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Fifth Quarterly Meeting of the Equitable Healthcare Access Consortium Meeting Record Notes

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Organizations and Attending Participants

Organization	Participants
Aravind Eye Care Systems (AECS)	Mr. Thulasiraj Ravilla (Thulsi)
Basic Health Care Services (BHS)	Dr. Pavitra Mohan (Pavitra)
DHAN Foundation	Mr. R. Rajapandian (Rajapandian) Ms. Palaneeswari (Palaneeswari)
Ekam Foundation	Mr. Sai Kiran (Sai Kiran)
Equitable Healthcare Access Consortium	Ms. Arnaz Dalal (Arnaz)
Fernandez Hospital	Dr. Evita Fernandez (Evita) Dr. Tejaswini Basavarj (Tejaswini)
Indian Institute of Management - Udaipur (IIMU)	Prof. Prakash Satyavageeswaran (Prakash) Ms. Manisha Dutta (Manisha) Ms. Vedha Ponnappan (Vedha)
Indian School of Business (ISB) - Hyderabad	Prof. Rajendra K. Srivastava (Raj) Prof. D.V.R. Seshadri (DVR) Prof. Sarang Deo (Sarang) Prof. Madhu Viswanathan (Madhu) Prof. Ram Nidumolu (Ram) Dr. Devendra Tayade (Devendra) Prof. Raghu Bommaraju (Raghu) Ms. Astha Sharma (Astha) Ms. Minal Agarwal (Minal) Mr. Harsh Parekh (Harsh) Mr. Sujit Mallick (Sujit)
L V Prasad Eye Institute (LVPEI)	Dr. G. Chandra Sekhar (Dr. GC) Dr. Raja Narayanan (Raja) Ms. Anshu Bhargava (Anshu) Mr. Jachin David Williams (Jachin)

PEOPLE TREE Hospitals	Dr. Chandrasekar C. (Dr. C)
Sant Singaji Institute of Science and Management (SSISM)	Mr. Pranjal Dubey (Pranjal) Mr. Prashant Sharma (Prashant)
SMILES International Institute of Colo-Proctology	Dr. Parameshwara C.M. (Paramesh)
Individual Members	Dr. Harish Iyer (Harish) Mr. D. Nagarajan (Nagarajan) Dr. Rajesh B. Iyer (Rajesh) Dr. Sudha Murthy (Sudha) Ms. Vidhya Srinivasan (Vidhya)
Observers	Ms. Anumeha Srivastava (Anumeha) Ms. Anuprita Turwankur (Anuprita) Dr. Amit K. Jotwani (Amit) Mr. Jagdish Rattanani (Jagdish) Dr. Laxmikanth Galla (Laxmikanth) Mr. Martin Steret (Martin) Mr. D.V.N. Pradeep (Pradeep) Dr. Rajesh Reddy (Rajesh) Mr. Y. Rakesh (Rakesh) Dr. Ramesh Maturi (Ramesh) Dr. Sanjeev Upadhyaya (Sanjeev) Mr. Shashikant (Shashikant) Mr. K. Shiva Charan (Shiva) Ms. Swetha Bapatla (Swetha)
Guest Speakers: **B&M Healthcare Consultancy** **Tata Memorial Hospital** **Basavatarakam Indo American Cancer Hospital & RI** **Care Hospitals**	Dr. Aniruddha Mukherjee (Aniruddha) Dr. C.S. Pramesh (Pramesh) Dr. Senthil Rajappa (Senthil) Dr.B. Soma Raju (Soma Raju)

Meeting Notes

Day 1

Introduction

Arnaz welcomed the gathering and invited DVR to introduce the members.

DVR introduced the members and observers, providing a brief background about each of them.

Welcome Address

Raj talked about the need for equitable healthcare as this forms the basis of progress for the family. If disproportionate resources are spent on healthcare, it does not leave enough for children's education and their future. ISB has been pushing the agenda of healthcare, with the Max Centre for Healthcare. ISB has also been partnering and networking to improve access and to bring together people and institutions on a common platform. He stressed on the need to export knowledge from India, rather than importing knowledge from the west. In the medical space, India provides care at far more efficient prices compared to the west.

Raj pointed out that there is a need to address the looming problems of non-communicable diseases. We need to bring in alumni of ISB and other educational institutions to help address some of these issues. To enter deeper into rural markets, we need to adopt technology; create our own rules of privacy and data

management to fit our circumstances. We need to bring in the government and educational institutions to tackle these, especially from the perspective of addressing gender inequality of access to healthcare.

Raj stated that ISB is additionally involved in healthcare through the startups it is incubating as well as through the AMPH programme. There is a need to find ways to effectively work with the public sector to join forces. ISB would be happy to work together with other institutions to start discussions with the government.

Raj thanked the participants for being here at ISB to tackle the serious problems posed by the need to provide equitable healthcare access.

Report on EHAC Activities

Arnaz started her report with reading out the Vision and Mission statements of the EHAC. She also shared the structure of governance, listing the core committee members. The membership structure and validity were also shared. As on date there are 15 institutional members and 5 individual members. She invited the observers, guest speakers, and others to consider joining EHAC as members.

Arnaz invited DVR to talk about the cases that have been written about members of EHAC. DVR introduced the DHAN cases, the Fernandez Hospital cases, the LVPEI case, BHS case and the SSISM case. DVR also introduced the book on LVPEI and DHAN Foundation. Arnaz informed the participants that the synopsis of all the cases are available on the EHAC website.

Arnaz provided a summary of the medical students' interaction session held at LVPEI Auditorium on 22nd August 2019. There were 73 participants from ten medical institutions. She also suggested that the way forward would be to go to the medical institutions in future rather than invite students of multiple institutions onto a central location.

In the current quarterly meeting, the EHAC has focused on inviting guest speakers for talking on current topics. Arnaz closed her session talking about sustainability of EHAC and the follow up on initiatives as key to the way forward. She suggested that these will be discussed in detail the next day in sessions anchored by Prakash.

National Cancer Grid – A Model to Improve Healthcare Access

Pramesh provided a background of the National Cancer Grid – some facts and figures. The healthcare sector has not submitted itself to regulation on quality, despite variability across the country. The guidelines and outcomes of institutions currently need not be put up in the public domain. Systematic research strategy is non-existent in India. The mortality to incidence rate in India for cancer is 67%, which is significantly greater than the 35% in the USA. Across the regions there are inequities in access to cancer care. Lack of education, taken as proxy for lower SES, is a good indicator of cancer death. Infrastructure is less than half of what is needed; the number of oncologists is a quarter of the requirement. Human resource is always a crunch; India operates with about one-tenth of the number of required physicians.

To overcome the barriers, Tata Memorial Hospital discussed and formed the national cancer grid. Geo-tagging of patients showed that most of the patients to the TMH in Mumbai came from Maharashtra and from North East and Bengal. Building 4 hospitals in 4 corners of the country was seen as insufficient. One of the first initiatives taken was to come up with set of guidelines on various types of cancer. Currently the NCG is coming up with stratified guidelines, accounting for different abilities to pay. However, as per the western value frameworks, empirical evidence suggests that there is inverse correlation between value received and amounts paid in cancer care.

NCG also focused on palliative care and surgical pathology as these are areas that are often ignored. This is a voluntary program for the members (as are all other programs of NCG). NCG also created Navya, an online platform, to provide a second opinion on diagnosis and treatment, thereby saving time and money for people who don't have to come all the way to the TMH. The National Virtual Tumor Board is a weekly virtual meeting providing discussion platform for the member centres to bring up complex cases. The NCG also provides free e-access of journals and books to members. The Digital Nerve Centre is like a national 1800 number to get advice and guidance on cancer. The NCG also runs MOOCs on oncology and also funds research studies. It also conducts an annual workshop on research methods and protocols for young researchers and students.

The philosophy of the NCG is to use what we already know today to help reach out to the people who have not been reached out to. There are 183 cancer centres as members of NCG.

Raja shared a comment that the burden of prevalence of cancer is going to increase as discovery and survival increases. He then posed a question on the Navya platform on the issues

of complexities of second opinion, especially the involvement of the original doctor. Pramesh responded that short of seeing the patient, the platform provides large amount of details to arrive at the second opinion. Pavitra thanked Pramesh for the talk and congratulated him on the achievements of the NCG. He asked Pramesh about the preventive and the screening aspects, especially at the primary healthcare level. The primary healthcare centres could also potentially play a role in providing continued care. Pramesh responded by agreeing that access to care at local level is important. With TATA trust, NCG has a distributed model of healthcare in Assam - there are 3 L1 centres (medical colleges), L2 centres (district medical colleges) with chemo and radiation, and then L3 centres with pallative case, daycare chemo, and screening. From the prevention side, Pramesh said that the NCG chose to go the awareness route due to the sheer logistics associated with screening. Sudha asked about what could be done with the costs of reagents and consumables for pathology. Pramesh stated that the group buying would help in reducing the costs for pathology.

Pramesh pointed out that the NCG was not founded by TMH or other large institutions or the government; it was an initiative that came about through a number of smaller cancer centres coming together. Anumeha inquired about how important adherence to the NCG guidelines is. Pramesh answered that with the partnering between NCG and the PMJAY, the following of guidelines has become mandatory for about 60% of the treatments. Anshu enquired about the continued care and documentation. She also asked about any initiatives to reach out to the poor patients. Pramesh stated that other than working with insurance such as PMJAY and driving down costs, there has not been inclusion initiatives. Data has been a challenge as many of the centres continue to maintain paper records. However, currently there is a pilot going on with a CAMS like centralized repository of electronic medical record. Vidhya asked about linkages to livelihood organization. Pramesh answered that this is important but is not something that NCG is working on currently. Thulsi commented that NCG has been looking at the problem from a System and Design approach rather than a Behavioral approach. He also asked about how NCG brought out the collaboration; there is a need to understand in more detail.

Rajapandian stated that over 1.8 lakh women have been screened at DHAN for breast and cervical cancer, with 162 women were identified with cancer through a five-step process. He wanted to understand about the process effectives of this approach. Pramesh responded by congratulating DHAN for this large screening and said that NCG would be happen to look at the data together with DHAN. Rajesh inquired about the reason for why a large number of people from Kerala come to TMH. Pramesh responded that Kerala is an enigma as there are good quality hospitals locally. He speculated that there is possibly a large number of people traveling for second opinion. Rajesh also enquired about the large margins on many of the drugs.

Pramesh stated that the government law tried to mandate that the margins should not be greater than 30%; however, hospitals are not willing to sign up. Evita stated that she wished that the grid could be replicated for maternal care as the NCG gave hope.

Tea break and Group photo

Sustainable Financing and Provision of Healthcare by Government

Aniruddha talked about the genesis of the West Bengal Health Scheme, a program to support poor patients. Government hospitals often do not have the necessary facilities. Whereas many private hospitals have the facilities, they are not affordable. The reimbursement system from the government was long and unpredictable. The WBHS had three legs – the empanelment of hospitals with fixed rates, the enrolment of employees, and the mode of reimbursement – all being managed by the Health Scheme Authority. Many of the standards of the NABH were leveraged for the empanelment and the rates. The reimbursement rates varied between 100% to 60%, depending on the NABH accreditation level. Upto Rs.1 lakh was cashless, and over that the DDO could reimburse amounts greater than that. The scheme was created without any upper limit on amount and on the number of treatments.

With linkages between the Health Scheme Authority and the WB Medical Council, course corrections were done were fast. Permissions for availing the scheme came from the head of the office. For higher amounts, permissions came from Director or from Principal Secretary. For non-cashless cases, the employee could draw 80% of the estimate as advance.

The rates for various procedures were a problem, especially since the hospitals typically do not have calculations on the actual cost of treatment. Checks were put in place for preventing fraud from the employee side.

Jagdish raised the question of what it would take to get such a scheme for common man. Aniruddha responded that it is eminently possible as it does not require any insurance or middlemen. Rajesh enquired whether the scheme covers even OPD, to which Aniruddha responded that in-patient or OPD both get covered as long as it is part of the 15 diseases. Raja stated that there are many stories about Ayushman Bharat being taken for a ride through fraud. Aniruddha responded by saying that no organization wants to do fraud if they get proper incomes. The rates need to set at level that will cover costs. Dr. C said that there is a general perception among doctors in other parts of India that the government in WB harasses the doctors. He wanted to understand the efforts of the government in safeguarding the good doctors. Aniruddha stated that there is nothing draconian about the practices of WB government. Pavitra wanted to understand the cost per employee in terms of the premium. This works out to Rs.5,500 per year per employee.

Lunch Break

Violence Against Doctors

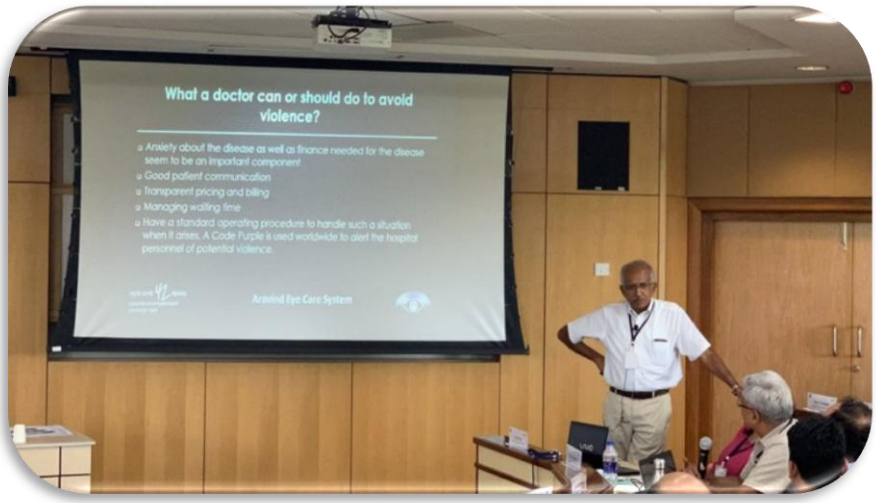
Thulsi started the session stating that the problem of violence is global and that it is an age-old problem. While the violence may occur in public or private institution, but it is more common in public facilities. In the case of public institution, the case is not precipitated by finances. Often it can be precipitated by shortages. There are laws on protecting against violence and vandalism, but it needs to be enforced better.

DVR interjected stating that there is in general an increasing tendency for violence, not only in the healthcare space, but in other areas as well including road rage, etc. Thulsi agreed that there is an increasing level of intolerance, not only India but also across the world. DVR asked

whether the DNA of the hospital, whether it is a for profit or a trust hospital, could make a difference. Thulsi affirmed that the DNA does seem to make a difference.

Discussing potential solutions, Thulsi emphasized that patient communication is very important. Transparent pricing and billing are important. Additionally, waiting time can trigger violence. Finally, there needs to be a preparedness for such events through a Code Purple or equivalent. The media also often does not provide clarity; there needs to be an understanding that medicine is not black and white. Given the nature and stickiness of the violence, the members need to deliberate on what are the actions within our control.

Dr. C stated that the experience at People Tree hospital has been much less violence compared to his previous hospitals. His experience is also that the case is not necessarily precipitated by money. In private hospitals, the violence is often linked to extortion. Even in trust hospital death of a patient has led to severe violence and vandalism. Manisha stated that while a doctor is evaluating the patient, the patient is also evaluating the doctor. There is a need to also understand the socio-cultural background of the patient. The violence is possibly a reaction to some event of the past. Laxmikanth shared that the quantum of fees is not a factor as there have been instances where patients have gotten violent even for consultation fees. He stated that they have an ABC process – Act Fast, Be Accurate, and Communicate.



Soma Raju stated that one of the important factors that is not taught in medical school is how to deal with death. This leaves the junior doctor trying to figure out how to handle death in an ICU. They do not know how to deal with it or how to communicate with the relatives. He also stated that when one is wrong, apology works. Anshu inquired whether this violence is acting as a disincentive to join the profession of medicine among the youth. Dr. C said that they have been involved in training high school children on CPR. After the session, less than 5% of the session want to become doctors. Pavitra pointed out that most government hospitals and facilities do not have security guards, even for patient safety. There are cases of baby snatching, etc. It is important to ensure patient safety alongside doctor safety.

Martin stated that we do not have grief counseling in India. Tejaswini stated that Fernandez Hospital has set protocols for such issues. Pramesh stated that doctors often treat patients and relatives with arrogance and when there no more skin in the game (after patient dies), the

relatives react. There is also a general perception of doctors being mercenaries and greedy people. This also needs to be addresses. Evita said that her experience has been that communication is key. She agreed with Soma Raju that apologizing is important and it works. Sanjeev agreed and shared that communications is important but is missing in the medical curriculum.

Madhu shared his experience as a consumer of healthcare. He stated that there is a need for customer-centric approach; we need to have a mindset change about how we approach the patient and the family. DVR shared his experience of facing death of his parents in the hospital, where there was no sensitivity among the hospital staff about the death. Soma Raju said that taking a customer-centric approach also led to some mistakes. He stated that there is an overall decline of trust on hospitals among the public. The board meetings of corporate hospital only talk about revenues and profitability, not on quality and outcomes. Soma Raju also responded to Anshu's question saying that there are many more lucrative alternative careers available today. Jagdish stated that the story shared by DVR, while shocking, is not unusual given the power that doctors wield. One way in which 5-star hotels address the issue of inconvenience to customers due to security checks by simply bowing down before the check.

Thulsi summarized and closed the discussion by stating that as a group we are open to acknowledging the problem. There is a need for patient-centric and customer-centric approach. Soma Raju stated that there is a need to move from disease-centeredness to person-centeredness. Thulsi made closing remarks on the need to decode what patient-centricity means and how the communication needs to be done.

How to Make Equitable Healthcare and Private Hospitals Co-exist? – Panel Discussion

Evita opened the discussions by referring to an EY 2019 report, stating that 67% of people do not trust our hospitals in India. There is a lack of belief that they will be cared for. Dr. C questioned the title of the session asking whether the assumption is that private hospitals do not provide equitable healthcare. He said that his own experience in the west has been that most hospitals try to do the best for the patients. He stated the even in India, his own attempts have been to provide equitable care through foundations or other sources, ensuring that the patients get equitable care. His view is that the case maybe that of increasing the proportion of equitable care in private hospitals. He also pointed out that less than 5% of hospital beds belong to the so called giant corporate hospitals.

Senthil started off by asking what is equitable in a particular situation. Can every patient be given the same treatment in oncology where there are very expensive therapies that may only extend the life of the patient by a short period? Where does one draw the line?

Soma Raju said that there are a few professions or services such as nurses, security, doctors, etc., which need to be designed differently. Today there is a need to bring together the public and private efforts in order solve the problem which can solved be neither alone. He said that neither the poor nor the rich get treated equitably, where the rich get over-treated and the poor under-treated. Mistakes are common, new infections are contracted in ICUs, and most of the complications are lifelong and need to be taken care of lifelong. There is a need to look at the totality of a person.

Evita requested Dr. C to discuss about the impact of PMJAY. Dr. C responded that while the amounts are not enough, it is a good beginning and there is a need to take it forward together. Collaboration is the way. Senthil stated that PMJAY is a game changer for the poor and gives a chance for them to be cured. There is a need for the medical providers to sit down together to go back to government to readjust rates or ask for support. Or to find donors or paying patients to support the gap.

Soma Raju added that the health of the community should not be confused with health care. The health is determined by a number of factors including social determinants. Health care is only the top of the iceberg.

Dr. GC stated that often the question is about increasing scale and how that affects equitable healthcare. Growth for the sake of growth is cancer. This attitude brings in the attitude of getting into unethical practices that involve un-necessary procedures that may not cause harm to the patient. Ethical growth will be slow. Senthil agreed that growth will happen in ethical service but may be slow. The issue in developing country such as India is that there are budgetary constraints and treatment takes precedence.

Sarang responded that the meaning of equitable has to come from philosophy and justice. The key question is whether health is a fundamental right or is it a commodity. The society needs to debate of whether private capital should be part of the healthcare system. DVR pointed to the case of Narayana Health, where private equity has supported the growth, the balance of equity may have been lost. This also seems to be a case of rate of growth affecting equity. Anumeha pointed to how the capital came in in the first place. Senthil responded by saying that equity in healthcare can be brought in by not losing sight of what was the original objective. Evita posed the question on not losing sight to Soma Raju, to which he responded that there is a way. The

answer lies with the doctors. The doctors do not refuse large salaries and are now in golden handcuffs. It becomes difficult to refuse un-necessary diagnostics and procedures. Over a period of time, the doctors who choose to earn less do not lose out in the long run.

Jagdish talked about the experience of Business Schools of putting out incorrect placement numbers. This was curtailed by some IIMs coming together and agree to release audited placement numbers. Using the same example, he agreed with Soma Raju that the members of EHAC can set the professionalism expected. Potentially EHAC can have a position paper on views on private equity in healthcare. Pavitra echoed Jagdish's thoughts stating that there is a necessity to work together and there is a role for private sector.

Rajapandian brought forward the point that there are poor people and there are service providers in private sector. The connect happens when there is a facilitator such as DHAN and can convince the private sector that the poor people provide the volumes and scale. Soma Raju pointed out the today healthcare is multi-disciplinary and all the stakeholders need to involved to make things happen.

Lakshmikanth added that every district has two medical colleges and in five years' time there will be 1,000 doctors in every district. The supply-demand system should result in equitable practices as there will be oversupply. However, some other members pointed that this could result in more unethical practices to withstand the pressures. Senthil pointed out that doctors who are also MBA should govern the hospitals. Soma Raju gave a rejoinder that the person who can do a good job at governing should govern; that may or may not be an MBA or a doctor.

Thulsi pointed out that there must be a mindset among all service providers, private and public, is that there is some rate provided by PMJAY and we must figure out how to operate within that. The other question is about who is calling the shots – there are impact funds. We need to bring in the private investors to our table and include them in the discussions. They need to understand how healthcare works, an often non-linear work. How do you scale a compassionate workforce?

Tea break

How can EHAC help Design Integrated Primary Healthcare Systems in India?

Pavitra initiated the session with a few definitions of primary healthcare in order to sensitize participants on different perspectives on primary healthcare. A large number of people present themselves at secondary and tertiary care in the absence of comprehensive primary healthcare.

Thulsi pointed out that some of the definitions are from a context and time which as different from what we face today. Today, for almost all specializations, there is a primary level component to it. If it can be caught at the primary level, many cases would not have to be escalated to secondary and tertiary. Technology is also available to do better and cheaper diagnosis. He stated that we could fundamentally relook at the scope of primary healthcare.

Dr. GC added that the preventive component is also something to look at from the primary healthcare perspective. The family practice should look at a larger scope of diseases. There is a need for a framework / model to understand what services can be provided at the primary level.

Pavitra summarized that we are discussing about identifying the scope of services in primary level. The next level of clarity that is required is who provides what services, and what skills and resources are needed to be added to provide these services. What competencies need to be built? The role of technology also needs to be looked at as most of the current technology is geared towards tertiary care.

Dr. GC suggested that in order to identify these services, there is need to do research. Some of the members can come up with that, which can then be added to by specialists such as Fernandez Hospital, LVPEI or AECS. Thulsi added that there is also need for a shift in policies, such as the one about push for institutional delivery. Nagarajan added that based on his experience with Sightsavers, often we ask the wrong question – what a blind person can do rather than the right question, what can a blind person cannot do. Applying the thought to primary healthcare, one may ask what can be the things that primary healthcare cannot provide. He also pointed out that most service providers do not close the loop in terms of compliance follow-up. A similar thing needs to be built into primary healthcare.

Evita pointed out that Lancet studies show that 83% of maternal and child health care can be provided by a well trained and accountable mid-wife. This mid-wife can also talk to adolescent girls and for family planning. These mid-wives can act as the backbone of primary healthcare services. She can also refer the high-risk patients/ mothers to secondary or tertiary levels. The

problem is that the training has to be at global levels. Pavitra brought out the government perspective that who would be training the mid-wives.

Rajapandian stated that their perspective is more of prevention and promotion rather than curative services in primary healthcare. The ANMs manage prevention and promotion and the doctor takes care of curative services with mid-wife. Health seeking behavior promotion is the major focus of primary healthcare services. Under the government instructions, there is a promotion of institutional deliveries. The role of mid-wife is central in primary level. The capacity constraint of Village Health Nurses is one of the key problems in this delivery. The role of EHAC may be to fill the capacity constraints of VHNs or ASHAs. It could also look into what could be the role of technology in the primary services. Madhu reiterated that the scope of services is very important.

Palaneeswari added that there are instances of urgency in primary healthcare and the other is affordability and accessibility. The latter may be provided by other systems of medicine such as Ayurveda, homeopathy, or siddha or others. There is also a need for clear guidance on escalations. There is finally also a need for curbing malpractices in primary healthcare, including high value prescriptions, and the unregulated sales of medicines. Sai Kiran pointed out that we have lost sight of traditional promotional practices including traditional diets and yoga. Transport to reach PHCs is a problem. At the PHC, there is also lack of facilities there is lack of motivation and lack of manpower.

Pavitra also raised the question of who pays how much for primary care. Thulsi suggested a PPP model with a capitation fees which is capped. There would be an incentive to keep people healthy. Devendra pointed out that in the field in Udaipur they saw that there is paying capacity among the people. Providing everything for free maybe counterproductive. DVR added that there needs to be revenue enhancement. This would be necessary to attract talent in the remote areas. Sustainability requires this. DVR pointed to Teach for India as an interesting program to replicate as perhaps ‘Heal for India’, which can be motivated with a bit of training.

Sanjeev said that perhaps we are trying to sell health in a shop that is meant for treating diseases. The shift needs an army, something akin to what DVR stated. Pavitra added that people need both health and healthcare. We need to find the right balance. Amalesh posed question on the paradox between the availability of last mile system but which still fails. There are organizations that are teaching communities to demand services. Perhaps that is what is necessary. Rajapandian responded by saying that community is the final answer for all of these problems. If there are facilitators to empower the community, this would be possible. This has been the experience of DHAN.

Pranjal pointed out that there are many players working in the primary level across India. From an integration perspective, there is large scope to bring these organizations together.

DVR asked a question to Rajapandian about the possibility of creating communities where no income or opportunities exist. Rajapandian responded by saying that there are generational changes. In some case this will need longer periods, and at others this can be done in a fast tracked manner.

Dr. GC summarized that the strength lies with BHS, Ekam and DHAN, as they are the doers in this space. The challenges of cleaning up that needs to be done at the primary level needs to be also discussed. He also suggested that the core group could discuss this point tomorrow. Thulsi added that the scope of services is also something that came up repeatedly. Financing models were also discussed. Pavitra suggested three ways forward – scope of services need to be defined, the technology package needs to be finalized, and finally the alternative financing models. A fourth came from Pranjal, which is about the list of organizations in primary level. Dr. GC added the fifth point from Palaneeswari of alternate systems of medicine.

Pavitra volunteered to work on the scope of services.

Wrap up for the Day 1

Dr. C summarized the day's event along with appealing photos of the presenters.

END OF DAY 1 SESSIONS

Day 2

Core Group Meeting

Enabling Beingful Work and Wellbeing in Hospital Settings

Ram started the session talking about ancient wisdom; the two birds analogy from the Upanishads, where there is a higher self and a lower self. The ability of operate from the higher self in the context of today's work place is what Ram focused his discussions. Beingfulness at work would help to get to this goal. He distinguished between happiness and meaning and stated that meaning is what is relevant in workplace. He then described the pilot done with LVPEI.

Vedha opined that the results seem what they are, close to ideal, probably due to the nature of the organization – medical care. Would similar results be seen in IT or other companies? Ram responded that the issue is that most companies do not make the connect between what they do and how it serves society.

Harish opined that perhaps the ratings also may depend on the age of the participants and Ram agreed on this. Pavitra suggested that this may be also connect with Maslow's hierarchy.

Anumeha suggested that the beingfulness index could be used among high school students to help them make career choices through testing. Harish added that making children aware of these issues would itself be useful.

Ram talked about two projects deployed in LVEPI based on the gaps in the beingfulness index. Each intervention had small steps including thank you cards, recognition, teaching, patient care, etc. The idea was to change the mood of the place. The doctor became the role model. There were qualitative improvements in the mood of the participants. The other intervention was on health including health check, water drinking, walking, etc. Both interventions also had quantitatively improved results. This lead to better team building.

Manisha repeated the question that Thulsi had asked yesterday – how do you scale up compassion and work culture? Ram responded that the scale up happens through participants' experience. Dr. GC summarized by saying that the need was to trickle down the culture of the organization down to the last level.

Update on EHAC Financials

Prakash informed the members that the EHAC bank a/c has 1.62 lakhs. The point of discussion was what can be the sources of funding for EHAC and what are the activities we need to fund with the amounts collected. The showcasing of activity based on monetary transaction was deemed necessary by CA Sridhar for applying for Income Tax exemption.

Arnaz pointed out that DVR has been making expenses out of pocket for last one year and EHAC needs to reimburse him for the same.

Nagarajan pointed out that there are sources of funding both within India and outside. The money once can raise outside country is large. Not only activities but the intentions can also be funded (if we are aware of that). A lot of money is coming in for service delivery but once they dry up the activities don't last.

DVR pointed out that we need budget against which we can raise money. We must know how much and what for we need money and then we can put our efforts to raise it. With NDA government focusing on the use of foreign funds, getting money from outside be tricky.

Ram- suggested that if we know what are those ambitious projects for which we want to raise money then it will be easy to raise money.

Prakash pointed out that EHAC needs money not only for projects but also for sustainability of the organization as a whole. Nagarajan suggested that EHAC could portray it as money we need to make things functional. Pavitra pointed out that people will not fund for sustainability of the organization unless there are any tangible outcomes. So, EHAC needs to come out with these outcomes. Pranjal shared his experience that with Crowdfunding clarity on activities and showcasing the activities help in fund raising. DVR voiced his skepticism with CSR type of funding where there is anecdotal evidence of green washing.

Nagarajan opined that is we could get overseas organization to be part of our consortium we can get funding from them for few projects. He also pointed out that quite a few members of EHAC are themselves trying to raise funds and hence EHAC should make sure that it is not in conflict with member organizations.

Arnaz pointed out that the money we are trying to raise is for organization sustenance and not the pilot projects (between member organizations). Dr GN Rao had earlier suggested that we could approach few people since we don't need a lot of money.

DVR suggested that in order to sustain the salaries and expenses related to the EHAC, we may need about Rs. 20 lakhs per annum. Prakash promised to share a budget with the core team in a couple of days. Ram suggested that small amounts can be raised from within the membership. Alternately, for larger amounts, EHAC could invite CSR heads next time and let them experience the EHAC, which may prompt some of them to fund the institution.

Updates about Current Pilots and Way Forward; New Pilots

Pavitra shared the discussions that have been going on between BHS and Fernandez Hospital on pilot. He talked about BHS taking over a trust hospital with the support of Fernandez Hospital. He also stated that there would be a substantial update by the next meeting. DVR pointed to the experience of LVPEI on taking over a trust hospital.

Anshu provided an update on the pilot between BHS and LVEPI on NABH accreditation for AMRIT clinics. Pavitra shared that one of the issues has been that NABH also needs to realize that the difficulty of getting it done for a small organization is very taxing as the requirements are same as big organization. Anshu suggested that a case study of the BHS NABH accreditation could be made.

DVR requested that abstract of relevant papers by member organizations could be placed on the EHAC website. The abstract and the link to the papers could be placed.

Paramesh and DHAN pilot on colo-rectal awareness has not made progress in the last quarter. Rajapandian shared update of all the pilots of DHAN with other member organizations. There are six pilots that have progressed. On the eye checkup, about 1000 DHAN members were screened and supported with LVPEI over 10 camps. SIICP and DHAN work will resume in the upcoming quarter. With Kaveri hospitals two screening camps were held. DHAN and FH has started discussions on potential partnership with mutual visits. The epilepsy screening with Dr. Rajesh is delayed and will be done next quarter.

Jachin filled on the updates from other LVPEI pilots.

Arnaz pointed out that there is a need for the pilot participants to share the data. The data is important for us to seek funding. Anshu also added that two forms have been circulated. However, this has not been complied. Devendra suggested that the forms can be printed and filled up immediately.

Dr. C shared updates on an offline conversation on project with SSISM on working with 10+2 graduates. People Tree hospitals has been training and absorbing students from SSISM. He shared his experience of finding the students to be very bright, ready to work, and have the right attitude. The training includes accommodation and food and a Rs.4000 stipend per month. This is a 1-year program. From SSISM, Prashanth shared the work done to prepare the potential students for the People Tree partnership. There is a one-month preparation that is done which also includes discussions with the parents. He also shared that a similar pilot with Fernandez Hospital. Similar to the People Tree pilot, food and accommodation is arranged by FH. This is a 3-month internship. A third pilot is being planned with Saksham. After the internship there is a screening program based on which they are absorbed. Evita shared that the enthusiasm of the girls and she shared that she was humbled by their gratitude and their attitude. She said we need to do more. Sudha suggested that the BSC. Biotechnology students can be also considered

at Indo American. Finally, Prashanth shared that 10 students had done their internship with Narayana Health through the pilot.

DVR requested that SSISM should enroll 5 more similar rural educational institutions into the EHAC.

Prashanth also shared that about 30 students will be visiting ISB, LVPEI, and FH. Dr. GC shared the training programs at LVEPI which can be potentially tapped by SSISM for their graduates.

BHS and SSISM are in discussions about potential visits and cooperation. DVR suggested that BSc. Nursing to be started by SSISM. However, members shared that a hospital is necessary.

Prakash shared the upcoming pilot on comprehensive primary healthcare services. Pavitra added that there would be primary and secondary research and consultations. Sanjeev proposed that EHAC could come out with a health and wellness centre. UNICEF is working with the government on this. He offered to work with EHAC members in AP, Telangana and Karnataka in coming up with pilot centres. Rajapandian shared that DHAN is already working in Ramanagara. He said that they can have offline discussions with Sanjeev.

Tea Break



Costly Mistakes Made and Lessons Learnt

Paramesh shared his experience through 14 years of entrepreneurship. He stated his humble background. Started 150 bed hospital without any capital on his own. He started without any base. Started educational institution with another family, but it is floundering because there is no trust between the people. Lack of legal compliance created problems for both institutions. He then started a eye hospital. The lack of focus meant he was opportunistic.

For all ventures, he had borrowed money from family, friends, and money lenders. There were cheque bounces cases through fraud. He got arrested along with family members. Not adhering to rules and regulation and legal compliances has led to so many problems. With the help of CA Sridhar, compliance issues have been sorted out and complied it.

In the course of business, Paramesh trusted people without doing the homework. He also made the mistake of involving family members who were not part of the day to day operations. He

summarized that his ego and his belief that he can get away with anything based on connections led him astray.

He shared that the improvements have come from associating with good people and good mentors. He also realized that his core competency is as a doctor and not as entrepreneur. Ethics is key in every aspect of work, including legal compliance. He also pointed out that after 17 years after post-graduation, he had his first course on ethics in his management education. This is something not taught in medical school.

Evita echoed the audience sentiment by saying that she admires Paramesh's courage. Devendra shared the experience of Johns Hopkins in the mistake, admitting their mistake, and then corrected it. He said that by sharing the experience Paramesh can help youngsters avoid potential mistakes. Anumeha emphasized that Paramesh should share his story.

Paramesh summarized that any mistakes can be made as long as one remains ethical; people will forgive and support. DVR emphasized that surrounding oneself with the right people is important. Aniruddha shared that there are 52 licenses required for any healthcare institution; most doctors are experts in their work but not on compliance and getting advice on the compliance is not easy. He suggested that there is a need for a unifying organization to provide this advice. Anshu shared that all of us have made mistakes and have paid costs, some financial and others emotional. She talked about the support she got from Evita in navigating this life. She also pointed out that Paramesh with his experience could be a good mentor.

How to Scale-up Ethical, Specialized, Quality Care at Hospitals?

Sudha talked about the quality component. She said that quality-cost relationship is affected by volumes. Simplifying and standardizing processes also helps improve quality and reduce costs. She shared her thoughts about lean thinking and reducing waste. Identifying the key operational metrics is important. Often actual costing of services is not done, and competitive pricing is resorted to. She suggested that this is not optimal. There is a need to do the actual costing, including the costs of the complexity of the test. There is a need to bring in the support of the top management to ensure quality. There is scope to leverage technology and IT to reduce costs.

She said that EHAC should focus on quality curative care at low cost in the spirit of equity. It cannot be restricted to only the preventive care. She emphasized that the quality of diagnostics needs to be understood by all stakeholders.

Rajesh approached the topic from a different perspective. The quality aspect needs to be understood from the different stakeholders' perspectives. Quality from medical professional perspective includes facilities, learning, academics, technology, peace of mind, and beingful workplace. From the patient's perspective, quality may mean confidence in treatment, value for money, communication and empathy, ambience, and outcome. From management's perspective, quality may mean credentials of consultants, patient satisfaction, and profits.

Talking about specialization, Rajesh stated that even without being a multispecialty hospital one could have consultants from different specializations. In a single specialty care, there can be sub specialization. Scaling up is important to costs. From an equitable care perspective, consultants should have the ability to do differential billing. Discounts and subsidies need to be worked out. Referrals to free clinics and low-cost setups can help. Larger volumes help in allowing for cross subsidies and discounts.

Rajesh talked about the need to define quality in healthcare. This would require research, especially from patient's perspective. EHAC can perhaps contribute by coming out with a quality parameter document.

Anumeha suggested that a platform like EHAC should try to avoid generalizations such as management is always after profits or that doctors are corrupt. DVR stated that there is a need to be clear about decisions coming from the values of the organization. Anshu pointed that there is a need to recognize that management alone is not the problem child. Management is not always trying to be corrupt or unethical.

Dr. C shared that administration is an art and science and there is a need to have specialists to run the administration. It cannot be in general run by doctors. DVR gave a rejoinder stating that the general direction that healthcare is taking seems to be about profit making, which is the concern.

Dr. C suggested that the Robinhood policy is not good. Taking from have's and funding the have not's is not great as it reduces the transparency in the organization. If one is not aligned with the top they should not work with that organization.

Harish interjected that there is a third side i.e. public, and that is what we should be worried about. We should be worried about creating transparency and gaining trust. May be its behavioral; nudging people towards that. Everyone makes a difference. Some excellent points were raised in terms of how good players can nudge the bad players.

Dr. GC said that from the organization point of view DVR gave an excellent example. Similarly, while there was a case for increasing consulting fees, LVPEI said no as we'll push away the people. He said that he is guilty of starting the suggestion that MBA being guilty of corrupting healthcare; he stated that he should have said economists. Sarang made an excellent point the other day that we need to be careful about from where the money/ capital is coming. No generalization is valid.

Jagdish suggested that we cannot be unmindful of the way profit maximization has taken the center stage.

Evita said that she has benefited by having good administrators and the experience they bring with them. She said that she is not good with the numbers and she has made costly mistakes as she thinks more from the heart. When FH had introduced childbirth classes, there was significant difference in the way the women who attend the classes came to delivery compared to those who didn't. So, Evita had asked the manager to make it free for everyone. After FH incurred huge costs (for 4,600 people), the manager said that this is not feasible. Hence, a consultation fee was introduced to manage the costs. This practicality came from the administrators.

DVR pointed out that the DNA of the organization is important. This is true not only for healthcare but everywhere. The DNA drives the decisions.

Nagarajan stated that the margin comes from the difference between price and the cost. Lots of things like high inventory are waste, especially where the hospital does not follow FIFO and end up with expired medicines. Many hospitals don't know about the library stocks. He said that we have three cornered formulae- one is patient volume, the other is quality. If you get these two right, we can manage the third, i.e. cost, as well.

Rajapandian pointed out that other than the pricing, the aspect of respect to patients is important. Patients need to be treated with respect. Lakshmikanth shared that the new medical curriculum includes ethics.

Lunch break

What Active Role Can Educational Institutions Play in Equitable Healthcare?

Sarang started the session by talking about what ISB does in healthcare – research, education and policy and industry. The Max Institute is not a purely research institute, but one that works with students and industry to apply the findings. He shared the four themes of the institute – management of healthcare systems, innovation and entrepreneurship, healthcare financing and public policy, and patient centricity/ consumer behavior. He shared some of the research output from the healthcare research. There are case studies and books supported by the Max Institute.

He then shared some opportunities of overlap with the EHAC agenda. These included violence against doctors, health technology assessment, technology-enabled healthcare delivery and community health workers. He also said that there is possibility of jointly applying for funding for potential research projects.

Dr. C asked whether we could look at onsite activity-based research projects and Sarang affirmed that all the research at Max Institute is based on that. Dr. C clarified that it could be prospective and Sarang agreed. Dr. C brought up the point that one area where healthcare is struggling is in finance, irrespective of the type of institution. He proposed that academic institutions should do more work on sustainability. Sarang suggested that EHAC could invite economists working on financing angle to give an overview of this space in the next meeting. DVR pointed out that there is an increasing number of acquisitions of large hospitals and chains by foreign private equity and we need to see what the implications of this move are.

Anshu suggested that some of the case studies could be integrated into the online modules of EHAC. She also suggested that some of the pilots of the EHAC could be converted into case studies. Sarang agreed that ISB could contribute in evaluation also. Prashanth asked whether we could have community driven healthcare delivery instead of community health worker healthcare delivery. Sarang agreed that this is eminently possible.

Reaching Out to the Medical Student Fraternity

Arnaz shared the details of the medical students' interaction that took place at LVPEI on 22 August'19 for the benefit of participants who were not present yesterday. She also shared that the general thought seems to be that we should go to the medical colleges rather than asking them to come to a central venue.





Dr. C shared his conversations with current students of the BMC. Through multiple meetings with the students, he has found that doing the session as part of the festival event of the medical colleges in Bangalore may provide a good reach. The fest has competitions and cultural activities as well as discussion and clinical sessions. He suggested that we can customize the session on offer to the students including what they want – career path, options, etc. He called for volunteers for the program in October in Bangalore. This would be about a 3-hour session on one of the days of the festivals. Arnaz suggested that our members from Bangalore can join. Dr. C called for senior members of the EHAC to join in order to inspire them. Devendra suggested that the program could be done in a workshop mode. Arnaz suggested that if Dr. C can finalize the date and she will coordinate with core members to get faculty from the membership.

Arnaz also suggested that we could do something similar in Hyderabad.

DVR raised the question of how do we increase participation from among the students. Rajesh said that we need to find out what the students want. We need to blend what we want to convey alongside with what the students want.

Sanjeev shared that there is an opportunity for public health domain case competition. This can bring more people on board. He also suggested that we could be part of conferences; even going to medical colleges would get better response.

Online Free Educational Courses

Prakash initiated the session by sharing the status of the various courses. He provided a background behind the thought process for these courses for the new participants in the meeting. Among the seven courses that were initiated, only one course has been completed.

Prakash invited Astha to present her module on Patient Rights. Astha walked through the course, pointing out the design, the various modules involves, and the self-assessment component.

Prakash then requested the members for suggestions on how to proceed as there were multiple issues concerning the course development; lack of time as the volunteers had other

priorities, lack of ownership or at the other end possessiveness over the materials, lack of subject matter expertise, etc.

Dr. GC suggested that if we were to consider it from the perspective of the other key focus area of EHAC, viz., medical students education, then the courses on Empathy, Patient Rights, and Respectful Maternal Care are important. He suggested that we focus on getting these up and running in the first instance and relegate the remaining modules to a later date for development.

Dr. C requested that the module on Patient Rights be completed for trial in such a manner that it can be tested during the Bangalore event with the medical students that he is coordinating.

Next Meeting Location and Dates

Pranjal shared that there are two options in terms of venue – Aravind Hospital at Chennai and ISB Mohali. DVR said that ISB can provide support. Pranjal also offered to host at SSISM at Sandhalpur.

It was decided that the venue and dates would be decided over email by 1st of September 2019.

DVR shared a framework bringing together business orientation and social orientation as a closure for the earlier debate on whether professional management is to blame.

Wrap-up of Day 2 and Vote of Thanks

Dr. GC shared a wrap up of day two. The updates on the pilots has been encouraging and gives motivation to do more.

He thanked Raj, DVR, and Sarang for hosting the QM and the ISB team for bringing together the event. He thanked the guest speakers and the people who brought it the guest speakers. He also thanked the observers. He thanked Arnaz for brining everyone together.

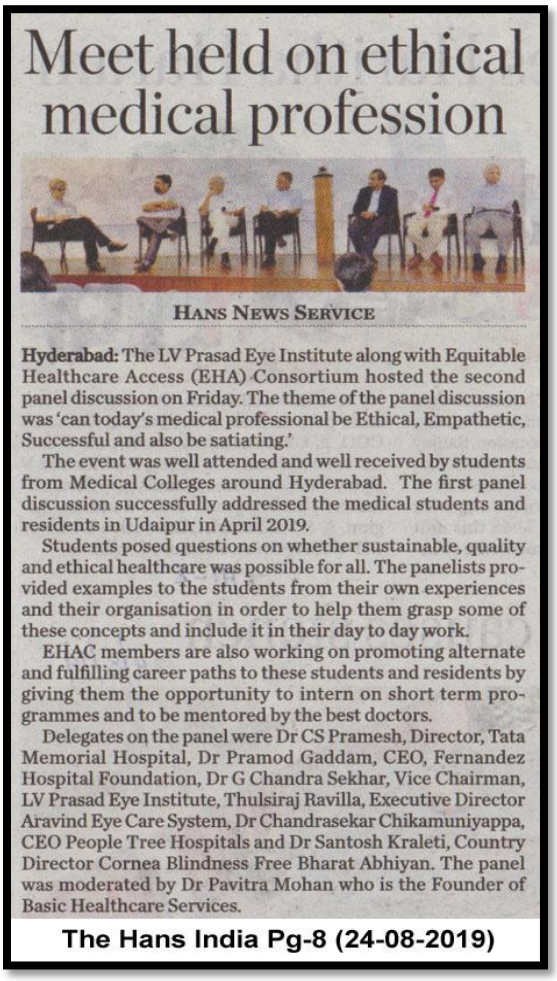
END OF QUARTERLY MEETING

Press Coverage

Medical students participate in a discussion on exploring ethical, successful and professionally satisfying career
http://businessfortnight.com/medical-students-participate-in-a-discussion-on-exploring-ethical-successful-and-professionally-satisfying-career/

Equitable Healthcare Access Consortium to facilitate mentoring of medical students
http://businessnewsthisweek.com/business/equitable-healthcare-access-consortium-to-facilitate-mentoring-of-medical-students/

Meet held on ethical medical profession
https://thehansindia.com/news/cities/hyderabad/meet-held-on-ethical-medical-profession-557635



Meet held on ethical medical profession

HANS NEWS SERVICE

Hyderabad: The LV Prasad Eye Institute along with Equitable Healthcare Access (EHA) Consortium hosted the second panel discussion on Friday. The theme of the panel discussion was 'can today's medical professional be Ethical, Empathetic, Successful and also be satiating.'

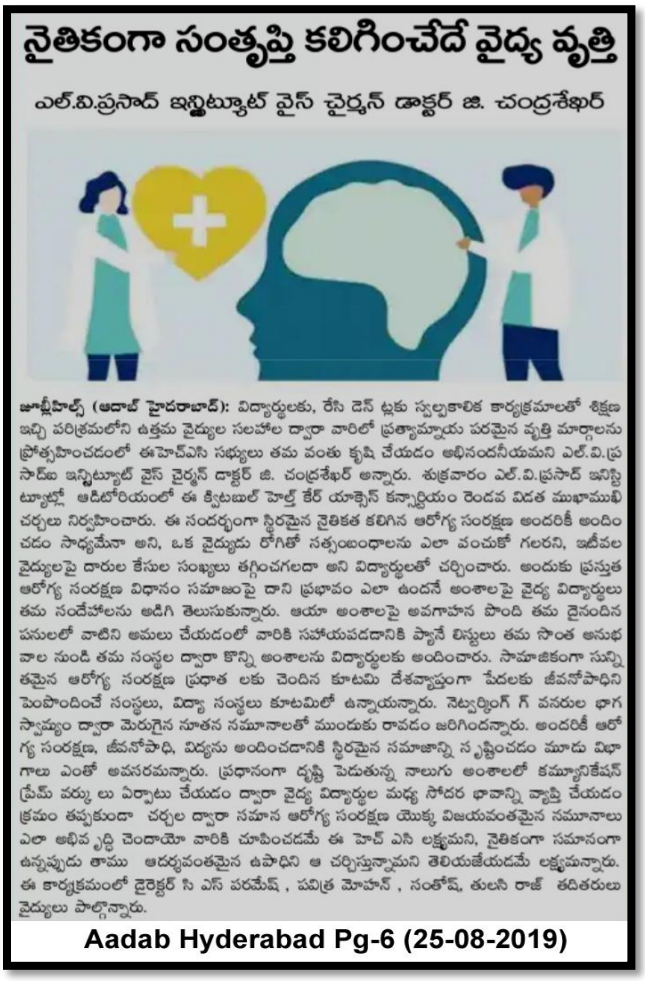
The event was well attended and well received by students from Medical Colleges around Hyderabad. The first panel discussion successfully addressed the medical students and residents in Udaipur in April 2019.

Students posed questions on whether sustainable, quality and ethical healthcare was possible for all. The panelists provided examples to the students from their own experiences and their organisation in order to help them grasp some of these concepts and include it in their day to day work.

EHAC members are also working on promoting alternate and fulfilling career paths to these students and residents by giving them the opportunity to intern on short term programmes and to be mentored by the best doctors.

Delegates on the panel were Dr CS Pramesh, Director, Tata Memorial Hospital, Dr Pramod Gaddam, CEO, Fernandez Hospital Foundation, Dr G Chandra Sekhar, Vice Chairman, LV Prasad Eye Institute, Thulsiraj Ravilla, Executive Director Aravind Eye Care System, Dr Chandrasekar Chikamuniyappa, CEO People Tree Hospitals and Dr Santosh Kraleti, Country Director Cornea Blindness Free Bharat Abhiyan. The panel was moderated by Dr Pavitra Mohan who is the Founder of Basic Healthcare Services.

The Hans India Pg-8 (24-08-2019)



నైతికంగా సంతృప్తి కలిగించేదే వైద్య వృత్తి

ఎల్.వి.ప్రసాద్ ఇన్స్టిట్యూట్ వైస్ చైర్మన్ డాక్టర్ జి. చంద్రశేఖర్

జూబ్లీహిల్స్ (ఆదాబ్ హైదరాబాద్): విద్యార్థులకు, రేసి డెన్ట్ లకు స్వల్పకాలిక కార్యక్రమాలతో శిక్షణ ఇచ్చి పరిశ్రమలోని ఉత్తమ వైద్యుల సలహాల ద్వారా వారిలో ప్రత్యామ్నాయ పరమైన వృత్తి మార్గాలను ప్రోత్సహించడంలో ఈహెచ్ఎసి సభ్యులు తమ వంతు కృషి చేయడం అభినందనీయమని ఎల్.వి.ప్రసాద్ఐ ఇన్స్టిట్యూట్ వైస్ చైర్మన్ డాక్టర్ జి. చంద్రశేఖర్ అన్నారు. శుక్రవారం ఎల్.వి.ప్రసాద్ ఇన్స్టిట్యూట్లో ఆడిటోరియంలో ఈ క్విటబుల్ హెల్త్ కేర్ యాక్సెస్ కన్సార్టియం రెండవ విడత ముఖాముఖి చర్చలు నిర్వహించారు. ఈ సందర్భంగా స్థిరమైన నైతికత కలిగిన ఆరోగ్య సంరక్షణ అందరికీ అందించడం సాధ్యమేనా అని, ఒక వైద్యుడు రోగితో సత్సంబంధాలను ఎలా వంచుకో గలరని, జబీవల వైద్యులపై దారుల కేసుల సంఖ్యలు తగ్గించగలదా అని విద్యార్థులతో చర్చించారు. అందుకు ప్రస్తుత ఆరోగ్య సంరక్షణ విధానం సమాజంపై దాని ప్రభావం ఎలా ఉందనే అంశాలపై వైద్య విద్యార్థులు తమ సందేహాలను అడిగి తెలుసుకున్నారు. ఆయా అంశాలపై అవగాహన పొంది తమ దైనందిన పనులలో వాటిని అమలు చేయడంలో వారికి సహాయపడడానికి ప్యానే లిస్టులు తమ సొంత అనుభవాల నుండి తమ సంస్థల ద్వారా కొన్ని అంశాలను విద్యార్థులకు అందించారు. సామాజికంగా సున్నితమైన ఆరోగ్య సంరక్షణ ప్రధాత లకు చెందిన కూటమి దేశవ్యాప్తంగా పేదలకు జీవనోపాధిని పెంపొందించే సంస్థలు, విద్యా సంస్థలు కూటమిలో ఉన్నాయన్నారు. నెట్వర్కింగ్ గ్ వనరుల భాగస్వామ్యం ద్వారా మెరుగైన నూతన నమూనాలతో ముందుకు రావడం జరిగిందన్నారు. అందరికీ ఆరోగ్య సంరక్షణ, జీవనోపాధి, విద్యను అందించడానికి స్థిరమైన సమాజాన్ని సృష్టించడం మూడు విభాగాలు ఎంతో అవసరమన్నారు. ప్రధానంగా దృష్టి పెడుతున్న నాలుగు అంశాలలో కమ్యూనికేషన్ ప్రేమ్ వర్క్ లు ఏర్పాటు చేయడం ద్వారా వైద్య విద్యార్థుల మధ్య సోదర భావాన్ని వ్యాప్తి చేయడం క్రమం తప్పకుండా చర్చల ద్వారా సమాన ఆరోగ్య సంరక్షణ యొక్క విజయవంతమైన నమూనాలు ఎలా అభివృద్ధి చెందాయో వారికి చూపించడమే ఈ హెచ్ ఎసి లక్ష్యమని, నైతికంగా సమానంగా ఉన్నపుడు తాము ఆదర్శవంతమైన ఉపాధిని ఆ చర్చిస్తున్నామని తెలియజేయడమే లక్ష్యమన్నారు. ఈ కార్యక్రమంలో డైరెక్టర్ సి ఎస్ పరమేష్ , పవిత్ర మోహన్ , సంతోష్, తులసి రాజ్ తదితరులు వైద్యులు పాల్గొన్నారు.

Aadab Hyderabad Pg-6 (25-08-2019)

నైతికతతో వైద్య వృత్తి నిర్వహించాలి : వైద్యులు

హైదరాబాద్ సిటీ, ఆగస్టు 23 (ఆంధ్రజ్యోతి): నైతికతతో వైద్య వృత్తిని నిర్వహించాలని పలువురు వైద్యులు వైద్య విద్యార్థులకు సూచించారు. ఈక్వెటబుల్ హెల్త్‌కేర్ యాక్సెస్ కన్సార్టియం ఆధ్వర్యంలో చర్చా కార్యక్రమాన్ని శుక్రవారం ఎల్‌వీ ప్రసాద్ ఐ ఆస్పత్రిలో నిర్వహించారు. చర్చలో టాటా మెమోరియల్ ఆస్పత్రి డైరెక్టర్ డాక్టర్ సి.ఎస్.పరమేష్, ఫెర్నాండెజ్ ఆస్పత్రి సీఈఓ డాక్టర్ ప్రమోద్ గడ్డం, ఎల్.వి.ప్రసాద్ ఐ ఇన్‌స్టిట్యూట్ వైస్ చైర్మన్ డాక్టర్ జి.చంద్రశేఖర్ పాల్గొన్నారు. నేటి వైద్య వృత్తి నైతికతను, బాధ్యతలను, విజయాన్ని అందించడంతో పాటు వారు వృత్తిలో సంతృప్తి చెందగలరా..? అన్న అంశంపై చర్చ జరిగింది. వైద్య విద్యార్థులు తమ సందేహాలను నివృత్తి చేసుకున్నారు.

Andhra Jyothi Pg-9 (24-08-2019)

వైద్య విద్యార్థులకు హెల్త్‌కేర్ యాక్సెస్ కన్సార్టియం

మన తెలంగాణ/సిటీబ్యూరో : నైతికతను, సంతృప్తిని అందించే వృత్తిని ఎంపిక చేసుకోవడంపై ఎల్‌వి ప్రసాద్ ఐ ఇనిస్టిట్యూట్‌లో వైద్య విద్యార్థులకు ఈక్వెటబుల్ హెల్త్‌కేర్ యాక్సెస్ కన్సార్టియం సీనియర్ వైద్యులతో చర్చా కార్యక్రమం నిర్వహించి వారి సందేహాలకు మార్గాలు చూపించింది.శనివారం ఆనుపత్రి ఆడిటోరియంలో నిర్వహించిన కార్యక్రమానికి పలు వైద్యకళాశాలకు చెందిన విద్యార్థులు పాల్గొన్నారు. నేటి వైద్య వృత్తి నైతికతను, భావోద్వేగాలను, విజయాన్ని అందించడం వంటి అంశాలను ప్రముఖ వైద్యులు సి.ఎస్:పరమేష్, ప్రమోద్‌గడ్డం, జి.చంద్రశేఖర్, తులసిరాజ్ రావిల్ల, సంతోష్‌క్రాలేటి వివరించి విద్యార్థుల ప్రశ్నలకు సమాధానాలు చెప్పారు. ఉత్తమ వైద్యులచే సలహాలతో వారికి అవకాశం ఇవ్వ డం ద్వారా వారిలో ప్రత్యామ్నాయ, వృత్తి మార్గాలను ప్రోత్సాహించడంలో ఇహెచ్‌ఎంసి సభ్యులు కృషిచేస్తారని వెల్లడించారు.

Mana Telangana Pg-12 (25-08-2019)

మారుతున్న వైద్య విధానంపై

అవగాహన అవసరం

సమావేశంలో పాల్గొన్న వైద్యులు

బంజారాహిల్స్: వెద్య విధానంలో వస్తున్న నూతన ఒరవడులను ఎప్పటికప్పుడు తెలుసుకోవాలని వక్తలు అన్నారు. బంజారాహిల్స్ రోడ్ నం.2లోని ఎల్వీ ప్రసాద్ నేత్ర వైద్య విజ్ఞాన సంస్థలో ఈక్వెటబుల్ హెల్త్‌కేర్ యాక్సిస్ కన్సార్టియం రెండో ముఖాముఖి చర్చను శనివారం నిర్వహించారు. ఈ చర్చా కార్యక్రమానికి నగరంలోని వైద్య కళాశాలలకు చెందిన విద్యార్థులు హాజరయ్యారు. ఈ ప్యానెల్‌లో టాటా మెమోరియల్ హాస్పిటల్ డైరెక్టర్ డాక్టర్ పరమేశ్, ఫెర్నాండేజ్ హాస్పిటల్ ఫౌండేషన్ సీఈవో డాక్టర్ ప్రమోద్ గడ్డం, ఎల్వీ ప్రసాద్ కంటి ఆస్పత్రి వైస్ చైర్మన్ డాక్టర్ జి.చంద్రశేఖర్, అరవింద్ ఐకే సిస్టమ్ ఈడీ తులసీరాజ్ రావిళ్ల, పీపుల్ ట్రీ హాస్పిటల్స్ డైరెక్టర్ డాక్టర్ చంద్రశేఖర్, కార్నియా, బ్లెయిడ్‌నెస్ ఫ్రీ భారత్ అభియాన్ కంట్రీ డైరెక్టర్ డాక్టర్ సంతోష్ తదితరులు ఈ కార్యక్రమంలో పాల్గొన్నారు. ప్రస్తుత ఆరోగ్య సంరక్షణ విధానం ఏమిటి, సమాజంపై దాని ప్రభావం ఎలా ఉంది అన్న అంశంపై వైద్య విద్యార్థులు తమ సందేహాన్ని అడిగి తెలుసుకున్నారు.

Sakshi Pg-14 (25-08-2019)