemes.

The group suggested that the Consortium could also look at robust protocols and treatments that can help reduce costs as the healthcare expenses are rising. The group also alluded to the role of livelihood organizations in improving affordability, which would supplement the efforts of reducing costs in order to bring about affordable care.

Dr. Nag shared that LVEPI can act as a resource point for sharing information about all funding opportunities regarding healthcare. Dr. Sharad pointed out that the EHAC can play an important role in taking into account ground realities in policies and protocols given their real-world experience. He also highlighted that we need to look at how the Consortium interfaces with the Government.

5.3.3. Group 3 – Equitable Healthcare for People who can Afford

The third group suggested enforcing protocols on hygiene and infection control. It also discussed the role of active communication between doctors and the patients. The group also suggested installing CCTVs to monitor treatment in ICUs. Additionally, it suggested counselling for the attenders of patients.

The group suggested that there needs to be transparency on the use of consumables that are charged by hospitals to the patients. Lab investigation charges need to be at a flat rate. Instead, at present, they vary by type of patient and the ward they use (common ward, executive ward, etc.)

EHAC can go to different organizations and help inculcate empathy. Another action that can be taken is to have an online program on how to bring in more empathy among young doctors. Dr. Roja has volunteered for the same.

DVR suggested that the ideas discussed need to be converted into action points with the help of members and put up checklists, guidelines, and white papers on the EHA Consortium website.

Dr. Nag emphasized on the need to ensure quality whether the service is provided for free or whether it is being paid for. Dr. GC highlighted on the need to balance reuse of consumables to contain costs versus the increased chances of infection.

Dr. Nag referred again to Dr. Dimitry and talked about the fact that with increasing technology the doctor can get back to the art of medicine and care.

5.4. Next Meeting – Venue and Dates

DVR led the discussion on the location and dates for the next meeting of the Consortium. IIM Udaipur was decided as the host institution and 8th & 9th or 15th & 16th March 2019 were tentatively identified as the dates for the next meeting, subject to facilities being available at IIM Udaipur during those dates.

5.5. Vote of Thanks

Pranjal thanked People Tree Hospitals team for the wonderful arrangements. He also summarized the key learnings and thanked the members and team for the wonderful organization and participation.

End of the 3rd Meeting of the EHA Consortium

Exhibit-1

Broad descriptions of primary, secondary and tertiary healthcare

Definition of Primary, Secondary and Tertiary healthcare

Primary healthcare
Primary healthcare denotes the first level of contact between individuals and their families with the health system. Primary healthcare includes care for mother and child which includes family planning, immunization, prevention of locally endemic diseases, treatment of common diseases or injuries, provision of essential facilities, health education, including counselling on food and nutrition as well as emphasis on need for consuming safe drinking water.

Secondary healthcare
Secondary Healthcare refers to the second tier of the health system, in which patients from primary health care are referred to specialists in the next higher hospitals for treatment. In India, the health centers for secondary healthcare include District hospitals and the Community Health Centre at the block level.

Tertiary healthcare[1]
Tertiary health care refers to the third level of the health system, in which specialized consultative care is usually provided on referral from primary and secondary levels of healthcare. Specialized Intensive Care Units, advanced diagnostic support services and specialized medical personnel are the key features of tertiary health care. In India, under the public health system, tertiary care service is provided by medical colleges, government hospitals in cities and advanced medical research institutes.

Reference:

1. Source:Budget 2018: 'modicare' A Good First Step, But Where Will ... (n.d.). Retrieved from https://swejosh.wordpress.com/2018/02/01/budget-2018-modicare-a-good-first-step-

[1] Source:Budget 2018: 'modicare' A Good First Step, But Where Will ... (n.d.). Retrieved from https://swejosh.wordpress.com/2018/02/01/budget-2018-modicare-a-good-first-step-