Identifying Enablers and Barriers for Healthcare Organizations to Deliver Equitable Healthcare in a Sustainable Manner

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D.V.R. Seshadri
Devendra Tayade
Prakash Satyavageeswaran
Thulasiraj Ravilla

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Prof. D. V. R. Seshadri, ISB Hyderabad

Dr. Devendra Tayade, ISB, Hyderabad

Prof. Prakash Satyavageeswaran, IIM Udaipur

Mr. Thulasiraj Ravilla, Aravind Eye Care System, Madurai

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Executive Summary

Healthcare is one of the fundamental needs of citizens in any country. It has a significant effect on the country's socioeconomic development. Equitable distribution of healthcare helps equitable growth of the country and the elimination of socioeconomic inequities.

Literature is replete with examples of the glaring inequities in healthcare delivery and attempts made by various countries in achieving equity in health and healthcare delivery. However, most of the countries have not been able to achieve it. Those who have been successful to a certain extent have focused on comprehensive financing of care through insurance, primary healthcare, and holistic reforms that aim at the development of society. While public healthcare of any country is deemed responsible for the equitable delivery of healthcare, in countries such as India the private sector takes care of a major chunk of curative healthcare delivery. Both, the non-government sector and private sector have a larger role to play. This requires developing a better understanding of equitable healthcare and enablers and barriers experienced by private healthcare providers in delivering equitable healthcare.

The objective of this study is to define equitable healthcare and identify enablers and barriers experienced by private healthcare organizations in delivering equitable healthcare. This study uses qualitative methods and relies on experiences of healthcare leaders from various domains such as eye care, cancer care, mental health, and dental care, among others, to achieve its objectives.

Acknowledgement and assessment of equity is a major facet of equitable healthcare that this study finds to be missing from all the previous definitions in the literature. Unless one acknowledges and measures the extent of inequities in society, it will not be possible to deliver equitable healthcare.

Certain markers such as how organizations define their market, proactively reach out to the needy, treat their customers, and price their services, among others, can be used to identify organizations that are equitable in nature.

Each organization decides whether it wants to deliver healthcare equitably or not. However, experts feel healthcare is a common good, and as good citizens who have benefited and learnt their skill by training on the poor, it is the ethical and moral responsibility of healthcare providers to practice equitable healthcare.

Healthcare organizations do experience various barriers in their quest to deliver equitable healthcare. While the literature focuses on the barriers experienced by public healthcare providers, the barriers experienced by private healthcare providers are also numerous. In addition to the ones already shared in the literature, this study finds poor infrastructure (which includes poor roads and unavailability of a good school), government red tape, geopolitical issues such as insurgency, unavailability of seed capital and capital to expand, lack of knowledge regarding public healthcare and management, nature of intervention for a certain disease, and high cost of consumables and medicines as barriers experienced by healthcare providers in delivering equitable healthcare.

Certain factors that enable healthcare organizations in delivering equitable healthcare are clear purpose, leadership, governance that is driven by purpose and value system, pricing strategy that is based on the patients' paying capacity, investing in people/human resources (HR), lower cost of consumables, availability of funds, and enabling role of international non-government organizations (INGOs).

Organizations that practice equitable care believe that sustainability of purpose and culture is more important than financial sustainability and that the focus on the former can make organizations financially

sustainable in the long term. This study finds that organizations that aim to practice equitable healthcare focus on understanding the market and the customer needs, stay aligned to the purpose, and delivers high-quality care. They grow organically and utilize non-traditional sources of capital such as community, networks, and freely available intellectual capital from peer and senior leaders for their growth.

The unavailability of HR in rural areas is a chronic problem faced by organizations across the world. Experts feel that doctors hesitate to work in rural areas due to prevailing prejudices about the rural areas, lack of basic amenities, lack of family support, and lack of knowledge and skills. The organizations that have been able to overcome this problem to a certain extent use a three-pronged strategy, i.e., task shifting to optimally utilize scarce doctors, developing a pipeline of HR by becoming an educational institute, and using employee engagement principles to retain the existing staff. It is important to look at HR as an investment that pays dividends in the future rather than as a cost to the organizations.

Building leaders for the future who can take the baton from the current leaders requires a better understanding of the mind-set of these leaders and influences that shaped them. These leaders believe in giving back. They are often irrational when it comes to solving problems and this has helped them in coming up with innovative solutions. They are driven by the purpose and put the purpose on a higher pedestal than themselves. Their experiences, alma mater, workplaces, society, family, and their spouses have played a critical role in shaping their mind-set. These points to the fact that it requires the whole society and multiple factors to build the character of a person. Building next-generation leaders thus requires educational institutes to provide the young generation the experiences that give them a reality check of the current status of healthcare in India.

If equitable healthcare has to become a reality, it will require a concerted effort from all the stakeholders such as government, public and private healthcare providers, insurance agencies, funding agencies, educational institutes, and healthcare researchers, among others. All the stakeholders need to arrive at a common purpose and then devise strategies to achieve it. Networks have an important role to play in facilitating cross-learning and motivating peers. The government may well have to play the role of an anchor and listen to various stakeholders while designing policies. If well orchestrated, efforts by all the stakeholders can help in delivering healthcare that is truly equitable and that results in an equitable society.

Introduction

Healthcare and socioeconomic development are closely intertwined and development in one is impossible without development in the other (Ramani & Mavalankar, 2006). For a society to be stable, the population must be assured of three fundamental needs, viz., livelihood, healthcare, and education (Butlin, 1989). Woefully, these are a far cry for a large percentage of the population across India as 56% of our country's population resides below the empowerment line; i.e., they have no access to eight basic needs, viz., food, drinking water, sanitation, healthcare, energy, housing, education, and social security (Gupta *et al*., 2014). At the same time, out-of-pocket private payments by patients make up a major component of the total expenditure on healthcare, putting tremendous financial and psychological pressure on middle- and lower-income classes. Only one-fifth of healthcare is financed publicly. Public spending on healthcare as a percentage of the country's gross domestic product (GDP), at about 0.9%, is the lowest among all nations in the world (Prinja, Kaur & Kumar, 2012). Even India's neighbours such as Bangladesh, Sri Lanka, and Pakistan fare much better on this dimension (Prinja, Kaur & Kumar, 2012). Differential distributions of services, power, and resources have resulted in extremely skewed access to quality healthcare for Indians, with the majority being left to fend for themselves for their healthcare needs.

The quality of healthcare that is affordable by the poor is often so bad, that they refrain from accessing it (Kruk *et al*., 2018). The only way for the poor to get access to decent healthcare is to borrow money or sell off their meagre assets to gain access to a reasonable quality of healthcare, often putting them into an inescapable debt trap. At the other end of the spectrum, corporate hospitals have business models that do not enable access by the poor and put enormous pressure on the middle class. Hence, these are out of reach for a major portion of the country's population (Barik & Thorat, 2015).

Eye care delivery in India, thankfully, has been a shining light. Exemplars in eye care delivery in India have shown the world that it is possible to deliver world-class care equitably, cutting across the entire income spectrum, through unique home-grown business models. Examples include Aravind Eye Care Systems that is based in Madurai; L.V. Prasad Eye Institute in Hyderabad; and Dr. Shroff Charity Eye Hospital in Delhi, to name a few. Much has been written about them, and these case studies are commonly used in business schools across the world. On the other hand, healthcare organizations from other domains have not been able to replicate the success achieved by the eye care organizations in providing equitable healthcare.

As the country battles with simple health issues due to a lack of provision of healthcare, relying entirely on the government to act would be futile. On the other hand, since the private sector accounts for 80% of the healthcare delivery across the country (Sharma, 2015), understanding the barriers that are faced by the private healthcare organizations in providing equitable healthcare and how some of them have overcome those barriers may inspire and inform other healthcare organizations regarding the practice of equitable healthcare.

This report, through primary research, brings out the enablers and barriers faced by organizations in different healthcare domains in providing equitable healthcare access in a sustainable manner. The report is divided into 10 chapters. The first chapter, i.e., "Introduction", lays down the context for the research study and shares an outline of the report. The second chapter reviews the literature on equity,

especially in the context of healthcare, and identifies the knowledge gap in the literature. Research methods used in the study are discussed in the third chapter. Equitable healthcare is an emerging term, and the fourth chapter attempts to define it and understand various aspects of it. The fifth and sixth chapters, respectively, discuss the barriers and enablers faced by organizations in delivering equitable healthcare. We focus on such barriers and enablers that are in addition to the ones that are already identified in the literature on equity in healthcare. The seventh chapter tries to understand sustainability from the point of view of equitable healthcare organizations and lays down the various steps taken by the organizations in achieving sustainability. The sustainability angle assumes significance given that the discussion in this report focuses on non-governmental organizations, both for profit and not-for-profit, providing equitable healthcare. The eighth chapter focuses on the problem of the unavailability of HR in the rural. It explores various barriers faced by doctors in practicing in rural areas and provides a few solutions to the problem. Practicing equitable healthcare at a large scale across the country would require building next-generation leaders. The ninth chapter discusses the traits of the current leaders who practice equitable healthcare and suggests a way forward for developing next-generation leaders. The 10th chapter discusses the findings, providing recommendations that various stakeholders of healthcare can adopt to ensure equity in healthcare.

The insights gathered by interviewing numerous healthcare leaders who have attempted to provide equitable healthcare is being shared in this report. The researchers hope that the knowledge of barriers may result in concerted efforts in overcoming them. Similarly, the knowledge of enablers may help well-intentioned organizations in adopting/replicating them and prevent these organizations from spending their energy in reinventing the wheel.

2 Literature Review

2.1 INTRODUCTION

Equity is an ethical concept. It is the ethical responsibility of a healthcare system to give priority to health conditions that disproportionately affect people based on their social status (Braveman, 2003). It requires resources to be distributed based on the need (Qidwai, Ashfaq, Khoja & Merchant, 2011). While the inequality in healthcare provisioning affects the overall healthcare of the community, it also results in inequality in the functioning of the people thus, affecting the whole economy (Bose & Dutta, 2018).

The World Health Organization (WHO) and the World Bank's commitment to eliminating extreme poverty and reducing inequity in healthcare has resulted in a worldwide effort to achieve socioeconomic and healthcare equity in the last several decades (Zhou *et al*., 2013). Any healthcare system's performance can be measured based on three themes, i.e., efficiency, effectiveness, and equity. Equity has been gaining widespread attention recently, especially from the policymakers, as a means to improve healthcare system's performance (Pulok, van Gool, Hajizadeh, Allin & Hall, 2019). While the policymakers are clear about the importance of healthcare equity, the means and practical approaches to achieve it remain unclear (Durand-Zaleski, 2011). With the growing burden of chronic illnesses, the healthcare systems need to improve their performance.

Despite good intentions, various societies and governments have not been able to achieve the goal of equity. Even some of the most developed nations such as the United States and the United Kingdom, despite gaining tremendous material wealth and having growing economies, have experienced greater social failure; eroding trust, diminished community life, reduced levels of mental health, reduced life expectancy due to drug consumption, obesity, violence, and teenage pregnancies among others (Chang & Fraser, 2017).

This signifies the fact that the growing economy of a country cannot be taken as an indicator of equity in society and its healthcare. If despite efforts from multiple stakeholders the goal of equity in healthcare remains unachieved, a deep dive into further understanding of the subject is warranted.

2.2 GLARING INEQUITIES

Inequity arises due to the variable position of people in society, attributed to their income, education, profession, gender, race, and ethnicity, to name a few (Qidwai, Ashfaq, Khoja & Merchant, 2011). When it comes to healthcare utilization, there are glaring inequities based on the social and the economic status of the people.

People from ethnic minorities receive substandard healthcare despite having the same pathological condition and the same coverage under insurance (Smedley, Stith & Nelson, 2003). Betancourt (2014) finds that as compared to white people, ethnic minorities experience a higher rate of medical errors, a longer length of hospitalization, and greater avoidable hospitalization for the same condition despite having the same financial coverage.

When it comes to healthcare expenditure, the rural population bears higher out-of-pocket expenditure (OOPE) on drugs and pharmaceuticals (OPEDP) and catastrophic OOPE on drugs and pharmaceuticals

(COPEDP) than the urban population (Hajizadeh & Edmonds, 2019). Different patterns of expenditures are noticed based on socioeconomic status (SES) as COPEDP is highest for lower SES and decreases with a rise in SES. The variation in COPEDP is also highest among people with lower SES than with higher SES (Hajizadeh & Edmonds, 2019).

With regard to healthcare utilization, Gwatkin and colleagues (2004) analyzed data from 51 countries and reviewed other studies to conclude that invariably across the world, the richer 20% of the population receives more benefits from the public healthcare initiatives than the poorest 20% of the population. Even with primary healthcare utilization, the richer 20% of the population receive greater benefits provided by the public healthcare than the poorer 20%; e.g., oral rehydration therapy and immunization are supposed to benefit the poor more than the rich. But the poor are benefited lesser by a margin of 20% points with regard to oral rehydration therapy and by 30–35% points in case of immunization than the richest 20% of the population in about 44 countries in Asia, Africa, and Latin America (Gwatkin, 2001). Between 1993 and 2008, the healthcare utilization data from China brought out that, given the same need, the rural rich utilize outpatient services more than the rural poor (Zhou *et al*., 2013).

Across the world, access to healthcare is inversely proportional to the need for it i.e., even though the poor have a greater need for healthcare, the rich have greater access to it and thus utilize it more than the poor (Qidwai, Ashfaq, Khoja & Merchant, 2011).

2.3 FINANCING CARE

In developing countries, people's paying capacity may affect their access to healthcare. Thus, the government's role assumes a great responsibility in providing financial security and access to healthcare (Bose & Dutta, 2018). In the absence of financial coverage, half the world is spending out of their pocket on healthcare (Dwivedi & Pradhan, 2017). Lack of other options for financing healthcare affects the equity in accessing of healthcare for the lower-income families; the absence of insurance support means that people with rare diseases have to bear a higher cost for healthcare (Rostampour & Nosratnejad, 2020). The non-inclusion of drugs and pharmaceuticals in universal healthcare coverage adds to the burden of OOPE (Hajizadeh & Edmonds, 2019).

The insurance system is the most equitable system of financing healthcare and OOPE the most unfair (Rostampour & Nosratnejad, 2020). Thus, many countries focus on public financing of healthcare to achieve equity in health.

To reduce inequity in healthcare utilization, China introduced various healthcare reforms from 1993 to 2008 that resulted in increased pro-poor utilization of outpatient services (Zhou *et al*., 2013). Despite these reforms to ensure equity in financing by altering the structure of the insurance and improving the coverage, it was unable to eliminate inequity due to disregard for vulnerable groups and gap between the rich and the poor, and not optimizing the insurance package for the poor while introducing the reforms (Rostampour & Nosratnejad, 2020).

A study comparing various schemes rolled out by the state governments of Rajasthan, Tamil Nadu, and West Bengal in India shows that providing free medicines and comprehensive coverage under the insurance scheme in Rajasthan and Tamil Nadu helped in reducing OOPE on medicines and increased the utilization of public healthcare; in West Bengal, the insurance scheme that covered only outpatient healthcare but not consultation fee, cost of investigations, in-patient services, and medicines drove people out of the public healthcare system and pushed patients to avail healthcare from rural health practitioners or quacks (Bose & Dutta, 2018).

This indicates that creating equitable access requires full financial protection for the patients through a comprehensive insurance package and free medicine program (Zhou *et al*., 2013; Bose & Dutta, 2018).

2.4 PRIMARY HEALTHCARE

As much as 70% of the population in India and Bangladesh resides in rural areas. Similar is the case with many other lower- and middle-income countries. Thus, to reduce the inequity in the rural population, these countries need to focus on improving rural healthcare infrastructure (Islam, 2012).

Appropriate identification of the patients and allocation of appropriate resources reduces the pressure on the upstream acute healthcare facilities, which further results in a significant reduction in healthcare costs (Zhang, Fry & Krishnan, 2015). Investment in primary care has proven to bring more equity than investment in the healthcare system in general (Castro-Leal, Dayton, Demery & Mehra, 1999). The gradual improvement in equity in outpatient care utilization in China between 1993 and 2008 can be attributed to the country's focus on primary healthcare (Zhou *et al*., 2013). Considerable evidence is available to show that the population's healthcare is better in areas with more primary healthcare centres and that the countries that put more focus on primary healthcare experiences better population health (Ward, 2009).

Due to increasing co-morbidities, family physician's role in offering comprehensive healthcare at primary healthcare centres becomes critical, and thus, achieving equity in healthcare requires a larger focus on primary healthcare and family medicine (Qidwai, Ashfaq, Khoja & Merchant, 2011).

2.5 MEASURING AND MONITORING HEALTHCARE EQUITY

Measuring healthcare inequity helped certain countries such as Brazil to achieve healthcare equity (Zhou *et al*., 2013). Two criteria can be used to evaluate resource allocation i.e., efficiency (ability to produce certain output with least waste of resources and in the least time) and equity (variation in allocation of resources across different patient groups); these two criteria often conflict with each other; for e.g., if a patient requiring low resources is taken up first, it may ensure efficiency but that may not be equitable. Thus, there has to be a balance between equity and efficiency (Zhang, Fry & Krishnan, 2015). According to Williams & Cockson (2006), efficiency and equity trade-offs cannot be managed based on assumptions or intuitions and require the usage of scientific methods that are already available.

The underdeveloped or developing nations may lack data and resources. However, if whatever data that is available is used properly, it can help develop a better picture of inequities in healthcare (Zere *et al*., 2007). Data collection through surveys, being a tedious process, can be avoided; the administrative data linked to the census data may provide a better picture of healthcare inequity and healthcare utilization (Pulok, van Gool, Hajizadeh, Allin & Hall, 2019). Healthcare information data in India is collected by several agencies but the efforts appear to be highly uncoordinated as the data is often incomplete and lack quality; non-inclusion of the private sector, which plays a significant role in healthcare delivery in India, does not give a true picture of the healthcare status of the people (Patel *et al*., 2015).

The improvement in population averages cannot be taken at face value and monitoring equity requires the usage of meaningful indicators; e.g., even though as a country Malawi appears to be performing well and seems well on its way to achieving the millennium development goals, if the data is disaggregated, the poor section of the society, which is almost 50% of the country, is far from achieving them (Zere *et al*., 2007). Efforts that aim to improve average healthcare often tend to increase the inequities as the benefits tend to first reach the advantaged and then trickle down to the disadvantaged (Starfield, 2007).

2.6 HOLISTIC REFORMS

Taking healthcare to the poor and eliminating inequity will require deeper reforms that go beyond healthcare (Gwatkin, 2001). Due to the Brazilian government's various social reforms, the inequities in healthcare, in general, decreased from 1998 to 2008 (Macinko & Lima-Costa, 2012).

Addressing the challenge of achieving equity requires the healthcare systems to redefine their objective in such a manner that the marginalized population gets benefit first; public healthcare systems need to apply the lessons learned from the other initiatives from across the world that have been able to achieve equity successfully, and empower the voices of groups that represent the marginalized and provide them a representation in policymaking (Gwatkin, Bhuiya & Victora, 2004).

The effectiveness of the current measures also needs be assessed and meaningful evidence has be generated to inform the policy measures that result in greater equity; here, epidemiologists and the community healthcare researchers have an important role to play (Gwatkin, 2001).

CONCLUSION

Among Asian countries, India's performance as a healthcare system is better only to Pakistan and Nepal. Sri Lanka's healthcare system is the best among Asian countries according to the WHO (Islam, 2012). Despite their good efforts, even most of the developed countries could not achieve equity in healthcare (Gwatkin, Bhuiya & Victora, 2004). This raises the question of whether equitable healthcare can be a reality. If yes, then is the current strategy to achieve equity working? The extant literature puts the onus on the public healthcare system to achieve equity, leaving out the private sector that forms a significant portion of the healthcare delivery across the world. The private sector, especially in countries such as India, has to be assigned a bigger role if equity in healthcare is to be realized. Thus, the barriers faced by private healthcare providers in delivering equitable healthcare need to be understood and taken note of. There are a few organizations that practice equitable healthcare. Taking them into account, it also needs to be explored what factors enable them to practice equitable healthcare. Competition in healthcare has resulted in a zero-sum situation, where the same effort would have created value if cooperation among all the stakeholders and providers had been promoted (Chang & Fraser, 2017).

3 Research Methodology

3.1 DATA COLLECTION

Equitable healthcare, being an emerging term, requires the researchers to develop a deeper understanding of it before identifying enablers and barriers to practicing it. Thus, the research was conducted in two phases that had the following objectives:

- **Phase I:** Understand and define equitable healthcare
- **Phase II:** Identify enablers and barriers for healthcare organizations in delivering equitable healthcare in a sustainable manner
  a. Phase IIa: Identify enablers and barriers for eye care organizations
  b. Phase IIb: Identify enablers and barriers for healthcare organizations from domains other than eye care

An interview guide was developed for each phase. The data was collected in the form of audio recordings from semi-structured interviews that were conducted either in person, telephonically, or through video conferencing based on the participants' convenience.

3.2 SUBJECT SELECTION AND RECRUITMENT

The subjects for Phase I were recruited from among healthcare experts. The subjects for the Phase II of the research were nominated by the healthcare experts interviewed during the Phase I. The professional network of the researchers also helped in identifying and recruiting the participants.

3.3 RICHNESS OF DATA

Richness of data of this study is provided in Table 3.1.

The organizations that were recruited for the study are largely non-governmental organizations (NGOs) that have the goal of providing healthcare to everyone irrespective of patients' paying capacity as their purpose. There were a few exceptions in the form of organizations that are registered as private limited entities. They were included in the study considering their aspiration to be an equitable healthcare organization. All the organizations were either located in remote areas or created access to remotely located

Table 3.1 Richness of data

Number of interviews	33
Duration of interviews	21 hours and 40 minutes
Areas of operation	Eye care, ENT, mental health, cancer care, dental care, leprosy and general health, maternal care, orthopaedic care, primary healthcare
Organization details	Provided in Annexure I

patients through various means. These organizations had provisions for free or subsidized care for those in need, thus ensuring the inclusion of the economically marginalized sections of the society.

The respondents from these organizations were the senior leaders assuming senior positions such as Chief Executive Officer, Medical Director, Associate Dean, Senior Manager, among others. A few of them were the founders of the organization. In addition to the senior leaders from the organization, a few experts from the field who had spent more than 15 years of their professional life in that field were also included as respondents in the study. Many of the respondents were highly decorated with awards such as Padma Shri, Ashoka Fellowship, Lifetime Achievement awards, and Oration Awards, among others.

3.4 DATA ANALYSIS

Data was collected between January 2020 and August 2020. The interviews were transcribed verbatim. The transcribed data was further subjected to thematic analysis using QDA miner lite software. The thematic analysis was done in four stages: organization, familiarization, reduction, and analysis. The researchers read and re-read the transcripts and thus, arrived at the key themes that sought to bring the data into a coherent structure.

4 Understanding Equitable Healthcare Access

4.1 WHAT IS EQUITABLE HEALTHCARE ACCESS?

Equitable healthcare even though being an emerging term has been used in various forms in the realms of public healthcare since the early 1980s. Various public health experts and researchers have attempted to define equity in health and healthcare delivery based on their research findings and observations. The definitions that appeared in our literature review are listed in Table 4.1.

While no single definition can be regarded as complete and comprehensive, each definition makes its contribution to the scholarly work done on equity in health. Each contribution helps in developing a better understanding of the subject. The definitions, together, bring out different facets of equitable healthcare. They are listed in Table 4.2.

Table 4.1 Definitions related to equity in health

S. Nos.	Terms	Definitions	References
1	Equity	"The concept of equity is an ethical principle; it also is consonant with and closely related to human rights principles".	Braveman & Gruskin (2003, p.255)
2	Equity	"Equity is the principle where that quality of care should not vary by patient characteristics such as race and ethnicity".	Betancourt (2020, p.7)
3	Inequity	"The term inequity has a moral and ethical dimension. It refers to differences which are unnecessary and avoidable but in addition, are also considered unfair and unjust. So, to describe a certain situation as inequitable, the cause has to be examined and judged to be unfair in the context of what is going on in the rest of society".	Whitehead (1992, p.5)
4	Vertical equity	Vertical equity is "unequal but equitable treatment of unequals".	Mooney (1996, p.99)
5	Horizontal equity	"Persons in equal need of healthcare should receive equal amounts of healthcare, irrespective of whether they happen to be rich or poor".	Wagstaff, van Doorslaer & Paci (1991, p.199)
6	Horizontal inequity	Horizontal inequity refers to the inequality in need adjusted healthcare use by socioeconomic status such as income or education.	Pulok *et al*. (2019, p.172)
7	Equity in health	Equity in health implies that everyone should have a fair opportunity to attain their full health potential and, that no one should be disadvantaged from achieving this potential due to avoidable reasons.	World Health Organization (1986)

(*Continued*)

Table 4.1 Continued

S. Nos.	Terms	Definitions	References
8	Inequity in health	"Differences in health that are not only unnecessary and avoidable but in addition are considered unfair and unjust".	Whitehead (1992, p.7)
9	Equity in health	Equity in health is defined as "minimizing avoidable inequalities in health and its determinants – including but not limited to healthcare – between groups of people who have different levels of underlying social advantage or privilege".	Braveman (1998)
10	Equity in health	Equity in health can be defined as "the absence of systematic disparities in health (or in the major social determinants of health) between social groups who have different levels of underlying social advantage/disadvantage – that is, different positions in a social hierarchy".	Braveman & Gruskin (2003, p.254)
11	Equity in health	"the absence of systematic and potentially remediable differences in one or more aspects of health between groups of people characterized socially, geographically, or demographically".	ISEQH (2006)
12	Equity in health	"Equity in health is the situation where no one is denied the possibility of achieving their full health potential because of unfair social processes or arrangements".	Ravindran & Gaitonde (2018, p.8)
13	Health equity	Health equity needs an equitable re-distribution of resources for healthcare that includes power and capabilities to demand and use these resources.	EQUINET (2004)
14	Health equity	"Health equity is not about taking care of the most disadvantaged in society but about creating opportunities and removing barriers to achieving health potentials of all people".	Whitehead & Dahlgren (2006, p.5)
15	Equity in health	"Striving to eliminate disparities in health between more and less-advantaged social groups, i.e., groups that occupy different positions in a social hierarchy".	Braveman & Gruskin (2003, p.254)
16	Equity in healthcare	Equity in healthcare is defined in terms of access, utilization, and quality, i.e., there should be equal access and equal utilization of available care that is of equal quality for all.	Leenan (1985)
17	Equity in healthcare	"Equity in healthcare is the principle that quality of care should not vary on the basis of patient characteristics, such as race or ethnicity".	Betancourt (2014, p.17)
18	Inequities in health	"Unjust differences in health between persons of different social groups, …(which) can be linked to forms of disadvantage such as poverty, discrimination and lack of access to services or goods".	World Health Organization (2013, p.6)

Our research that constituted multiple interviews with healthcare experts and healthcare leaders helped to develop a better understanding of the subject. Some facets that surfaced are largely the same as already being covered in the literature. In addition to these, our research finds that a vital facet that is missing from various definitions of equity in health or equitable healthcare is acknowledging and assessing inequity.

To create systems and processes that are equitable, *acknowledging and assessing inequity* should be the first step and most important aspect of equitable healthcare.

Table 4.2 Facets of equitable healthcare

S. Nos.	Facets	Brief	References
1	Fairness and justice	The systems and the processes, including the social processes that affect the health of a person, shall be fair and just for everyone. This facet is derived from and closely related to human rights.	Braveman & Gruskin (2003), World Health Organization (1986), and Whitehead (1992)
2	Quality	The quality of care shall be the same for everyone.	Betancourt (2020), Leenan (1985), and Betancourt (2014)
3	Avoidable differences	There shall be an attempt to eliminate the differences in health that are avoidable.	Whitehead (1992), Braveman (1998), ISEQH (2006), and World Health Organization (2013)
4	Need-based resource allocation	Resources shall be distributed based on the need.	Mooney (1996), O'Donnell, van Doorslaer, Wagstaff & Lindelow (2007), EQUINET (2004), Leenan (1985), and Pulok, van Gool, Hajizadeh, Allin & Hall (2019)
5	Access	There shall be an equal chance for everyone to access care. This includes the proactive elimination of barriers such as financial, social geographical, etc.	Wagstaff, van Doorslaer & Paci (1991), Ravindran & Gaitonde (2018), EQUINET (2004), Leenan (1985), and World Health Organization (2013)
6	Socioeconomic status	There shall not be any variation in care delivery based on the socioeconomic status of a person.	Braveman (1998), Braveman & Gruskin (2003), Pulok *et al*. (2019), and World Health Organization (2013)

In order to provide equitable health access or equity in healthcare, you need to first acknowledge and recognize inequity. You cannot deny inequity and then say I'm being equitable.

–Founder of a primary healthcare organization in the western part of India

The commonest inequities in India are the caste, minority, especially religious minorities, and then gender inequity. The point is, unless you recognize the inequities sufficiently in a granular manner and are able to measure inequity, you cannot provide equitable healthcare."

–Founder of a primary healthcare organization in the western part of India

Inequity exists in different forms, such as due to religion, caste, colour, race, gender, education, geography, among others. From time immemorial, certain groups of people across the world, for various reasons, have been victims of inequitable treatment in many spheres of their lives, including in healthcare. To correct the historical wrong in India through the constitution, a few provisions were made for such historically disadvantaged people for their social and economic upliftment. Healthcare somehow remains untouched; people deprived of reasonable healthcare continue to have little access to healthcare even after seven decades of the country's independence. Inequities are also like shifting goalposts that keep changing. As the systems succeed in achieving equity in a certain aspect, inequities in a few other aspects surface or arise. Unless one can measure the inequity that exists in the delivery of healthcare in the country, the idea of equitable

healthcare cannot be implemented effectively. Inequity, being a phenomenon that can be observed at the level of communities, and different forms of inequities being present in different communities, one of the first steps to provide equitable care is to understand the inequities that exist in that particular community and take actions based on that information.

Considering different facets of equitable healthcare that are already mentioned in the literature and the research findings from this project, it will be fair to sum up equitable healthcare as a way of delivering care wherein:

- There is an acknowledgement of the fact that inequities in society exist and they are measured to guide decisions relating to creating equitable systems
- The systems and processes are fair and just for everyone
- The chance to access care is equal for everyone and there is a proactive attempt to eliminate all forms of barriers to access care
- There is a constant attempt to eliminate avoidable and needless differences in health
- The quality of care is the same for everyone
- The resources are allocated and used based on the health need
- There is no variation in any aspect of the care based on the socioeconomic status of a person or any other patient characteristic

4.2 IDENTIFYING EQUITABLE HEALTHCARE ORGANIZATIONS

A few of the experts we interviewed for the purpose of this study believe that differentiating equitable healthcare organizations from the ones that do not practice equitable healthcare is not easy. However, the interviews revealed that there can be several markers through which equitable healthcare organizations can be identified and differentiated from the ones that do not provide equitable healthcare. They are discussed hereunder:

4.2.1 Definition of the Market

> *Where do you put your boundaries? There is a whole lot of people whose eyesight and their lives could become better if they got some intervention. Maybe glasses or whatever. And only some of them are able to make it, because of whatever reason. You know it could be money, or its ease of access. And others who are not able to do that, is a kind of inequity, in terms of who is able to access, and who is not able to access. So, if you look at it from a different perspective, then your game shifts to a broader canvas, including the community as a whole. So that itself is the main difference.*
>
> –Senior leader of a large eye hospital in the southern part of India

Equitable healthcare organizations do not pick market segments based on the economic status of the target patients or geography. They tend to own the larger problem and their market includes everyone who suffers from the health problem in which they have the expertise and to whom they provide care.

4.2.2 Regular Outreach

> *If you say, "we are also community-oriented, we go there and do two large events every year,", that is the kind of... cutting through that symbolism versus true design. That is on one front.*
>
> –Senior leader of a large eye hospital in the southern part of India

Some organizations reach out to the people residing in remote locations once or twice a year through outreach camps. This does not ensure consistent access to care for the underprivileged. Equitable healthcare organizations, through regular outreach programmes and/or systems, ensure round the year access to the people residing in remote places.

4.2.3 Presence in the Place Where Inequity Exists

But if I find that there are hardly any marginalized or poor, then I will not even work there. I'll try and set up my service in a location where the marginalized have some hope of coming to me, or I going to them.

–Founder of a primary healthcare organization in the western part of India

To ensure physical access, equitable healthcare organizations proactively establish themselves in the areas where the inequities exist. In India, the inequity that can be clearly seen is the inequity in the availability of care in rural areas. Thus, organizations that practice equitable care tend to have a presence in remote areas or develop systems and processes that would ensure such access.

4.2.4 Pricing

how easy and intimidating - not intimidating, costly - not costly, friendly - not friendly, or whatever it is! I think that aspect of it. How is the pricing? Is it inclusive? And how is the bureaucracy around getting subsidized or free care?

–Senior leader of a large eye hospital in the southern part of India

Equitable healthcare organizations price their services to make them attractive for people from all economic strata or make certain provisions so that the pricing of the healthcare services does not put a financial burden on the economically underprivileged groups.

4.2.5 Behaviour Towards the Poor

Are they very welcoming of those who cannot afford?

–Senior leader of a large eye hospital in the southern part of India

While some healthcare organizations do claim to be serving the poorest of the poor, in reality, they discourage them from availing services at their organization. This may be through indifferent behaviour or by the way of not educating the needy about the provision that has been made for them to avail care at these organizations.

4.3 WHY SHOULD ANYONE PROVIDE EQUITABLE HEALTHCARE?

The literature on equity in health, by far, has focused on the public healthcare system's role and its responsibility in making provision for equitable care. The extant literature puts the onus on the country's government to provide equitable care. But in a country such as India, where private healthcare accounts for 80% of the country's overall healthcare delivery, its role in delivering equitable care and thus, ensuring equity in healthcare among the people of the country cannot be ignored.

If there is a hospital which says, "this is my clientele, this is who I am.", then, do it. Otherwise do not call yourself equitable; there's no crime in not being equitable.

–Founder of a primary healthcare organization in the western part of India

Some of the experts believe that it is each organization's prerogative whether to provide equitable healthcare or not. It depends on the respective organization's purpose. But if equity is at the heart of the organizations' purpose, then the organization must reach out to all people who need care.

The health of an individual also affects the health of others. Immunization is one such aspect. For example, if you are immunized, then you know that you are protected and you help protect the entire community. If you are treated for tuberculosis, then you also prevent infection in others. So, it's a public good or a social good.

–Founder of a primary healthcare organization in the western part of India

There is a common belief that healthcare and education being public goods, should not be looked at from the perspective of profiteering. If one section of the community remains unhealthy, that may affect the other sections as well. While the government must provide healthcare to everyone, but looking at the current scenario, this task cannot be left to the government alone.

The experts opine that when half of the country's population sleeps on an empty stomach every night, in such a scenario, this group of people cannot be expected to think of spending money on healthcare.

As doctors who benefitted from getting an education in India and learnt because of the poor people, as professionals, we are indebted to them. If we pay back loans taken by the bank, then we should pay back this debt as well.

–Founder of a large eye hospital in the southern part of India

As professionals who have benefited from getting good quality medical education in India and having learnt at the expense of poor people (e.g., the students in medical colleges learnt their surgical skills on live patients who generally belonged to the lower socioeconomic strata), the healthcare fraternity is indebted to them. Just as people pay back loans taken from a bank, the healthcare fraternity has a responsibility to pay back this debt.

That by getting a college degree from a prestigious college, one automatically becomes powerful, and if one does not use that power to help the powerless, then the degree has no meaning.

–Founder of a large eye hospital in the southern part of India

Some believe that by getting higher education one attains certain power and platform. If that is not used for the betterment of the powerless, education loses its meaning. Consequently, while the already powerful gains more power, the powerless further slips back into poverty, thus further increasing inequities in the societies. Hence, it is the moral responsibility of those who have received good healthcare and education in their lives to help others climb up the socioeconomic ladder.

Some of the experts opine that providing equitable care does and can make business sense.

May not be more money coming here, but certainly you develop a greater respect in the community, some extent better recognition. The staff is completely aligned. They behave and interact in a very purpose-driven way. You will recall that most institutions visiting us pick up very quickly. Everyone is aligned to the purpose.

–Senior leader of a large eye hospital in southern part of India

By providing care to everyone, organizations get to serve a large volume of patients. Providing equitable care helps in building trust between the organization and the community, which results in significant intangible benefits. The goodwill earned from the community brings in volunteers to further the purpose and helps in building HR that are purpose-driven. The trust gained from the community further brings more patients into the system. This helps in scaling up operations, which in turn helps organizations in providing training and generating scientific evidence through research. High volumes also drive down the cost per patient and hence make healthcare cost affordable for everyone.

Thus, the experts believe that it is the responsibility of the healthcare fraternity to deliver equitable healthcare and that while doing good work (socially) it is possible to do well (financially).

5 Barriers in the Delivery of Equitable Healthcare

Equity in healthcare has been an aspiration for countries across the world. As they attempted to deliver equitable healthcare, they experienced multiple barriers. The barriers that are documented in the literature are listed in Table 5.1.

Even though the barriers mentioned in the extant literature are from the point of view of public health, the barriers faced by the private healthcare providers, which are the focus of our study, also experience similar barriers. Our research finds a few additional barriers to the ones already discussed in the literature. They are discussed hereunder:

Table 5.1 Barriers in the delivery of equitable healthcare

S. Nos.	Barriers	Descriptions	References
1	Lack of awareness	Lack of awareness among the healthcare providers regarding possible inequities results in an inequitable system. This leads to stereotyping of the patients and the delivery of prejudiced care by the healthcare providers. On the other hand, lack of awareness regarding the disease among the patients result in stigma and delayed visit to healthcare centres, resulting in further health inequities.	Betancourt (2020), Schwartzmann (2009), Höglund *et al*. (2018), Balarajan, Selvaraj & Subramanian (2011), and Marmamula, Keeffe, Raman & Rao (2011)
2	Complex systems with poor communication	Systems that are complex to navigate and do not facilitate adequate communication between the patients and healthcare providers repel the patients away from the healthcare system. The vulnerable groups may not speak the same language as healthcare providers resulting in a communication gap and trust deficit.	Betancourt (2020), Qidwai, Ashfaq, Khoja & Merchant (2011), and Betancourt (2014)
3	Lack of community engagement	Different communities have different beliefs regarding health conditions. Failure of the system to engage with the community, understand their beliefs, and incorporate them into the system to device interventions result in a clash of two opposite belief systems. This further act as a barrier to achieving desirable health outcomes and affects health equity.	Qidwai, Ashfaq, Khoja & Merchant (2011) and George, Davey, Mohanty & Upton (2020)

(*Continued*)

Table 5.1 Continued

S. Nos.	Barriers	Descriptions	References
4	Lack of data on health inequities	Lack of data on health inequities becomes a big barrier as it hinders the identification of priority areas, the creation of informed policies, and monitoring and assessing their impact. In the case of policy decisions that are not evidence-based, the lack of data again makes it difficult to conclude whether the policy decision was able to reduce inequities or not.	Pulok *et al*. (2019), Zere *et al*. (2007), Gwatkin (2001), and Patel *et al*. (2015)
5	Disproportionately high focus on tertiary care	Disproportionately high focus on tertiary care delivery increases the cost of care. The higher allocation of funds for tertiary care renders primary care weak and thus, acts as a barrier in achieving health equity.	Qidwai, Ashfaq, Khoja & Merchant (2011) and Ward (2009)
6	Inadequate healthcare financing	Inadequate public financing of care that does not cover all healthcare expenditures (e.g., consultation, diagnosis, investigations, hospitalization, and drugs) increases OOPE which pushes families into poverty further resulting in inequities in health.	Rostampour & Nosratnejad (2020), Hajizadeh & Edmonds (2019), Betancourt (2020), Bose & Dutta (2018), Dwivedi & Pradhan (2017), Liaropoulos & Goranitis (2015), Villa & Skrepnek (2012), Marmamula, Keeffe, Raman & Rao (2011), and Khanna *et al*. (2018)
7	Unavailability of HR	Unavailability of the skilled HR willing to work in rural areas acts as a big barrier in achieving health equity.	Volmink (2018) and Patel *et al*. (2015)
8	Leadership	Frequent turnover in leadership and their lack of buy-in acts as a barrier in creating a sustained strategy for achieving equity in healthcare.	Betancourt *et al*. (2017)
9	Logistics	While the patients may understand the need for care, their inability to travel to the healthcare centres due to poor logistics acts as a barrier to access care.	Khanna *et al*. (2018)
10	Rigid organizational culture and siloed functioning	Public organizations are characteristically rigid in nature and function in a silo. The nature of decision making is often vertical that does not consider other related departments. This culture that hinders convergence of all allied healthcare departments from working together and putting a concerted effort acts as a major barrier in achieving equity in healthcare.	Ward (2009), Gopalan, Mohanty & Das (2011), and Patel *et al*. (2015)

(*Continued*)

Table 5.1 Continued

S. Nos.	Barriers	Descriptions	References
11	Suboptimal and inequitable distribution of resources	Sub-optimal public expenditure (in terms of GDP) on healthcare and its distribution that is not based on the varying needs of different geographies results in inequities in healthcare. Further, most of the resources are concentrated in the urban areas, whereas 70% of India's population resides in villages. This results in inequity in access to care and health outcomes.	Islam (2012)
12	Poor quality of care	Previous experiences of self or others regarding indifferent treatment and poor quality of care met at the hands of public healthcare providers prevent patients from seeking care at public healthcare facilities. This pushes them towards seeking care from private healthcare providers, majority of whom are unqualified. This results in higher OOPE and inequities in healthcare.	George, Davey, Mohanty & Upton (2020)
13	Priority	Striving for equity in healthcare as a goal might be a "nice to have" kind of goal for organizations. Lack of priority among the leaders with regards to the goal acts as a barrier for the organization in realizing the goal of equity in healthcare.	Betancourt *et al*. (2017)

5.1 POOR LOCAL INFRASTRUCTURE

There was bad terrain with difficult transport mechanism and scant public transport. And to add to this, matters such as scarce population density would make matters very difficult as compared to looking at a plain area or area which would be relatively easier to work.

–CEO of a large eye hospital in the north-eastern part of India

One of the iniquities in healthcare is the lack of provision of healthcare in rural hinterland as compared to the urban areas. Majority of healthcare organizations are located in the cities. The organizations that try to bridge this gap and consciously decide to operate from the rural parts of India face multiple challenges due to poor local infrastructure. This is true especially in case of organizations that are based out of the rural hinterland and the north-eastern states of India. These areas have low population density ranging somewhere between 10 and 150 people/km^2. While well-intentioned organizations try their best to reach out to the last-mile patients, poor roads or their complete absence makes access to such areas a challenge. The hilly terrain compounds the problem.

The mindset of the people and the lack of health seeking behaviour was a very major barrier. People still prefer to go ahead and get tribal, I mean, traditional practice for a long period of time, primarily because there was no trust with the public health delivery system.

–Senior leader of a large general hospital in the north-eastern part of India

The poor roads and unavailability of transport mean poor connectivity for the residents to the urban or relatively more developed areas where they can avail acceptable quality of healthcare. This nudges them

towards the locally available quacks and to indulge superstitious beliefs and practices. This disconnect from conventional care for many years has resulted in a lack of awareness among the local population, which is another challenge that the organizations must focus to provide equitable healthcare. This requires a greater investment of time and effort to develop trust, wean off people from superstitious practices, create awareness, and bring people back into the fold of mainstream healthcare delivery.

> *Imagine till four years back, one of India's largest eye hospital did not have electricity. Although we get it now, the supply is only for 12 hours. There was no road either (leading to the hospital) till seven-eight years back.*
>
> –CEO and founder of a large eye hospital in the eastern part of India

While reaching last-mile patients is a big challenge, running the hospital itself is not easy in the rural hinterland. Some of the hospitals located in the rural hinterland still face power cuts lasting over 12 hours a day. The situation was worse a few years earlier, as some of the hospitals reported power cuts that lasted for several days. These hospitals used diesel generators to run the hospital, which increased costs significantly. It is the sheer grit and determination on part of the healthcare providers that has kept them going amid such barriers.

Hilly terrain, poor roads, and lack of convenient means of transportation make it difficult for hospitals to receive medical supplies in a timely manner. Those supplies that are available come at a higher cost. The poor connectivity also means that the hospitals did not receive timely servicing support for their equipment. If any equipment stops working, the hospitals are at the mercy of the servicing company that sometimes take weeks to respond to the service request. This badly hampers patient care.

> *But it (tele-medicine) worked out only for a few years. And it was very good when it was working out. Eventually you know there was a lot of pipeline wiring and re-wiring work that was done from BSNL, which was not reliable.*
>
> –CEO of a large eye hospital in the north-eastern part of India

In such remote locations, telemedicine can play a big role. However, one of the key ingredients for telemedicine to work is the availability of good internet connectivity. Unfortunately, good internet connectivity has not reached the rural hinterland extensively, with the north-eastern states faring worse. Overcoming this on their own requires hospitals to purchase sophisticated equipment, which comes at a higher expense. The higher cost of technology thus increases the cost of care delivery. The INR 0.6 million required to set up a satellite clinic in the rest of India explodes to INR 3–4 million in the north-eastern states. This is clearly out of bounds of most healthcare organizations.

Few healthcare providers face another issue that is not directly related to healthcare delivery but has a significant effect on it.

> *We had good doctors there (in a hospital located in a rural place), then they had a child. They said, there is no good school and hence, they would like to move. So, some excuse is there, and people do not stay (in rural places) for long.*
>
> –Senior leader of a large eye hospital in the central part of India

The poor education system in the rural hinterland means that competent healthcare professionals who have children have to think twice about staying on in the rural hinterland. While their hearts remain in service of the people, the worry about their children's education makes them shift back to the urban areas, where good schooling is available.

5.2 GOVERNMENT RED TAPE

According to an anonymous source, among the barriers that make it difficult for healthcare providers to provide equitable healthcare sustainably, one seemingly intractable aspect is the government's pervasive indifferent attitude, corruption, and excessive bureaucracy.

While the government understands that it will not be able to provide healthcare to everyone on its own, the suspicion and high handedness with which it treats private hospitals (including the NGOs) do not augur well for public–private partnering, which is vital to facilitate the avowed goal of the government of providing healthcare for all citizens, irrespective of their ability to pay. The organizations feel that the onus is on the government to identify partners in furthering their goal and once such partners are identified, they need to treat them with respect and be an enabler for them to take healthcare to last-mile patients. However, the reality is very different from the intent.

5.2.1 Confusing Policies

> *What we earn depends on 'X' number of surgeries. During elections, we are not allowed to conduct any outreach camps. I cannot stop the HR from paying my outreach staff money, even if there is no work during elections. We have got elections for two months. I cannot stop paying them. And as a hospital, it still needs to survive. Somebody has to think from that perspective also.*
>
> –Anonymous

The organizations felt that government policies are confusing. As an illustration, on the one hand, the government states that their goal is to provide quality care at affordable costs to everyone; on the other hand, the government charges higher import duties and goods and services tax (GST) on healthcare equipment, which considerably increases the cost of healthcare. Another example is that according to the poll conduct rules, the hospitals that have any form of linkage with the government are not allowed to conduct outreach camps for a period of 2–4 months prior to the elections. Ostensibly, this is to avoid possible bias among the electorate. Many organizations find this policy absurd. It makes them wonder where the patients will seek care during that period and whether the government has public welfare on its mind.

5.2.2 Bureaucracy: Slow, Corrupt, and Excessive

> *75 to 80% of the clientele is now through Ayushman Bharat. But if I do not get that payment in due time, how am I going to run the show on that scheme? Like we had to stop ECHS, CGHS, if they did not reimburse on time.*
>
> –Anonymous

The slow government procedures, especially in case of reimbursement of insurance payments, are another matter of concern. While by introducing the Ayushman Bharat insurance scheme, the government has devolved the power of making payments for healthcare to the public, several organizations complain that they are not being empanelled as provider hospitals despite having all the required documents. Several others opted not to get empanelled due to their previous experiences of considerable delay in insurance payments. The corrupt system sometimes requires them to make under the table payments to receive the payments legitimately due to them.

Getting government permissions to conduct outreach camps to reach the poorer sections of the population is a big challenge for certain hospitals, as the officials frequently demand bribes to give permission.

When we started with this RSBY scheme, half of the people approached us with their card, just like we have the PMJAY card and half of those people would say, 'you see, how much money will the hospital get from that (insurance scheme)? I will pay the balance (over the insured amount) in cash, please conduct a surgery'." When you are poor, you are supposed to not have any money. And then you realize that, when the list of people below the poverty line was made, half of the people who are actually not poor, they bribed the officials to get into that with some other name.

–Anonymous

The corruption in identifying people who can avail the insurance facility, by virtue of having below the poverty line (BPL/yellow) card[1] also means that the benefits are not reaching the right beneficiaries. Well-to-do people bribe officials to get the false BPL cards issued to them, thus robbing rightful intended beneficiaries of the healthcare.

The hospitals that are registered as charitable trust come under the ambit of the charity commissioner of that state. The charity commissioner is bestowed with the responsibility to ensure the transparent functioning of the charitable organizations and to ensure that they achieve their stated objectives. To ensure that the deserving people are treated for free at the charitable hospitals, the charity commissioner asks for evidence from the charitable hospitals during the audits. The most prominent form of evidence in this regard is the ration card. Due to corruption and lack of knowledge on the patient's part, many a time, the patients are not able to produce any evidence to justify their economic status and that they are poor. When some of the hospitals treat the truly deserving people for free, who did not have the BPL cards, the charity commissioner raises objections and demands evidence. While the charity commissioner is well within his/her rights and is discharging his/her duties, this makes it difficult for well-meaning organizations to discharge their duties.

5.2.3 Minimal Support

The hospitals complain that even though they are doing charity work that supplements the government's work, they must pay commercial charges for electricity and water. Amid the government's indifferent attitude, corruption, and frequent hindrances in discharging care, some wonder if there are any incentives in practicing equitable healthcare.

5.3 GEOPOLITICAL ISSUES

Then they (local musclemen) will send one patient (relative). For each surgery costing around sixty thousand rupees, they will ask to do it for free.

–Senior leader of a large eye hospital in the central part of India

Geopolitical issues are another barrier that makes the delivery of equitable healthcare difficult. In the rural interiors, threats by local musclemen with vested interests to maintain the status quo affect the safety of the working personnel.

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[1] Under Common Minimum Programme of the Government of India, families residing BPL are provided food grain through Public Distribution System. To identify these families based on their economic status, they are issued ration cards that come in three colours. Families with annual income <INR 15000 are issued a yellow ration card (also known as BPL card). Families with annual income >INR 15000 and <INR 100,000 are issued orange card and families with annual income >INR 100,000 are issued white card. The benefits that come along with different cards vary. This card also acts as an identity card for people belonging to that economic stratum to avail benefits under various schemes offered by state and central governments under the Sarva Shikhsa Abhiyan (SSA), the National Rural Health Mission, National Rural Employment Guarantee, etc.

North-East India had a lot of problems because of militancy, like the civil war and at that time, the whole of Tripura was affected by militancy, you cannot go from here to Agartala without an armed escort, every day there were murders and abductions.

–Senior leader of a large general hospital in the north-eastern part of India

In the north-eastern states, insurgency issues in the past made it unsafe for hospitals to reach out to the last-mile patients. The insurgency also meant frequent curfews. During that time while patients were deprived of care, the unpredictable stoppage of hospital operations for uncertain periods badly hurts their financial sustainability.

5.4 SEED CAPITAL TO START AND SCALE UP

Many well-meaning entrepreneurs in the healthcare space have been unable to give wings to their vision, as they lace seed capital and other vital resources, to set up their venture, and sustain it to grow and scale-up. Hence, often they are unable to grow, despite availability of a huge opportunity and potential to utilise their services. These are briefly discussed in the following.

5.4.1 Unavailability of Seed Capital

The biggest challenge is getting the money to get the work going.

–CEO and founder of a large eye hospital in the eastern part of India

When well-intentioned doctors plan to start their own hospitals for the delivery of equitable healthcare, the first barrier that they stumble upon is seed capital to set up their facilities. Second-generation doctors may not face much trouble as they had a base readied by their parents to build upon. However, first generation doctors find it extremely difficult to overcome this hurdle. Setting up a hospital requires considerable capital to purchase land, construct the physical infrastructure, purchase good quality equipment, and recruit good people, among others. This requires the doctor to take large loans, with consequent pressures to pay instalments on time. The financial burden shifts the focus from the purpose of serving poor patients to one of survival and attaining financial sustainability, thus pushing the entrepreneurs to seek patients who can pay for the care.

5.4.2 Lack of Emotional Appeal to Get Donations

So, if you do a hundred cataract surgeries, most probably, all hundred will succeed. However, in other departments, you operate on a hundred patients, probably 40 of them or 30 of them maybe long-term survivors. So, for an investor (donor agency), you know, it is pleasing to invest in eye care. They will not want to put money on something where there is uncertainty in the outcome.

–Senior leader of a large eye hospital in the northern part of India

The nature of the intervention and the uncertainty of the impact mean that donors are not interested in funding care for specialties that require more funds per patient and have a doubtful outcome. In eye care, a donation of INR 2000 gives eyesight to a typical cataract patient. Donating for cancer care, orthopaedic care, mental health, and dental care will not yield such a high impact from the donors' perspective and hence relatively less funding is available for the care delivery. In eye care, a common vision and a national policy that is focused and comprehensive helped in bringing various stakeholders together.

That alignment brought in multiple INGOs, who continue to fund various aspects of the care. That effort is lacking in other healthcare specialties.

5.4.3 Funding to Scale Up

Funding is the issue. It is true that we have the research funding, and we have some stable collaborators also. But when you want to scale up, there is an issue.

–CEO of a mental healthcare organization in the western part of India

Organizations that work among the vulnerable groups and experiment extensively to come up with solutions to provide equitable care, face problem while scaling up the interventions. While there is enough funding available to experiment and ascertain the impact of an intervention, the research funding does not cover scaling up the intervention. This means that the unconventional solutions that are tested in the field do not see the daylight of regularization in conventional practice.

5.5 LACK OF KNOW-HOW

During the 5 years of course work, there is hardly any effort to make them (medical students) understand where the burden (of disease) is, what kind of population we have. You know, most dentists practice only in urban areas as they think it cannot be practiced in rural areas. I think the basic curriculum lacks these kinds of things and learning aspects.

–Senior leader of a large dental college in the southeast part of India

A simple answer to "why hospitals do not practice equitable care?" is that they are more often than not lead by doctors and they did not have any understanding about how to practice equitable healthcare. The curriculum of medical education is focused solely on the clinical aspects of the care and ignores the public healthcare aspect of it. There is certainly a lack of focus on the burden of the disease. The focus of education remains on creating clinically sound doctors but how they will go about practicing their trade once they are out in the field is not given adequate attention during their education. The lack of focus on various models of care delivery as part of medical education, lack of rural experience that can help build a better understanding of the community needs, and the prevailing assumptions regarding what is possible and what is not in a certain specialty, makes it a Herculean task for somebody to come out of the mould and attempt to provide equitable healthcare.

A lot of people do not understand how these organizations run, even those who work here are not clear on how these things are done because the medical curriculum does not explain any modelling (healthcare models) or anything.

–Senior leader of a large eye hospital in the northern part of India

Once the doctors step out of the medical college and consider starting their hospital, clinical knowledge alone is not sufficient. They are not trained in project management, managing operations of the hospital, financial aspects of running the hospital, among others. The knowledge of healthcare models, entrepreneurship, and administration can enable them in making sound decisions and smoothly run the hospital. The leaders who have come up with out of the box models to tackle the myriad problems in healthcare in the country are thus, very few.

5.6 NATURE OF INTERVENTION AND THE HIDDEN COSTS

The radiation therapy would be for 30 or 35 days and conventionally they will be given 5 days in a week and the treatment will last for a minimum of 5 to 6 weeks. Sometimes, even for 7 weeks also. So, for that much of time, the patient will have to visit the hospital or live in the hospital.

–Senior doctor of a large cancer hospital in the north-eastern part of India

The interventions required treating a condition in cancer care and mental health are quite long. For example, cancer care typically takes 3–7 months, while psychological illnesses require regular counselling for months. Even after undergoing a full cycle of care, there are chances that the disease may recur. In the case of people who live a hand-to-mouth existence, the thought of such a long treatment prevents them from seeking care, or even if they commence with the treatment, it makes them drop out of the care. While the cost of care remains a worry, even if the insurance or the hospitals fund the whole care, there are hidden costs involved. The nature of the disease keeps the patient out of the job for several months. If the patient is the earning member of the family, then there would be no one to take care of the family. Someone is required to be with the patient while the care is administered. This means that another person must sacrifice his/her job to stay with the patient. Apart from delivering clinical care, the hospitals also must address such other issues.

5.7 THE HIGH COST OF MEDICINES AND CONSUMABLES

In ENT, I am not talking about the higher end hearing aid, but a basic level of hearing aid, which is for 7000 thousand (rupees) versus a cataract operation where the total cost of treatment is 2000 (rupees).

–Senior leader of a large eye hospital in the northern part of India

The high cost of medicines and consumables means that the cost of intervention remains high and sometimes out of reach of common people. The manufacturing industry that played a critical role in lowering the cost of eye care by bringing down the price of an intraocular lens (IOL) from US$ 210 to US$ 10 in the 1990s, certainly does not seem to be playing its role in other specialties. The cost of implant placed inside the body as part of the intervention in other specialties remains quite high (Fig. 5.1).

As much as 60% of the cost of dental care is spent on consumables and lab work. Similar is the case with medicines that are very costly in cancer care, orthopaedic care, and other specialties. This high cost of medicines and consumables makes it difficult for the organizations to bring down the cost of care and thus provide equitable healthcare.

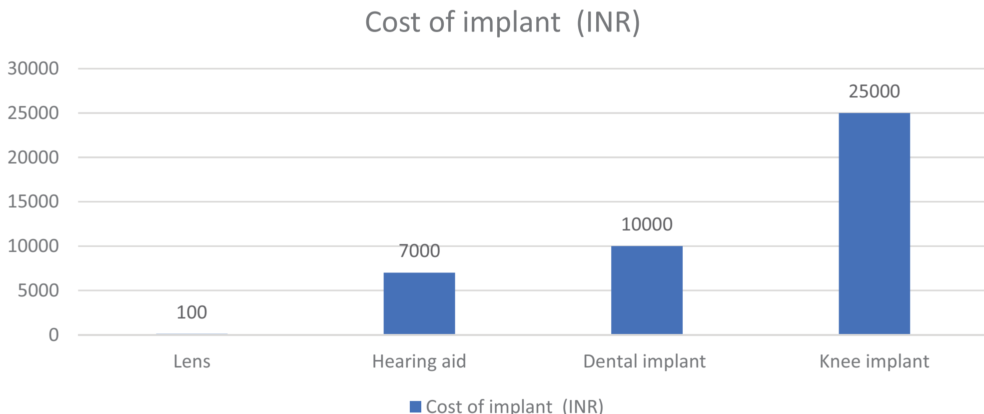

Figure 5.1 Cost of implant[2]

[2] Costs in Fig. 5.1 are as per the information provided by the respondents.

6 Enablers for Delivery of Equitable Healthcare

Various healthcare organizations have been successful in providing equitable care in the previous four or five decades. Certain factors enabled them to achieve their goals. The factors that enabled these healthcare organizations or healthcare systems in delivering equitable healthcare as found in the literature are listed in Table 6.1.

Table 6.1 Enablers for the delivery of equitable healthcare

S. Nos.	Enablers	Descriptions	References
1	Acknowledgement	Acknowledging that the inequities exist in society in general and healthcare in particular, acts as an enabler towards reducing inequities.	Betancourt (2020)
2	Awareness	Awareness of the staff regarding the inequities that exist in the society and the impact of the social determinants on healthcare equity helps them in taking necessary actions at the frontline. Their awareness helps in identifying and addressing inequities in the system that might lead to inequitable access to care.	Höglund *et al*. (2018) and Betancourt (2014)
3	Comprehensive healthcare financing	Healthcare financing that provides comprehensive coverage to everyone is one of the major enablers in ensuring healthcare equity. The comprehensive coverage includes all the expenses including consultation charges, investigation charges, hospitalization, and cost of drugs.	Rostampour & Nosratnejad (2020) and Bose & Dutta (2018)
4	Comprehensive outlook towards the problem	Health inequities do not always arise due to problems associated with the healthcare system. Factors such as availability of clean water, roads connecting the disconnected areas play a huge role in determining equitable healthcare utilization and hence affect health equity. Having a comprehensive outlook towards the problem acts as an enabler in reducing healthcare inequities.	Braveman (2003)
5	Network of like-minded organizations	Access to a network that aims at addressing disparities or achieving equity helps leaders in benchmarking their efforts against other organizations, facilitate cross-learning, being up to date with various pieces of evidence of inequities, and keep up the energies in change initiatives to eliminate disparities.	Betancourt *et al*. (2017)

(*Continued*)

Table 6.1 Continued

S. Nos.	Enablers	Descriptions	References
6	Internal marketing	Frequent communication by the leadership regarding organizational initiatives to eliminate health inequities, creating a pool of people from across the hierarchies of the organization, and working towards the culture change acts as an enabler in the organization's quest towards eliminating health inequities.	Betancourt *et al*. (2017)
7	Operational efficiency	Identifying the waste in system, processes; allocating appropriate resources at the appropriate level and task shifting helped in reducing the healthcare costs that acts as an enabler in achieving healthcare equity.	Zhang *et al*. (2015) and Joshi *et al*. (2014)
8	Focus on primary healthcare	Providing primary care through primary healthcare clinics located in geographically remote areas with a focus on vulnerable populations improves access to care and health equity.	Zhou *et al*. (2013) and Macinko & Lima-Costa (2012)
9	Technology	Technology plays an enabling role in two ways: (a) The availability of various software and computers makes it relatively easy to gather and analyse data on social determinants and inequities and (b) Technology in form of telehealth helps in connecting geographically remote places and patients to doctors residing in the urban areas thus improving access and assuring timely intervention.	Pulok *et al*. (2019), Höglund *et al*. (2018), and Srivastava & Shainesh (2015)
10	Societal efforts	Societal efforts through self-help groups helps in creating awareness among the people regarding health conditions, preventive measures, and requisite steps in case of emergency. Self-help groups support their group members in their development through financial support and help them during financial crisis. This prevents the vulnerable groups from getting pushed into poverty which is one of the determinants of health equity.	Schwartzmann (2009) and Saha, Annear & Pathak (2013)

6.1 A CLEAR PURPOSE

> *Dr. V said, 'my mission is to eliminate needless blindness globally', and Dr. Rao said, 'so that all may see, irrespective of their ability to pay, wherever they are, I will provide eyecare.*
>
> –Ex-senior leader of an international eye care NGO in India

The discussions with various healthcare leaders bring it out clearly that the purpose of the organization, followed by the value system are the biggest enablers in their quest to provide equitable healthcare. The organizations that are already providing equitable healthcare have a purpose that does not just speak about becoming the best organization or achieving a certain target but aspires to eliminate the disease altogether in their chosen geography. Having such a larger than the life purpose makes the organizations and the leaders think about "what is needed" rather than "what is possible". This leads to innovative models and practices that these organizations adopt to take healthcare to everyone. The simplicity and the clarity with which the purpose is articulated help leaders and employees across the organization work in unison, leading to synergistic effects.

6.2 LEADERSHIP

Leadership plays a vital role in charting the course for the organization to achieve its purpose. Clarity on their own life's purpose helps them take the unconventional path that is often difficult to walk.

> *So, for the greatest impact, we need to move to a place where the crowd is very big, where there are no other hospitals, and no other people like you (a trained doctor). Then, the impact of this work becomes very big.*
>
> –Senior leader of a large general hospital in north-eastern part of India

Their belief in the organization's mission and ability to take decisions, that are not the norm, galvanizes the teams that are often ordinary to achieve something that is not achieved earlier.

> *Then I think at some point of time, he (chairman) used very strong words. He said, 'when I am ready to support it as an owner, I am ready to stand by you in terms of investment for infrastructure, then why you people are hesitant to do the things? Whether the outcome is a failure or a success, you do not have to worry about that. I am there'.*
>
> –Senior leader of a large dental college in the southeast part of India

Leaders in the past led by example. This guided the behaviour of the employees and the way they made their decisions.

> *Like timekeeping. If seven o'clock is the time for reporting to work, Dr. V is standing at the gate of the hospital at 6:55 am. To the person (staff and student) who comes in at 7 in morning, he would say, "good morning", that's all. That person knows if he comes in one minute late in LVPEI, the doors of the lecture hall will be closed. You may be late by just two seconds, still the door will be closed.*
>
> –Ex-senior leader of an international eye care NGO in India

During discussions, many examples of such role-modelling surfaced. For instance, to emphasize the importance of punctuality, the leaders went the extra mile and reached much ahead of the scheduled time of commencement of the meeting, which made it possible to enforce punctuality on the organization. To emphasize dignified care even for the non-paying patients, the leaders themselves checked if the toilets that free patients used were clean. Any number of directives in the form of notices or posters to shape the employees' behaviour cannot be as effective as "walking the talk" by these leaders. When practiced for longer periods, these actions and behaviours become part of the DNA of the organization, coalescing into "culture" and core values of the organization. Organizations that have such strong foundations have achieved success in their quest to provide equitable healthcare.

6.3 GOVERNANCE

An overarching purpose and strong core values play a crucial role in the success of the organizations in delivering equitable healthcare. While this is important, an equally important challenge is in operationalizing the purpose and vision. The organizations that are successful in delivering equitable healthcare have a strong emphasis on the professional governance that is directed by the purpose and the core values of their organization. The systems and processes must be consistent with the core purpose and core values.

6.3.1 Purpose and Value-Driven Decision Making

Are the values reflective of the mission? And if yes, are your medical systems, processes and protocols reflective of those values? Unless all these three get aligned, in my mind true sustainability can never happen. You may be able to have economic sustainability only for small periods of time. But it may not lead to word of mouth. Somewhere or the other, all the negative aspects will start coming in.

–Senior leader of a large eye hospital in the northern part of India

The dissonance between what the organizations say and what the organizations do determine the level of trust that key stakeholders have in these organizations. Examples of such dissonance include: organizations' claiming to provide equitable healthcare but making patients who cannot pay to wait longer than the ones who can afford to pay; senior doctors examining only the patients who can afford to pay, but not the ones who cannot. Such actions result in creating a trust deficit among various stakeholders.

At Makunda, there is only one queue. Very often the rich patients stand behind in the queue and when a person gets admitted in the ward, he/she is in the same ward as the other patients who are well off. So, he/she feels equal here because that psychological thing is very important to get them to come.

–CEO of a large general hospital in the north-eastern part of India

Operating in a rural area that faces severe poverty means that most of the patients are not able to pay for healthcare. This also means that if these organizations must provide equitable healthcare, then the services to certain sections need to be offered free of cost. These organizations do so by various means. Several organizations have established a separate department to raise funds. They counsel the patients at the time of registration to not worry about the cost of care and that it will be taken care of by the organization. This ensures that the patients do not sell off their assets, which can push them further deep into poverty.

Organizations that practice equitable healthcare go the extra mile to ensure that their systems and processes reflect their purpose and core values. For them, the sanctity of the core purpose and core values is more important than possible short-term financial losses. Every key decision in these organizations is governed by the overarching core purpose and core values.

6.3.2 Transparency: A Key Component of the Governance

The governance is more important, how transparently you run things and what your key commitments are. This decides whether partners come up and look to you or the systems. Then automatically one thing leads to another and word of mouth spreads. We should be aware; that is how I see it. Subsequently, the local people will also come forward. Then, the government will also start considering you because you are delivering scale and quality.

–Senior leader of a large eye care organization in the northern part of India

One of the critical aspects of good governance is transparency. This again is related to what the organizations say and what they do. For patients, one of the concern areas is the cost of treatment. These organizations try to alleviate this fear systematically by having counsellors who counsel patients and listen to their concerns. While counselling the patients, these hospitals make it a point to share the cost of the treatment transparently. There are no hidden charges. Patients are informed about all the choices they have. Risks and benefits are discussed upfront. These processes empower patients, by allowing them to make decisions without making them feel coerced into making decisions that suit the organization. Some of the organizations empower the counselling staff to waive off the charges of the patient if they find out that

the patient cannot afford the treatment but needs to be treated. This manner of empowering staff at the lower level of the hierarchy is in line with the purpose of the organization.

The good governance structure helps in building trust among various stakeholders such as patients, funding agencies, employees, and government, translating into lasting relationships. In the case of patients, the trust that is established with the organization based on their first-hand experience results in positive word-of-mouth and brings in more patients who need the care but cannot afford to pay for it. This is in line with the organization's purpose of providing equitable healthcare.

6.4 PRICING STRATEGY BASED ON PATIENT'S PAYING CAPACITY

When it comes to the pricing of services, the usual practice among healthcare providers is to calculate the cost and then come up with a price to be charged to the patients, after incorporating acceptable margins. Being an equitable healthcare organization means it has to provide care transcending various socioeconomic inequities. This means that they have to operate in remote areas where healthcare is traditionally not available and provide care to people who cannot pay for it. In the rural hinterland, if one charges a patient based on the cost then, owing to poverty, majority of the population will be deprived of the care. Thus, to provide equitable healthcare, it requires hospitals to come up with a different pricing strategy that enables care to be provided to even those patients who cannot pay for the services.

6.4.1 Understanding True Paying Capacity

While designing any health care model, it is extremely important to understand the true paying capacity of the geography from where you are (wanting to start hospital). It is also important to discount the catastrophic spending and to really understand the disposable income in hand (of the local people).

–CEO and founder of a large eye hospital in the eastern part of India

Coming up with a different pricing strategy requires organizations to develop a deeper understanding of the local population and their paying capacity. This paying capacity varies based on location. For example, the paying capacity of people in Mumbai or Delhi will be different from the paying capacity of people in Bhuj or Champaran. To arrive at the real paying capacity of the local population, organizations also need to factor in the spending by people for funding catastrophic healthcare events for themselves or their family, since when it comes to survival, people even sell all their belongings to arrange the money for treatment. Such aberrations must be filtered out to arrive at a more accurate measure of the real paying capacity of the people. Consequently, the true paying capacity of a person is the amount that he/she could pay from his/her disposable monthly income, which is in general very less for people residing in rural India, compared to those who live in urban areas.

While this method of pricing does not help organizations to recover the cost from every patient, it certainly creates access to a larger segment of the population, which fits with the spirit of delivering equitable healthcare.

6.4.2 Variations in Cross-Subsidizing Care

So how we have managed to still go ahead and do this (provide care to everyone) over a period of time? Basically, we have put the profits that come from medicine sales, optical sales, consultation diagnostics, into surgeries, which were not self-sustaining for long.

–CEO of a large eye care hospital in the north-eastern part of India

To be sustainable, organizations must recover their costs, and also create a surplus to grow. Various innovative models of financing care allow them to do so. The common theme of these models of financing is cross-subsidizing, wherein money from paying patients is used to finance the non-paying patients. Other organizations cross-subsidize care using money from other verticals such as optical and medicine sales. Cross subsidizing augmented by a continuous attempt to reduce any form of waste in the system and continually improving efficiencies, helps in reducing the overall cost. When cross-subsidizing is inadequate, organizations can raise funds to cover up the deficit.

6.5 BUILDING OWN PEOPLE

6.5.1 Being a Training Institute

So, I think if you look at all the largest organizations, they have also indulged in training, i.e. creating the human resource and using that trainee/human resource as work-force.

–Senior leader of a large eye care organization in the northern part of India

Scarcity of HR is the biggest barrier that organizations face in providing equitable healthcare. Organizations committed to providing equitable care build their HR as per their need instead of lamenting over the gap. They become a training institute and offer training for medical as well as paramedical staff. This creates a continuous pipeline of HR. For such organizations, getting people is not enough; equitable care requires people that are aligned with the organization's value system. The trainee doctors can see the legends in action, which helps them in imbibing similar values. Some of the organizations sponsor higher studies for their doctors. Growing with the organization develops loyalty among the employees. Further, shared experiences during challenging times create alignment towards the purposed and value system of the organization.

We created framework for grooming entrepreneur skills; we call that program as Dentrepreneur.

–Senior leader of a large dental college in the southwest part of India

Lack of doctors with entrepreneurial knowledge is often blamed as a reason for doctors not practicing equitable healthcare. To change this scenario, a few organizations have incorporated entrepreneurial skills into their curriculum. Being a training institute allows these organizations to build HR for the future.

6.5.2 The Birth of Auxiliary Cadre: Allied Ophthalmic Personnel

We have a paramedic school. There we train young women as eye care paramedics. At one level you have given them livelihood, and training, making a difference to their life. On the other hand, while in training, they act as helping hands and in doing so you are facilitating task shifting, a task that traditionally doctors used to do, can also be done by a paramedic and so you are freeing up the doctor.

–Senior leader of a large eye care hospital in the northern part of India

Even though task shifting helps in reducing the need for a higher number of doctors, these tasks still require to be done by someone. Task shifting from doctors to the nursing staff requires the latter to be additionally trained. This made organizations come up with a unique cadre, whose roles are designed based on the needs of the hospitals. This cadre takes care of carrying out clinical investigations on doctors' orders, assists the doctors in the operation theatre, counsels patients, manages the delivery of patient care, and repairs

instruments among other functions. These are the functions that were earlier either handled by the doctors or were outsourced. In eye care, this cadre comprises of several designations such as vision guardians, mid-level ophthalmic personnel, ophthalmic assistants, vision technicians, etc. These personnel who assist in clinical and non-clinical work, in eye care, are referred to as allied ophthalmic personnel (AOP). They are recruited locally or from nearby villages at a very young age after their schooling or their graduation.

When a hospital realized that patriarchy was one of the reasons behind the inequity in the region and could not be resolved unless girls from the community were economically contributing members in the family, it made it a point to offer employment opportunities to girls from the community for AOP positions. Many of the girls are deprived of education due to economic reasons and social norms. After recruiting them, the organization went on to take care of their schooling and graduation. Due to patriarchy, these girls were also not able to come out of their houses resulting in low self-confidence. This hospital innovatively used sports to build their confidence by training them to play football, a game that is only played by men in rural India.

6.5.3 Community as a Resource

Meanwhile, we take the help of the community to deliver mental healthcare, because many people become more open and transparent to the community setting, and when they go to mental health clinics as a patient, they feel the discomfort.

–CEO of a mental healthcare organization in the western part of India

In certain domains, such as mental healthcare, the availability of doctors is abysmally low, i.e., 4000 for a population of 1.2 billion. The gap between the demand and supply is so large that it cannot be met in the near future by creating extra seats in the medical colleges alone. This made the organizations use the community as a resource. They trained people from the local community that included teachers, mothers (to support pregnant women during the postpartum depression) in identifying mental illnesses, counselling patients for minor issues, and referring complicated cases to the higher centres.

Building such cadres within the organization and utilizing the community as a resource not only helps in resolving the problem of availability of competent HR, but also helps in reducing cost and building a cadre of committed people who are aligned with the organization's purpose and core values.

6.6 LOW COST OF CONSUMABLES AND MEDICAL SUPPLIES

We do not give it enough credit that the intraocular lenses which, when I was getting trained in the early 90s, used to cost a hundred dollars. They were all imported, and it was an elitist surgery, only somebody rich could avail it. In those days it was a thousand dollars as compared to a hundred dollars. It was quite big. It was not that (easy and common) the common man would go and get a surgery for five thousand or seven thousand rupees. So, it became an elitist surgery, till Aurolab started making it in less than 3 dollars. And now, it is less than a dollar or about a dollar.

–Senior leader of a large eye care organization in the northern part of India

Organizations feel that one of the most underappreciated factors that had helped organizations provide equitable healthcare, especially in the eye care domain, is the lowered cost of consumables. The Indian consumable industry has played a big role in this. To quote an example, when imported intraocular lenses (IOLs) had just entered the Indian market in the mid-1980s, their unit price was around US$ 210. When an Indian company (Aurolab, a part of Aravind Eye Care System) entered lens manufacturing, the price of a lens was brought down to US$ 10. The continued innovation by Aurolab has resulted in the IOL being available for about US$ 1. Drastic reduction in the cost of lens enabled hospitals across the country to

provide good quality of vision to their patients at a much lower cost. However, it was interesting to note that the manufacturing company Aurolab was the brainchild of Dr. G. Venkataswamy, Founder of Aravind Eye Care System, whose sole aim was to provide high-quality care to everyone irrespective of their ability to pay. Similar was the case with sutures and medicines. Hospitals point out that in no other discipline, an implant that goes inside someone's body comes at a cost as low as a dollar. Since outreach has helped hospitals build volumes, the other consumable manufacturing companies could see a huge potential in the market and thus play a vital role in ensuring sustained innovation, which in turn helps drop prices of their products, which is a vital factor in delivering high quality of care at much lower costs.

> *We contacted the manufacturers. At first, they were not willing to give it to us or even to talk with us. And then for some reason, I do not even know who decided to give it, but one fellow (manufacturer) started (selling directly to the hospital), and then everybody followed suit.*
>
> –Senior leader of a large cancer hospital in the north-eastern part of India

A few organizations found a way out of the problem of the high cost of consumables by trying innovative methods including direct supplies of medicines and consumables. This helped them cut down the margins that would otherwise be paid to the middlemen. The drugs that were available for INR 14 through the middlemen were now available for as low as INR 3, resulting in significant savings.

A few organizations decided to go for generic drugs and the drugs that were one or two generations older. Those drugs, being tried and tested for their efficacy over a long period, benefited patients and came at a much lower cost.

In the domain of dental care, dental chairs are a high capital expense while setting up a dental clinic. The organization that we interviewed, instead of buying new chairs, sourced older, used dental chairs, refurbished them in-house, and used them at their satellite clinics that were set up in remote villages. They could thereafter be used for three or more years. By that time, the satellite clinic had earned enough money on its own that could be used for the clinics' further development, thus reducing the financial burden of the hospital.

6.7 AVAILABILITY OF THE FUNDS AND ENABLING ROLE OF INGOS

The pricing model that organizations adopt in their quest to provide equitable healthcare requires them to raise funds to cover the cost of care. While a few of them decided to be self-sustainable from their operational expenses and focussed on operational excellence and cross-subsidization, others who could not cross-subsidize care, covered the cost by actively getting involved in fundraising. While in the initial years, the fundraising was taken care of by the leaders or promoters of the organization, later on, a few hospitals created a separate department in the organization that looks after fundraising or resource mobilization.

6.7.1 High Impact of Donations

> *The cost of intervention in eyecare for a basic cataract surgery across the length and breadth of the country, would boil down to, somewhere around, say 2000 rupees.*
>
> –Senior leader of a large eye care hospital in the northern part of India

The most common causes of avoidable blindness, namely cataract and refractive error, are amenable to fund mobilization. The cost of intervention for both the problems is quite low. Cataract can be operated for as low as INR 2000–3000 and refractive error can be corrected with the help of spectacles for as low as

INR 50–500. The impact of the intervention can be experienced immediately by the beneficiaries: patients get transformed from being blind to being able to see immediately upon receiving the intervention. Thus, the low per-patient cost of intervention and resulting readily visible large-scale impact enthuse donors to donate for the cause.

6.7.2 Partners in Purpose

INGOs such as Sightsavers, Seva, Orbis, etc., play a crucial role in providing funding support to eye care organizations. Over a period, the relationship between the INGOs and the eye care hospitals has turned into a symbiotic one as both the parties share a common purpose, which is to eliminate needless blindness. While the INGOs have funds to operationalize their purpose, they need diligent organizations to make the transformation on the ground a reality, a role that is played by the hospitals. Thus, the INGOs and hospitals over a period have become partners with a shared purpose, resulting in scale up of providing equitable eye care across the country.

6.7.3 Need-Based Support

> *So what exactly translated into longer period of time (due to INGOs support in hospitals capacity building) is that, you went from not having a retina department to a full-fledged one, from not being in a position to treat patients with that disease to be in a position to treat it regularly. You went in a position from not at all being equipped to having built in-house capacity.*
>
> –Senior leader of a large eye hospital in the central part of India

The initial support by the INGOs came in the form of a fixed amount of token money for every cataract surgery done. Soon they realized that this was not a sustainable way of supporting a hospital. Also, hospitals had started getting support for cataract surgeries under the National Programme for Prevention and Control of Blindness. Hence, there was no value in duplicating the effort. Thus, the INGOs changed their objective from funding cataract surgeries to funding the capacity building of the hospitals to create a long-lasting impact.

6.7.4 Positive Impact on Governance

> *It created a very good work ethic and helped us implement a lot of SOPs because we had to do it. We had to make a manual; we were audited on that. Our accounting process has improved greatly. We have got way more accountability (into the system) in the process (of reporting to the INGOs).*
>
> –Senior leader of a large eye hospital in the central part of India

The INGOs awarded grant money to the hospitals through certain projects that had clear goals such as creating awareness regarding diabetes, carrying out school screening programmes and teachers' education programmes, developing sub-specialty functions within the hospital, and improving functions such as counselling. The progress on these objectives was regularly monitored by the programme managers assigned by the INGOs. While the projects brought much-needed funds to the hospital for their development, the requirement of standard reporting and regular monitoring of the progress on objectives brought much-needed discipline, accountability, and improvement in the governance of the hospitals.

While the INGOs had their own set of projects that they offered to the hospitals, certain hospitals that had established their credibility in the market and commitment to the shared purpose were able to write their own projects and avail funding for the same.

6.7.5 Corporate Social Responsibility: The Other Source of Funding

> *So, we had to give that plan. Without that plan, nobody gives big ticket money. So, when you go to big-ticket donors, you actually need to, first, give them a plan of sustainability. Every CSR and every corporate in India, in their format, will ask for an exit policy.*
>
> –CEO and founder of a large eye care hospital in the eastern part of India

Even though most of the funding came through the INGOs, certain eye hospitals were able to mobilize funds through corporate social responsibility (CSR). If the organizations can convince the corporates regarding their plans and possible impact, there could be plenty of funds available. This requires organizations to have clear plans and demonstrate the ability to execute them, which in turn need hospitals to have strong governance systems.

6.7.6 Need for a Clear Strategy for Lasting Impact

> *I'm not here to ask you for a bottomless pit. I want support for a limited period for the next four to five years. That is all, after that I do not want money from you.*
>
> –CEO and founder of a large eye care hospital in the eastern part of India

While plenty of funds are available, the organizations that benefit the most are the ones that have a clear strategy. Such organizations use the external funds for support in terms of building capacity and have plans in place to be self-sustainable in the long term. This reflects in their attitude towards the use of the funds. Most of them ensure that they are frugal in their approach while using the funds. They often return the unused funds to the donor agencies while achieving all the project objectives on time. This further results in mutual respect and trust between the donor agencies and the organizations.

7 Beyond the Financial Capital: What is Required to be Sustainable?

When it comes to delivering equitable healthcare, financial sustainability comes up as a big starting hurdle for the organizations. The ever-increasing cost of clinical setup diverts the focus of the organizations from being equitable to survival.

> *Nowadays, unless you have a good social and financial background, even though you have good dealing with patients and a good start, nobody will come and get operated by you. So that is the biggest hurdle, regarding ophthalmology. Unless we are in this field for a long time and basic infrastructure is put up by some of our family members, it is very difficult for a new person to come and invest, start and run their practice in ophthalmology because of the costs involved. Every machine is very expensive.*
>
> –Senior doctor of a small eye care hospital in the south-east part of India

The cost of clinical setup is quite high for which the doctors must take a loan. Paying back loans requires the doctors to recover every rupee they can from their services. This makes it difficult for them to deliver equitable healthcare. They believe that in the current times setting up independent practice may not be possible for a first-generation doctor who does not have a financially strong background. Thus, providing equitable care and being financially sustainable is a challenging task.

> *Financial sustainability, at one level, is a simple equation of what is the revenue coming in and how much are you spending. So, some of these interventions would help the revenue and some would reduce the cost. For example, reducing waste. At one level, it reduces unnecessary tasks, at another level it leads to higher acceptance rate and then it increases revenue.*
>
> –Senior leader of a large eye care organization in the southern part of India

The organizations that practice equitable healthcare believe that being financially sustainable requires focus on two things: one is the revenues/resources coming in, and the second being the spending done by the organizations. To be sustainable, the organizations need to keep the flow of resources/revenues coming in slightly higher than their expenditure. Avoiding unnecessary expenditures and eliminating waste in each process can be a good starting point.

> *The first thing which comes into mind is financial sustainability. Fair enough. I personally feel that more than financial sustainability, you should be sustainable on your mission and vision.*
>
> –CEO and founder of a large eye care hospital in the eastern part of India

It is possible to ensure the financial sustainability of the organization through the proper application of mind and management principles. For equitable healthcare organizations, sustainability has a wider meaning that includes sustainability of transformative change as well as the organizational culture.

Equitable healthcare organizations can be financially sustainable, but the sustainability of mission and purpose requires greater attention.

Some of the aspects that equitable healthcare organizations focus on and become sustainable are discussed hereunder:

7.1 UNDERSTANDING THE PROBLEM, CUSTOMER, AND THE MARKET

Healthcare organizations usually tend to fight over a small segment of the population. However, the reality is that there is a huge segment that remains underserved that they can target and still do well. This requires organizations to develop a better understanding of the market.

> *While designing any health care model, it is extremely important to understand the true paying capacity of the geography where you are. And it is also important to discount the catastrophic spending and second to really understand the disposable income on hand.*
>
> –CEO and founder of a large eye care hospital in the eastern part of India

India has two distinct geographies, i.e., rural and urban, with majority of the population residing in the rural hinterland and having low paying capacity as compared to the urban population. Estimating the most accurate paying capacity of the local population and pricing the services accordingly is very important.

> *This lady had 35-kilogram ovarian tumour, so she came here last year. She had not undergone any surgery because after talking to the doctors, they felt that if they wanted to treat her, they would have to sell all (the property) that they had, so they decided to let her die so that the money would be with them. Only desperately poor people think like that.*
>
> –Senior leader of a large general hospital in the north-eastern part of India

There is tremendous poverty in rural India. It forces people to take desperate decisions such as letting someone die due to disease as treating them will take away whatever fortune or assets that were left. In poor sections of the society, as most of the people survive on daily wages, even if they are provided free care, they drop out of care cycle as in the absence of income their family will not be able to survive. Lack of education and prolonged deprivation of conventional care means that healthcare known to the locals is quackery to a great extent. The unavailability of HR is also a big factor when it comes to serving in rural areas.

Thus, while designing services, healthcare organizations have to be mindful of the need, customer characteristics, and resource availability.

7.2 STARTING SMALL AND GROWING ORGANICALLY

> *Vijay asked him (a senior leader and mentor), 'so, what you think is the one thing which we should have if you want to see a change in a place?'. He replied, and Vijay keeps repeating those words again and again, that the latter did not give a big lecture of what you should do and what you should not do. Rather, he said about perseverance with the strength of God.*
>
> –Senior leader of a large general hospital in the north-eastern part of India

As various organizations start working in marginalized areas, they have to work towards changing perceptions of the local people. They need to develop a rapport with the patients so that they can be brought into the folds of conventional care. The organizations that have been delivering equitable healthcare started

small with whatever resources they had. They demonstrated grit and perseverance while encountering various challenges.

See it is like a marathon. Run one step at a time. It cannot be like you and I meet and see someone running and start running, right? It has to be experienced. You will have to run and work hard for it. The sacrifice must be there and sweat has to be there. All of that is part of the learning, right?

–Senior leader of a large eye care hospital in the southern part of India

Staying on for a long period works in the organization's favour as visibility for a long period helps in building trust with the locals. They did not have all the knowledge and experience while starting. Such organizations respond to the need rather than manufacturing need and develop their services organically. They learn on the job, many a time from their mistakes. Getting started with whatever resources are available and persevering for a long period are the key common characteristics demonstrated by equitable healthcare organizations.

7.3 ALIGNMENT WITH THE PURPOSE

Because I am looking at it and thinking that he is a free patient, I may get a donation for this case which will come after one month. But there is a man ready to pay in cash. He has 10,000–15,000 in his hand. So, we can tell that man (free patient) to go away and put that paid patient (paying patient) over there. We take one step towards financial sustainability, but we take a step backward from our mission and vision. Because from the next day, our doctors and staff will say, "oh, that smelly patient is not my patient. That person in the car is my patient." And the whole approach changes.

–CEO and founder of a large eye care hospital in the eastern part of India

For the organizations that aim to be providing equitable care, the sustainability of the mission and vision becomes supremely important. To stay aligned to the purpose, these organizations actively make choices based on the purpose. Thus, it is the purpose and not the bottom line that guides the decisions at these organizations.

If the focus of organizations is to provide equitable care, they need to build systems and processes that match with what they aspire for. They need to do it consciously and deliberately to ensure that the internal as well as external customers trust them. These organizations believe that if they give priority to paying patients over non-paying patients, then it will set a wrong precedent and convey to the employees that the non-paying patients are not important. Such practices will corrupt the culture of the organizations and thus it is important to be conscious of every decision.

We feel strategic plans for a hospital like ours should be two-edged. A standard practice i.e. a strategic plan with statistics and finances, approvals from government registered agencies then quality for branding, accreditation and awards and appreciations. This is what generally institutions look at. But we can also make another plan-identify an excluded population, and study as to why they are excluded, and identify areas where the transformational impact is possible by the institution.

–Senior leader of a large general hospital in the north-eastern part of India

The organizations that aim to do transformative work, in addition to a regular business plan, need to create a plan to guide and measure their transformational work. A few of the organizations even connect the

value system of the organizations to the key performance indicators. This helps them in staying on course and aligned to their original purpose.

> *Most of the senior doctor level staff were brought into the system at a young age, and they either came from organizations that also happened to believe in these philosophy or they were grouped here and so this becomes second nature.*
>
> –Senior leader of a large eye care organization in the northern part of India

These organizations need a workforce that is aligned with the organization's purpose and fits into their culture. Most of the organizations are helped by the fact that the people who work with them join them at an early age. These employees are not experts when they join the organization but grow with the organization. These employees sometimes come from organizations that have similar culture and value systems and thus fit into the culture of these organizations easily. These employees stay long and as they face various challenges together, culture building happens slowly but surely.

7.4 QUALITY

> *Serving does not mean just free work, it has to also be with dignity. So that is something I do not find in a lot of these so-called NGO hospitals. Now, I think that is one of the reasons why they are not able to provide sustainable care. If you go and see many of these hospitals, you get really angry. I mean, I used to get really upset… you know, it could have at least been clean including the beds and everything. I would not have gone under the surgery there.*
>
> –Senior consultant in capacity building of eye hospitals

> *Because of the focus on quality, they (NGO hospitals that became sustainable) were able to attract wealthy patients. They charged fees to the patients based on the latter's socio-economic status.*
>
> –Senior consultant in capacity building of eye hospitals

There are pathological conditions that do not depend on the economic status and affects everyone, e.g., eye diseases and hearing problems, among others. The "need" is never a problem with regard to healthcare. The challenge is, if the services can be made attractive for everyone, for those who can pay as well as for those who cannot. Most of the NGO hospitals are not sustainable as they lack quality in clinical care and dignity in service delivery. The organizations that focus on clinical quality, as well as the service delivery part of the care, make availing care attractive to everyone. It helps them ramp up the volumes, cross-subsidize the care, and be sustainable.

7.5 UTILIZING NON-TRADITIONAL FORMS OF CAPITAL

Developing an organization and working towards providing equitable healthcare is a challenging task, especially due to a lack of knowledge regarding practicing equitable care. Thus, in addition to monetary funds, organizations require different forms of capital such as intellectual capital, network capital, and community capital. These are the non-traditional forms of capital, which if utilized properly can help organizations overcome various challenges.

7.5.1 Intellectual Capital

> *Not only Dr. V, but everyone in Madurai has also been of great help- in training our doctors and giving us ideas to develop. We had multiple mentors. Among them, the role of Dr. V and Madurai,*

I think has been very important similarly Dr. Badrinath, I've known him since my time at army services. He also helped me in training my cornea people (doctors trained in cornea sub-specialty) and all.

–Senior leader of a large eye care hospital in the central part of India

The pioneer organizations in the space of equitable healthcare form a key intellectual capital. Their openness to share the knowledge gained from their own experiences prevent others from reinventing the wheel. While most of them share their knowledge informally, a few also formalized capacity building of others as their organizational offering. As the purpose of these pioneer organizations is to eliminate the disease, they proactively help others.

7.5.2 Network Capital

Then we joined Vision 2020 and through that again we have been able to learn a lot. You can hear from all the stalwarts whenever they have these meetings. But the maximum help I have got is from Aravind.

–Senior leader of a large eye care hospital in the north-eastern part of India

The organizations that practice equitable healthcare proactively create multiple networks of peers that facilitate cross-learning. They realize that the problem at hand is large and cooperation rather than competition is the right way towards solving the problem. This was peculiar to eye care.

So, we were enrolled as a mentor by Seva foundation. When they (Seva Foundation) visited us, they said that as a mentor, if we are strong, then only we will be able to mentor somebody. So, what is our weakness now? Mentoring projects also helped us develop our own systems because when you grow as a mentor, then only you can teach somebody. When you have to mentor, you must do introspection – "what level I am at?"

–Senior leader of a large eye care hospital in the central part of India

The INGOs and the pioneer organizations that developed sustainable equitable healthcare models together created such networks. Such networks later helped the other organizations avail mentoring both formally as well as informally. In the process of mentoring, the mentees benefit by gaining knowledge and all the support in their capacity building. On the other hand, the mentors have a lot to gain too. The staff members of the mentor organizations, while sharing the model, develop a better understanding of it. The staff involved in mentoring activity demonstrate higher levels of engagement and alignment towards the organizational purpose.

7.5.3 Community Capital

If Muthu had not come, I would have probably never learned about the administration. If Shanta had not come, I would have probably never learned how to teach the nurses to calculate, and If Juna would not have come, I would not have known how to teach the nurses hand washing.

–Senior leader of a large cancer hospital in the north-eastern part of India

The good work done by the organizations is often rewarded in the form of the goodwill gained in the community. The community responds in different ways and help organizations in achieving their purpose. This bond between the community and the organization is akin to a symbiotic relationship where both gain in different ways.

We realized that they (local tribal community) had a very good system in place. Senior women from those communities deliver the mothers at home and they stayed back in the house and looked after the children and did the work of a mother till everything was stabilized. So, we approached those delivery providers and when we started talking to them, they started telling us the horrible stories about people who died in the village. So, we said, why do you want to take those risks, instead refer the difficult cases to us.

–Senior leader of a large general hospital in the north-eastern part of India

Local communities sometimes have good traditional practices that take care of the community's health. These practices when amalgamated with conventional practices help in delivering equitable care. Since the local solutions are incorporated into the conventional practice, it makes the locals believe that the organizations are their well-wishers, which further helps in developing trust, a precious form of capital.

As the organizations continue doing good work, people from the community respond by volunteering and helping organizations with various activities. Such resources do not bring direct monetary benefits to the organization, but these alternate forms of capital help organizations' growth and movement towards sustainability in numerous ways.

Lack of HR in Rural India: What are the Problems and How to Deal with Them?

Working in the equitable healthcare space requires healthcare organizations to work in the areas where there is a tremendous need. This means that they have to work in remote or rural areas.

You know, having people to live and work in such areas is not that easy. It is neither natural, nor normal for most of the people. They are not ready. When they study medicine or nursing, that is not what they have in mind. They have not been exposed to those possibilities.

–Senior doctor of a large cancer hospital in the north-eastern part of India

Getting people to work in these areas is a hard problem that is faced by organizations all over the world. It is difficult to get people willing to work in rural areas. There is a tremendous scarcity of medical as well as paramedical staff to work in rural areas.

One huge lacking I see in oncology, especially because it is a specialty care. It is not a speciality but a super speciality care. There is a dearth of skilled human resources. No CSR (funding) or government supports human resources, which I feel is a huge problem.

–Senior doctor of a large cancer hospital in the north-eastern part of India

This shortage is felt more when it comes to getting staff that is trained in delivering care for non-communicable diseases such as mental health and cancer care. The equitable healthcare organizations that are already constrained financially find it difficult to start their own training activities as no CSR or government fund supports capacity building of the organizations in terms of HR.

As solving this problem of unavailability of the HR to work in the rural areas is critical to delivering equitable healthcare, it is worth exploring the issue and what some of the organizations have done to address it.

8.1 THE BARRIERS IN GOING RURAL

8.1.1 Prejudice

We would go to any place on earth but not Assam, there are only bomb blast and floods.

–Senior leader of a large cancer hospital in the north-eastern part of India

People have a set image of rural India. For example, when it comes to the northeastern part of India, people relate it to floods and bomb blasts, which while true a few decades back, is no more the case.

They feel that as professionals, it is not academically very challenging. You cannot be an academic, let alone be a leader. The standard will be absent if we come to poor places like this. Yet here there are so many problems, which are research questions, which had not been addressed.

–Senior leader of a large general hospital in the north-eastern part of India

In the absence of modern equipment and basic medicines, doctors fear if they will get to use their skills in rural settings. They believe that providing care in such a resource-scarce setting is impossible and may not help them grow. Further that they will not be able to deliver good quality of care. Research and publications are becoming a parameter of one's success. Those who are looking for an academically rewarding career believe that doing research will not be possible in the rural setting.

On the contrary, the organizations that work in rural settings feel that the rural health being unexplored, have many research questions unanswered, and thus has significant scope to grow academically. Lack of resources in a rural setting also offers unique challenges while practicing medicine. Thus, if somebody loves challenges, the rural setting is meant for them and with strong basics, one can achieve good results.

8.1.2 Lack of Knowledge and Skills

I do not think there is great transformation in terms of curriculum. From the time we studied BDS, as compared to today, the curriculum is more subject specific consisting of clinical subjects. We were never taught about its distribution. Even though we studied about the disease, body of various communities in literature, we were not extensively taught about the disease distribution. I think it is just for the sake of it, because it is in public dentistry course. There is no experiential learning to understand our local scenario.

–Senior leader of a large dental college in the southeast part of India

The curriculum for medical education is clearly lacking when it comes to preparing students for life after medical school. The focus is only on clinical knowledge and ignores management knowledge. Though public health is part of the curriculum, some believe that it is a mere formality and that is how it is being taught in the medical colleges. The absence of experiential components does not help students in gaining knowledge of the real situation in the rural areas. The pertinent question is, if the youth does not even know about the problem that exists, then how can they attempt to solve it?

8.1.3 Family Support

So, a lot of it (to work in rural area or not) I think depends on family support and a lot of things depends on the person. So, I am more of a person who says, "this is what I mean to do". I am more of a decision maker kind of person. But one of the bottlenecks I guess even for the new people who join or appear, is actually the lack of family support that they get.

–Senior leader of a large general hospital in the north-eastern part of India

People can be categorized into three groups: first are the ones that will never work in the rural areas, second are the ones who will work there despite all the problems, and the third category has people who are on the borderline and with some help, they can shift to the second category. It is important to understand what stops these people in the third category to work in rural areas. The major barrier for these people is that they cannot make decisions on their own and have to think of their families first which for some reason does not support their desire to serve in the rural areas. If the families of this group are convinced, then a huge pool would become available to work in rural areas.

8.1.4 Basic Amenities

One of the main things, we wanted to do is (when shifting to remote place) we did not want to compromise on our daughter's education. We wanted to make sure that she gets a good education; other things do not matter.

–Senior leader of a large cancer hospital in the north-eastern part of India

There is a good chunk of people who are willing to work in rural areas, but they hesitate when they have to choose between their child's education and their desire to serve in rural areas. While they are willing to make sacrifices, they believe that it will be unfair on their children if they are denied the good quality of education which is often not available in rural areas. The absence of such basic amenities prevents them from serving in rural areas.

8.2 WHAT HAS WORKED?

The equitable healthcare organizations have prevailed on their purpose by various means. They did so by a three-pronged strategy. The first is to use the available resources efficiently, which required the organizations to break down the processes into simple parts and shift non-critical tasks to other cadres. The second is to create a pipeline of HR by being a training institute. The third is to arrest attrition by treating HR as human capital and use employee engagement principles. All the three are discussed hereunder:

8.2.1 Task Shifting

Equitable healthcare organizations face the problem of scarcity of doctors. They have accepted this reality and have worked towards solving the problem by applying their minds. These organizations realized that if they supported the doctor by taking away non-critical aspects of work from them, then with a lesser number of doctors they could still treat a large volume of patients.

> *At one level you have given them livelihood and training, making a difference to their life. On the other hand, while in training, they are helping hands and in doing so, you are task shifting. If I have two people assisting me in surgery, I would probably do one and a half surgeries per hour. When I have three people assisting me, I can do 4 surgeries per hour.*
>
> –Senior leader of a large eye care hospital in the northern part of India

They broke down the processes into smaller parts and assigned the non-critical parts of the tasks to a group of paramedical staff who were trained to do it. These organizations created standard operating procedures for the staff to follow which ensured that the process did not deviate.

These paramedical staff members were recruited from villages. They had basic education and were trained in-house in the organization to perform those non-critical tasks. This was a win-win situation for the staff as well as the organizations. While the staff got an opportunity to earn a better living, the organization got cheap labour. This approach ensured that the doctors were more efficient than before, and the cost of the care came down.

> *Our experience has been that they (girls/women) are more loyal (than boys/men). They are more sensitive, and they are patient. There are long hours of work and you know one patient is not similar to the other one; you have to keep answering each patient's queries.*
>
> –Senior leader of a large eye care hospital in the southern part of India

Girls were preferred over boys to carry out these tasks as organizations believed that they were more loyal and hardworking. When recruited at a young age they could be moulded to fit into the organizational culture.

> *Our main methodology has been shifting towards a community worker or lay counsellor-based approach. And this approach signifies that we train and supervise frontline workers and lay counsellors who are non-psychiatrist or non-psychologists.*
>
> –CEO of a mental healthcare NGO in western part of India

A few organizations used the community to make up for the shortage of doctors. They trained people from the community to carry out diagnosis and basic treatment. This ensured that for most of the cases, a doctor's intervention was not needed.

8.2.2 Training Institute

A lot of organizations indulge in training, creating human resource, and using that trainee human resources as workforce. So that also reduces cost, like we have a paramedic school where we train young women as eye care paramedics.

–Senior leader of a large eye care hospital in the northern part of India

Most of the equitable healthcare organizations also doubled up as training institute for both medical as well as paramedical staff. Regularizing training ensures that they have a steady pipeline of HR that in the future could be recruited into the organization. Being a training institute also gives a chance to the staff to imbibe the organizational culture and to the organizations to assess if the candidate can fit into the organizational culture or not.

8.2.3 Engaging Human Capital

They went there (to other organization for training). They came back as if it was just an experience akin to coming out from a well to an ocean. Now, she (one of those trained) is managing the free patients, and a department of 300 patients is being managed by her including the pre-operative examination. She may not even realize what value that (visit to other organization) meant, but in her perspective, it is not about this tip or that tip, it is about broadening the perspective and the horizon that will enable her to come to a stage to step into greater responsibilities.

–CEO and the founder of a large eye care hospital in the eastern part of India

Few organizations believe that the challenge of scarcity of HR can be overcome if the HR are looked at not as a cost but as an asset. This thought process can help them in investing in HR, which will pay dividends in the future. They believe that the workforce is built over a period and is not a job that can be done overnight. This requires organizations to be patient and consistently invest in building people.

They said, your (leader's) children will study in the best schools and you will also have electricity in your house, but we will not. So I told them, my children will study here, we will slowly repair all the houses here and my house will be the last one to be repaired and I will not get any special privilege as compared to you. If I do not have the money to pay your salary, I will not take my salary, rather I will pay for you. So, initially they did not believe that, but slowly and gradually, they realized that I was exactly doing what I said.

–Senior leader of a large general hospital in the north-eastern part of India

Having a team that believes in the purpose of the organization and the leadership makes it easy for the organizations to practice equitable healthcare. Building such a team requires building trust. The staff develops trust with the leaders once they realize that the leaders are true to their words and not getting extra privileges when the staff is asked to sacrifice.

It is because we have shared experiences. They are all part of the whole story. Every one of them. Saritha, Aranab Debu, you know, Debu has been there with me from 2008 second January. Yeah,

Muthu has been with us for long the same way. They have all grown in front of our eyes, as individuals, and as professionals.

–Senior leader of a large cancer hospital in the north-eastern part of India

Growing with the organization and shared experiences while facing various challenges together helps the staff understand and imbibe the organizational culture. Knowing the ground realities that are facilitated through rural visits or outreach camps helps the staff understand the need and relate to the purpose of the organization.

While working in a community, they can see the change happening. So even if they are working with children or working with people who have depression or addiction, they can see the change happening.

–CEO of a mental healthcare NGO in the western part of India

It is important to understand why the staff continue to work in organizations that offer comparatively lesser monetary compensation. People often decide to work depending on what gives them satisfaction. Seeing their work, making an impact on the ground, and changing people's lives gives them a sense of achievement and motivates them to carry on with their work.

They (employees) said that they have been able to educate their children because they got their salary on time. So, they were able to plan. Second thing, they felt safe in this organization.

–Senior leader of a large maternal care hospital in the southern part of India

Employees, especially lower down the hierarchy, stay with the organization due to simple things done right, i.e., salaries that are paid on time and a safe environment to work, especially for the women staff.

Keeping in mind the staff's needs and their children's development, a few hospitals in rural areas built schools. These schools allow the staff to serve in rural areas for a longer period. The schools also ensure that the local community receive education and are uplifted in the true sense

8.3 POSSIBLE SOLUTIONS

To solve the problem of scarcity of HR in rural areas, the organizations may well have to try unconventional means.

Hearing about places like these is one thing, but unless you go and see a place, where health care is dismal, you do not understand. So, when you go and visit places like these, spend some time, and then, you decide this is not for you, then it is ok.

–Senior leader of a large general hospital in the north-eastern part of India

How can one solve a problem if one does not know that it exists? Students might read about the problem in rural places but may not completely understand the problem and the need unless they visit these places. Organizations may need to create an opportunity where students can get to experience the enormity of the problem and the impact they can create. After this, it is for the students to decide if that kind of work is for them or not. Media is also one of the tools that can be used to motivate the younger generation.

If the parents and families understand the perspective (of their children) like, my mom came here and saw this place and she said, "yeah…you know what…this is like Kerala was when I was growing up

as a child." You know that there is something for them to relate to. Then they understand, ok, you are contributing to this.

–Senior leader of a large general hospital in the north-eastern part of India

If families play a crucial role in deciding whether the doctors could serve in the rural areas, then a visit by the families to the workplace and some counselling of the families can help. These visits can help by alleviating the fears that families have regarding the remote places. By witnessing the impact these doctors can create with their support can help families provide full support.

The improving economy and economic condition of the rural households means that what worked yesterday may not work in the future. Thus, with the changing context, the ideas to attract and retain staff also need to be refreshed.

While there is "no one size fits all" set of answers, the solutions of the past can spark new solutions for the future organizations.

9 Learn from the Past to Build the Next Generation Leaders

Delivering equitable healthcare depends a lot on the organizations and their mindset. It requires them to think beyond the traditional boundaries and self. The traditional boundaries of a healthcare organization restrict them to the hospital, waiting for the patient to arrive. To deliver equitable care, organizations must redefine their boundaries and reach out to people who need care.

Leadership buy-in and people aligned towards the cause plays a critical role in the delivery of equitable care. The team that works closely with the leaders is influenced by their behaviour and further, along with the leaders, plays a critical role in building the culture of the organizations. The systems and processes that are established in these organizations are driven by the purpose of the founding leaders. As leadership plays a crucial role in building equitable healthcare organizations, it becomes important to understand the factors that influence them. Understanding these factors can play a significant role in building leaders for the future.

9.1 MINDSET

9.1.1 The Drive

> *For me, I felt like it was a calling in life. Sometimes, we would make choices in life and so, I felt, we should just do this. It was so somewhat great or a big decision those days.*
>
> –Senior leader of a large cancer hospital in the north-eastern part of India

The leaders who practice equitable care are self-motivated and have clarity about the purpose of their lives. They realize that the field of work that they have chosen is the calling of their life. This makes it easy for them to walk the uncharted path and prepare for the uncertainties. The work that they do or the difficulties they face then are the minor discomforts that are part of achieving their higher goal.

9.1.2 Giving Back

> *The education helped me go abroad. I went abroad; I realized there is a whole new way of looking at things. That experience gave me this idea of coming back, setting up a one-stop hospital, comprehensive services. I mean all that is… it is a kind of a domino effect. And so, you are very conscious that you are a very privileged person and privilege has come with responsibilities.*
>
> –Senior leader of a large maternal care hospital in the southern part of India

Practicing equitable healthcare requires one to be driven by a service mindset. The leaders believe that they have enjoyed privileges by being born in a good family and learned by training their skills on poor patients.

They look at their education as a gift from the higher powers that is meant to serve people. This belief in the higher power and constant inner reflections to hear the inner voice acts as a guiding light for them. The gratitude they feel for what they have received in their lives drives them to give back to society through their work.

9.1.3 Being Irrational

This girls programme started in 2010. And then slowly it grew. But the real impact of the girls programme only started coming from 2014 onwards when the first batch passed out. But in 2010, I had a lot of distractors, including the Trust Board itself. They said there is so much of security issue what will happen, or why take all this trouble, why go into all this? So, the CEO, the founder, should have the courage and the guts to stand by their conviction and decisions.

–CEO and the founder of a large eye care hospital in the eastern part of India

Since practicing equitable care is akin to a mystery that requires unconventional solutions, the leaders had to challenge the existing assumptions regarding care and care delivery. At times, they also needed to have self-belief, conviction in their vision and decisions, and stand their ground. To pull off something unheard of, they needed a team that did not have any baggage in the form of a pre-set mindset and who trusted them. They could build trust with their team members by being true to their words and not using any extra privileges.

9.1.4 Putting Purpose Above Self

Most of these institutions get into a lot of trouble when senior leaders leave. New leaders may not have a good vision and confidence and they are not very comfortable. So, we decided that we will hand over at year 25 (of their tenure at the hospital), and be around for some years so that the new team is able to manage all the responsibilities, comfortably and confidently.

–Senior leader of a large general hospital in the north-eastern part of India

To ensure the sustainability of the transformational change, the leaders think of stepping back and stepping down even while being in their prime. This is a clear sign of putting purpose before self. Once the culture of the organization is set, they allow the employees to make their own decisions that are guided by the culture and the value system of the organizations. This ensures that the organizational purpose stays alive and the transformational change continue even when the leader passes away.

9.2 INFLUENCES: IT TAKES A VILLAGE!

Leaders of the organization have a unique mindset and it cannot be attributed to one factor. As the African proverb says, “it takes a village to raise a child”, multiple factors came together to shape the mindset of the leaders.

9.2.1 Workplace, Alma Mater, and Peers

He would illuminate, you know, he used to say that when the patient does not have resources for his or her treatment, it is the job of the treating physician, to find those resources. He would tell us; the sick man’s penny must go back to the sick man. What you earn from the sick people must go back to them.

–Senior leader of a large cancer hospital in the north-eastern part of India

Workplace, alma mater, and peers play a crucial role in the formative days of the leaders. The good-intentioned leaders influence their juniors and peers through their actions, one-to-one mentoring, and timely support. The workplace and alma mater also instil certain values that the leaders carry along with

them throughout their lives. Working under the doyens of the field helps them to closely observe the doyens in action. This shapes their mindset and behaviour.

9.2.2 Society and Family

We have told them, 'If you study hard, you will become a doctor and when you become a doctor, you will get enough and more money.' In a way it is ok, but I think when I tell my daughters, 'If you become a doctor, you can take care of a lot of needy people and heal them and that would be so nice.'

–Senior leader of a general hospital based in the north-eastern part of India

Upbringing plays a huge role in shaping one's mind. The way society and family define success also plays a big role in the nature of choices made by people as they grow. If the society and the family measure a child's success just in terms of monetary aspects, then the child will have a particular understanding of success when he grows up. Several leaders interviewed as part of this project are women who worked in remote areas. In a patriarchal society, for a family to support a women's ambitions speaks a lot about the family's broadminded thinking and the society they live in.

9.2.3 Experiences

I saw the patients there (in an outreach camp at a remote place). They were completely blind, and nothing could be done. I think I saw around 25 to 30 patients like that. For me it was so traumatic to have come there and tell them that I cannot do anything for them, so I just burst into tears and ran away from there. I cried and cried.

–Senior leader of an eye care hospital based in the north-eastern part of India

The experiences that the leaders have had in their lives play the biggest role in shaping their mindset, thought process, and the crucial decisions they make in their lives.

Personal loss and suffering from the disease themselves helped them empathize with the sufferers. They respond to their loss by building systems that would eliminate the suffering they experienced. Education or reading about the suffering or plight of the vulnerable does not necessarily put people into action. When the leaders themselves visit remote areas, they witness first-hand the suffering of the vulnerable groups. They felt a calling to act on it and they did so. Had they not witnessed the suffering themselves, they might have never understood the problem or jumped into action. When employees of these organizations visited the remote areas, they also had the same experience. This helped the organizations get the staff that shared the same purpose.

9.2.4 Life Partner

One of the family members said that since you guys have no idea what has been happening there, why do not one of you (the doctor) go there, then you (wife) go and join him later. The wife refused and said, whatever it is, good or bad, or any challenge, we do it together.

–Senior leader of a cancer hospital based in the north-eastern part of India

Many leaders attribute the good work being done by them to their spouses. They felt that it would have been impossible to walk the unchartered territory and stay on course during the difficult times had they not got the support from their spouses. When both the partners believed in the higher purpose, it made the task of pursuing it and sticking to it during the difficult times easy.

9.3 BUILDING NEXT-GENERATION LEADERS

All people are not taught to think that way. In a way, I think, the doctors (senior doctors) are to be blamed. We are not teaching them the right values. I think, ethics has to be a subject in our curriculum since internalization is not there.

–Senior leader of a general hospital based in north-eastern part of India

Several leaders believe that if unethical practices have crept up in medical education, then senior doctors need to be held responsible for that as they have failed to instil ethical and human values in their students. Having said that, just including ethics and human values in the curriculum may not help. For the right impact internalization of human values is necessary and to do so the senior may have to step up and deliver.

Media being a powerful tool can be used to inspire the younger generation. A lot of good work is happening on the ground that the students may not come across sitting in their classrooms. If media as a tool is used effectively, a huge group of people can be motivated to serve in rural areas.

Hearing about places like this is one thing. But unless you go and see a place, where health care is very dismal, you do not understand this. So, when you go and visit places like that, spend some time, and then you decide this is not for you, then it is ok.

–CEO of a general hospital based in the north-eastern part of India

While media could be a starting point, it cannot be a substitute for experience. Exposing young students at the undergraduate level to various systems is crucial in preparing them to strive under such a resource-constrained environment. Rural places can be good learning places for doctors as one does not get all the support and back up. So, they will learn how to deliver care in absence of all the modern equipment, which is a big challenge. Exposing the students to low resource settings such as rural villages, by design through rural fellowships, can help them experience the need. They may not decide to continue working in the rural setting, but by virtue of having worked in the rural area, their decision will be an informed one rather than based on prejudices.

10 Discussion and Recommendations

10.1 ACKNOWLEDGING AND MEASURING EQUITY

This study identifies acknowledging and measuring equity as one of the key aspects of equity in healthcare delivery. To deliver equitable healthcare, healthcare organizations need to recognize the inequities in the health of the communities and delivery of healthcare. Further, the inequities vary from one place to another. Thus, it is important to identify the inequities that exist and measure the extent of it. Acknowledgment of the inequity can come from the awareness of it. Educational institutes have a great role to play in creating awareness among the budding healthcare professionals regarding the inequities in society.

From the literature, it is evident that healthcare systems across the world lack meaningful data that will aid policy decisions. This makes it imperative that the public healthcare systems focus on collecting meaningful data. Epidemiologists and healthcare researchers can play an important role by helping the government in creating structures that aid in capturing meaningful data and analysing the data to provide insights that can direct policy decisions.

10.2 CLARITY OF PURPOSE

Our study finds that clarity of purpose plays an important role for the individuals and the organizations to be able to work in an equitable healthcare space. Clarity of purpose helps individuals and organizations make sacrifices, go the extra mile to understand the problem, take decisive steps, and invent the systems to achieve the purpose. On the other hand, the lack of clarity of purpose that is observed in the government's approach to making policy decisions makes it difficult for the organizations to practice equitable healthcare. The lack of clarity on purpose thus becomes counterproductive.

Hence, individuals, organizations, and public healthcare systems must reflect and gain clarity on their purpose. While individuals can be facilitated to gain clarity on their life's purpose while they are getting educated, the organizations and healthcare systems will have to proactively seek help in such facilitation. Getting clarity on the purpose will help individuals, organizations, and systems to align their efforts.

10.3 SELF-REFLECT IF ONE IS TRULY EQUITABLE

Practicing equitable healthcare is not a legal requirement from any organization or person. One can practice it if it is their purpose. However, organizations that practice charity on and off cannot be called equitable healthcare organizations. If organizations call themselves equitable healthcare organizations, they must introspect and ask themselves a few questions, i.e., How do they define their market? Is their outreach to the marginalized population regular or a one-off instance? Are they present in the area where inequities exist? How do they price their services? How is their behaviour towards the patients coming from marginalized sections of the society? Organizations will have to deeply reflect and collect data from its stakeholders to answer these questions.

10.4 UNDERSTANDING THE MARKET

Equitable healthcare requires the care to be distributed based on the need and not on the paying capacity of the population. Thus, understanding the market becomes an important activity for equitable healthcare organizations. They need to understand the type and extent of inequities that exist in the community, the paying capacity of the local population, consumer behaviour, local health problems, and challenges among others. Resources being scarce, healthcare organizations may not be able to develop a comprehensive understanding of the market. Healthcare researchers have a significant role to play here in studying the market and informing the healthcare organizations about the market, its problems, and needs.

10.5 BUILDING PEOPLE: DOCTORS, LEADERS, AND PARAMEDICAL STAFF

Delivering equitable healthcare brings HR challenges that are twofold, i.e., regarding quantity as well as quality. While there is a tremendous scarcity of human resources, especially in rural areas, delivering equitable healthcare requires people with a service attitude and human values such as empathy and compassion. Equitable healthcare organizations more often than not work in areas that are underdeveloped and lack basic amenities. Hence, they must also be able to demonstrate grit and resilience. Building people that possess such values is a bigger challenge than just building HR. Building human values and character of a person requires long-term investment and hence this process should begin at an early age, possibly in school, and then carried on in medical school. This makes it imperative that the curriculum for medical education is changed to fit the need and build doctors with a strong moral character.

The curriculum of medical education also lacks in terms of preparing doctors for an entrepreneurial journey. The current curriculum of medical education requires significant restructuring to provide doctors with adequate public health knowledge and entrepreneurial skills to address community problems.

Further, each specialty requires paramedical staff that fits their needs. In absence of recognized training programmes, organizations suffer. Most of the eye care organizations have overcome this hurdle by designing and running their own training programmes. Eyexcel[3], a week-long workshop run jointly by Aravind Eye Care System and Seva Foundation teaches participants about the art and science of creating and running a training programme. Such workshops can empower healthcare organizations from other specialties to build their own cadre of paramedical staff.

10.6 HOLISTIC REFORMS

Healthcare in the marginalized areas suffers due to reasons that are beyond the healthcare sector, i.e., absence of good roads and schools in those areas. Poor infrastructure means that organizations and individuals are reluctant to work in those areas. This keeps the local population out of the folds of conventional care for a long period leading them to falling into the trap of quackery and superstitious practices. Those who chose to work in such areas must put in extra effort.

The high cost of consumables and drugs is one of the major reasons for high out of pocket expenditure. Insurance schemes in different states vary and may not always cover the whole cost of care, further pushing patients out of the folds of conventional care. Further, health insurance covers the cost of care, but when the patients are daily wage earners and their families depend on them, these patients tend to drop out of treatment. The corruption, red tape, and the delayed payments of the insurance amount due to the organizations put unnecessary pressure on the well-meaning organizations. Thus, the government needs to look at reforming the healthcare sector from a holistic view.

[3] https://aravind.org/courses/eyexcel-excellence-in-eye-care-training/

10.7 SEED CAPITAL

This study highlighted that the initial cost of the start-up was one of the major reasons that well-intentioned people do not enter the space of equitable healthcare. A few of the healthcare experts opined that if doctors are provided with a seed capital with no urgency to return, this can be a great enabler, especially for the younger generation that is just starting their career. Funding agencies that believe in patient capital may have a role to play here.

10.8 SUSTAINABILITY

The fact that there are plenty of healthcare organizations practicing equitable healthcare in India indicates that they have been able to sustain. These organizations studied the market and developed models that became financially sustainable over a period. However, being sustainable in terms of purpose and culture of the organization is more important for such organizations. They believe that with the right culture and focus on purpose, they can achieve a lot. An organization's commitment to the purpose can be seen through their actions and this builds a certain reputation and goodwill among the community which pays off in multiple ways. Similarly, the word of mouth can spread into the community if the organization deviates from its words. Thus, when it comes to sustainability, equitable healthcare organizations need to stay focused on their purpose and culture. They need to constantly and collectively introspect if their actions are aligned with their purpose and value system. Leadership plays a crucial role in defining the purpose and setting a certain culture in the organization. This cannot happen by mere display of posters of purpose and value system in the organization. A critical mass of the organizations has to embody the purpose and live those values.

10.9 MEANINGFUL COLLABORATION

It must be understood that the goal of equity in healthcare cannot be achieved if various stakeholders of the healthcare work in silos. The public healthcare system, private healthcare, insurance agencies, medical institutions, researchers, and the community have to come together to achieve this goal. All the stakeholders of healthcare need to arrive at a common purpose and a strategy to achieve it. This task, ideally, should be initiated by the country's government.

The healthcare organizations can also align themselves based on their purpose and form a network to facilitate cross-learning. There are several examples of such networks; Vision 2020 (eye care), mentoring network of eye care hospitals, National Cancer Grid (Cancer care), and Equitable Healthcare Access Consortium (a consortium of healthcare organization from different domains) among others. Such networks not only facilitate cross-learning but also provide much-needed encouragement from the peers while walking the difficult path of providing equitable healthcare. They also lead to meaningful collaborations that benefit healthcare at large. Since these are networks of like-minded people or organizations with similar purpose, it is relatively easy for them to align, work together, and achieve results.

Epilogue

There is significant progress in delivering equitable care in various domains of healthcare. A greater part of it has gone unnoticed akin to a sapling that grows its roots quietly. The success of a few organizations providing equitable care can provide much-needed role models to demonstrate that providing equitable healthcare is an achievable goal.

The factors that are in control of the organizations play a big role in enabling them to overcome various challenges in providing equitable care. Organizations can start with developing better clarity regarding organizational purpose; this must be driven by the organization's leadership. Being an equitable healthcare organization occurs as a response to the larger life purpose. The clarity of the purpose and well-articulated core values guide organizations in aligning/partnering with like-minded people and organizations.

The organizations that sustainably practice equitable healthcare have achieved it over a while. Hence, organizations need to be patient and focused on their purpose. The focus on the purpose builds credibility, which attracts various like-minded partners including funding agencies that are looking to support good work.

If what enables organizations to provide equitable healthcare had to be described in one sentence, then the following quote by Neitzsche that was quoted by Victor Frankl in his various books does justice to it: *"He who has a why to live can bear with almost any how"*.

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Annexure I

List of organizations and individuals interviewed

S. Nos.	Names	Designations	Organizations
1	Dr. Sharad Iyengar	Founder and Chief Executive	Action Research and Training for Health (ARTH), Udaipur, Rajasthan
2	Mr. Mritunjay Tiwari	Founder and Head of Projects	Akhand Jyoti Eye Hospital, Mastichak, Bihar
3	Mr. Thulasiraj Ravilla	Founding Member and Executive Director	Aravind Eye Care System, Madurai, Tamil Nadu
4	Dr. S. Aravind	Director-Projects	Aravind Eye Care System, Madurai, Tamil Nadu
5	Dr. Usha Kim	Director-Mid-Level Ophthalmic Personnel Programme	Aravind Eye Care System, Madurai, Tamil Nadu
6	Dr. Jennifer Vaid Basaiawmoit	Founder and Medical Director	Bansara Eye Care Centre, Shillong, Meghalaya
7	Mr. Aaron Basaiawmoit	Chief Executive Officer	Bansara Eye Care Centre, Shillong, Meghalaya
8	Dr. Pavitra Mohan	Founder	Basic Healthcare Services, Udaipur, Rajasthan
9	Dr. Ravi Kannan	Director and Surgical Oncologist	Cachar Cancer Hospital, Silchar, Assam
10	Dr. Poulome Mukherjee	Surgical Oncologist	Cachar Cancer Hospital, Silchar, Assam
11	Dr. Ritesh Tapkire	Surgical Oncologist	Cachar Cancer Hospital, Silchar, Assam
12	Dr. Umang Mathur	Executive Director	Dr. Shroff's Charity Eye Hospital, Delhi
13	Mr. A. K. Arora	Chief Executive Officer	Dr. Shroff's Charity Eye Hospital, Delhi
14	Dr. Shalinder Sabherwal	Head of Training	Dr. Shroff's Charity Eye Hospital, Delhi
15	Mr. Shantanu Dasgupta	Deputy General Manager	Dr. Shroff's Charity Eye Hospital, Delhi
16	Dr. Mayank Pangtey	Founder	Drishti Center for Advanced Eye Care, Haldwani, Uttarakhand
17	Dr. Bhanu Pangtey	Consultant	Drishti Center for Advanced Eye Care, Haldwani, Uttarakhand

(*Continued*)

S. Nos.	Names	Designations	Organizations
18	Dr. Nishi Gupta	Head-Department of ENT	ENT Hospital, Shroff's Charitable Eye Hospital, Delhi
19	Dr. Evita Fernandez	Chairperson	Fernandez Hospital, Hyderabad, Telangana
20	Dr. G. N. Rao	Founder and Chairman	LV Prasad Eye Institute, Hyderabad, Telangana
21	Ms. K. Sashipriya	Ex. Senior Faculty	Lions Aravind Institute of Community Ophthalmology, Madurai, Tamil Nadu
22	Dr. Vijay Anand Ismavel	Chief Executive Officer	Makunda Christian Leprosy and General Hospital Road, Karimganj, Assam
23	Dr. Ann Anand	Correspondent-Training Programmes	Makunda Christian Leprosy and General Hospital Road, Karimganj, Assam
24	Dr. Roshine Mary Koshi	Medical Superintendent	Makunda Christian Leprosy and General Hospital Road, Karimganj, Assam
25	Dr. Meher Tej Ravula	Director-Retina	Nayana Eye Care, Kakinada, Andhra Pradesh
26	Dr. Col. Madan Deshpande	Chief Medical Director	PBMA's H. V. Desai Eye Hospital, Pune, Maharashtra
27	Dr. Kuldeep Dole	Medical Director	PBMA's H. V. Desai Eye Hospital, Pune, Maharashtra
28	Dr. Chandrasekar Chikkamuniyappa	Founder and Chief Executive Officer	People Tree Hospitals, Bengaluru, Karnataka
29	Ms. Manisha Sanghvi	Executive Director	Sancheti Hospital, Pune, Maharashtra
30	Mr. Pinaki Mitra	Executive Director	Sangath, Panaji, Goa
31	Mr. D. N. Nagarajan	Advisor	Seva Foundation
32	Dr. Rajesh B. Iyer	Consultant	Vikram Hospitals, Bengaluru, Karnataka
33	Dr. Vinay Chandrappa	Associate Dean	Vishnu Dental College, Bhimavaram, Andhra Pradesh

Identifying Enablers and Barriers for Healthcare Organizations to Deliver Equitable Healthcare in a Sustainable Manner

India and many other emerging countries face an uphill task of providing healthcare on an equitable basis to all irrespective of their ability to pay. This is in stark contrast to many developed countries, where good healthcare is guaranteed for all its citizens. India has had several exemplars of equitable eyecare in the form of Aravind Eye Care System, Madurai and L.V. Prasad Eye Institute, Hyderabad, where even the poorest people can have high quality eyecare.

However—barring a few exceptions—outside the realm of eyecare, there have been few success stories with regard to addressing the health care needs for other medical specialties. This project—sponsored by Ernst & Young in collaboration with ISB through the Initiative for Emerging Market Studies (EY-ISB IEMS)—seeks to understand the barriers and enablers for providing equitable healthcare across various medical specialties, including eyecare.

The insights have been garnered through primary research based on discussions with over 30 healthcare leaders spanning different organizations, medical specialties, and geographies in India. It would be of interest to any individual or organization that seeks to embark on the journey of providing equitable healthcare to all its patients, with those who cannot pay being offered the same quality of care as those who can, and yet ensure sustainability of the organization. The key learning from this research is that it is possible to do good, while also doing well.