Webinar on Mainstreaming Equitable Healthcare

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Summarized by Arnaz Dalal

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Mr. Thulsiraj Ravilla said that Equitable Healthcare is about being inclusive (i.e., care for everyone) in design and delivery of healthcare, and to ensure that everyone has access to similar care, in terms of outcomes, benefits and quality of life.

Every government is mandated to take care of the healthcare of its people. However, very few governments are really organized to do so. For example, NHS in the UK is responsible for the health care of the entire country. Oman is another country, which does that. Not many countries are geared to provide health care to everyone, including the United States of America, where healthcare care is a major topic in every election. Hence, we need to recognize that there is only so much that the government can do. Therefore, private players need to supplement the government's efforts to provide healthcare to everyone.

Eyecare problems are very visible. When someone is blind it is very visible and it does invoke a sense of compassion in all. Over a century ago, Dr. Mathra Das, Dr. Rambo, and many other eyecare doctors took it upon themselves to provide eye care to the people. People know that they have an eye care problem, and hence seek help from such facilities. Over the years, many of the eye care providers recognized that they had an obligation to take care of blindness everywhere or at least in the areas where they are serving.

Enablers for providing equitable eyecare:

1. There is a very large need for eyecare. Every human being if they live long enough, will have an eyecare problem at some point in their lives. Once they cross the age of 40-45, they will need glasses, and in their 60s-70s it is most likely that a cataract surgery will be needed.
2. Eye problems do not have a bias. They cut across all economic strata, whether rich or poor. People will need cataract surgery, eyeglasses, etc.
3. Because of the high volumes in eyecare, all the interventions are well-proven, standardized and are cost effective.

When organizations have large volumes of patients and well-proven standard of care, then it is easier to figure out the model of care they want to provide. For example, to provide care for the poor, cross subsidization model could be an option. When the above parameters are applied to the clinical specialties of ENT, Dentistry, Childbirth, Obstetrics, etc., one would realize that it is possible to extend equitable healthcare to other realms of medicine as well.

One needs a high dose of idealism and the right mindset to be able to provide equitable healthcare. This is the foundation. However, the practical considerations soon switch to finances and that becomes one's reality. One can serve the poor by raising money, but that is not sustainable nor scalable. It is best to figure out a way of getting the finances through the earned income.

There are ways this can be done in order to have the wherewithal to provide equitable care:

1. **Closing the care loop**: In eyecare, every hospital loses a significant amount of revenue which is literally almost in their pocket, but they do not realize it because they do not have the mindset of 'closing the care' loop. So quite often, they would do the diagnosis and then leave it to the patient to make the decision to get operated or not. If the patient does not get operated, the organizations do not seem to own the problem. That is because of the way care is designed, not understanding the patient's barriers to access care, etc. In eye care, for someone who has come with a complaint of poor vision and who has been diagnosed with cataract and advised surgery, the acceptance rate could be as low as 40 or 50%. When we do not own the problem or do not do anything about it as a provider, we not only fail to improve the patient's visual status but also lose financially as an organization. It is important to recognize that some patients will be able to pay for the services provided, and designing the services in a manner to close the loop can enhance revenues. Needless to say, that the services should be of good quality and the doctor will need the patient's trust, which is what will make them want to get the surgery done.
2. **Enhanced productivity**: Many hospitals unknowingly spend a lot more than what they need to. This is largely due to low productivity. Healthcare being a fixed cost game, enhancing productivity not only requires better efficiency, but also larger patient volumes. If these two principles are understood and brought to play, i.e., enhancing revenues by serving people better and ensuring that one is not stopping at just a diagnosis and the patients are getting the intervention and getting cured, then it is relatively easy to figure out ways of becoming more efficient, thereby reducing the unit cost of providing care. That is how margins are created that can be leveraged to serve the marginalized.
3. **Contribution vs Profit**: Most providers do not fully understand the difference between the terms, contribution and profit. They decide to treat or not to treat a patient based on whether they are making a profit or not. For example, one organization came forward and said they will be able to provide Rs. 3000 per cataract surgery, which was significantly higher than the variable cost for doing the surgery. At Rs. 3000, you have a contribution of at least Rs. 2000. But many of the hospitals were not interested because they felt that their total cost per cataract surgery was around Rs. 4000 to 5000, and hence they would not make any profits on this patient and hence did not want to provide the treatment. In the process, they missed a huge opportunity to finance their costs through contribution, which directly adds to the bottom line. Unfortunately, very few doctors and providers really recognize this fine difference between contribution margin and profitability. As a consequence, the leadership quite often takes the wrong decisions with regard to treating patients. Where they could actually have had the chance to serve the poor and also make some surplus with it, it is foregone because they did not see profitability in serving those patients.

Providing equitable healthcare at scale and creating impact is not just about personal gratification but also about solving a problem. For this to work, a purpose-driven organization must be built, with all the staff being aligned and committed to the leader's vision. This is not an easy task.

Leveraging the community to play a role in outreach activities such as case detection, enabling screening, etc., could promote equitable eyecare. For example, during normal times, Aravind Hospital would do about 2500 outreach activities annually, which are very heavily community-supported, although the support may not necessarily be financial. The latter put in a lot of effort, arranging for space and volunteers, and taking care of promotion. These activities would have been extremely difficult for the hospital to do, and even if it did them, it would be at a huge cost. Hence, the community is a significant resource, which is seldom systematically leveraged.

Technology is coming up in a big way and can bridge the competence gap. For example, Aravind has 80 primary eye care centers and they are all run by girls with high school education and two years of ophthalmic technician training. Every one of these centers is equipped with a telemedicine setup. Broadband is widely available; in the earlier days, Aravind had to establish its own broadband. Today, that network alone handles about seven lakh patient visits a year and every patient gets a telemedicine consultation. A lot of eye care is visual, involving working with photographs and images. Today, there are powerful image recognition technologies at a very advanced level aiding diagnosis through algorithms or other technologies such as AI. Another skill which is hard to come by is optometry, where the nurses perform refraction and prescribe glasses. Today Aurolab has brought out a handheld automated refractor, which gives results as good as the gold standard. One has to ensure that the right technologies get developed with the right motivation. Technology development has many demands being made by venture capitalists. However, the motivation for the leaders then is to make money.

When the government is looking at public private partnerships, they are expecting the private sector to pitch in and take care of the community as a whole. However, the government assists by providing requisite funding to these initiatives through different mechanisms such as insurance. Ayushman Bharat, an insurance scheme for the poor people, is a good example of this approach.

In conclusion, it is largely the mindset and the intrinsic motivation of the leadership, that comes into play to really define the way we look at who our patients are.

Dr. Ravi Kannan

Director
Cachar Cancer Hospital

Dr. Ravi Kannan said that he had influential role models all his life. His mother wanted him to become a doctor and as child growing-up he would always hear her say, “we must serve the people in need”. During his oncology training days, working with Dr. S. Krishnamurthi, and Dr. V. Shantha had shaped his life, as they were inspiring role models.

The Cachar Hospital was formed by lay citizens of the valley in 1996, who joined together to form the Cancer Society with support from different individuals and organizations. The former Director visited the Cancer Institute in Chennai and spent three months there, post which, he was in regular touch and referring patients. At the Cancer Institute Chennai there was a policy of treating everybody. Nobody was denied treatment because they did not have resources.

When Dr. Kannan left the institute in 2006, he formed a loose group practice with several colleagues. He was at that point invited to come to Assam and join Cachar Hospital. After much pursuasion Dr. Kannan and family finally went and visited Assam in April of 2007. Spending considerable time in the hospital and the community, he realized that there is significant need in the community and this is where he needs to set up shop. Family and friends, while concerned, were extremely supportive of his decision to move from Chennai to Assam to serve the underserved. It would have been a difficult decision to make had he not had this overwhelming support and cooperation of his near and dear ones.

Some of the challenges the Cachar hospital faces while providing equitable healthcare are as below:

1. **Finances:** In the past what the hospital earned was enough to pay salaries of the staff, as salaries were much lower than what they are today. But there has been an evolution over the last 10-15 years and year on year hiking of salaries becomes a problem as no funding agency or individuals are willing to support costs for human resources.
2. **Human Resources:** Getting qualified nurses, technologists and doctors to join them is a huge challenge. And once they join the challenge to retain them in the organization is a mammoth task.
3. **Infrastructure development:** The hospital has to provide standard of care treatment to all their patients irrespective of their capacity to pay. At the same time, they also have to ensure that the costs of treatment are kept low. Cancer treatment infrastructure is very expensive, with drugs, equipment, instruments, surgery, etc. costing a lot of money. Hence, supporting infrastructure is a challenge. They are unable to undertake any infrastructure development on their own.
4. **Poor patient profile:** The patient profile is ill informed and poor. The abandonment rates of treatment are very high. Patients are addicted to tobacco and there is widespread malnutrition. Despite support in terms of treatment, food and lodging, dropout rates are very high. The hospital

has to go through a lot of typical and atypical measures to ensure that they accept and complete treatment.

During his training at the Cancer Institute in Chennai Dr. Kannan thought that if he could provide free treatment, accommodation and food for patients they would all complete treatment. That was the premise on which he started working in Assam. But in 2011 during a data analysis session, they realized that almost 60% of their patients never visited the hospital a second time. And of those who initiated treatment, less than half of them completed the prescribed treatment. The team wondered that if they were doing everything right then why were the patients not completing their treatment? Realization dawned on them as they dug deeper that almost 80% of their patients are daily wage earners and hence, when they earn they eat. If they are away for treatment, there is no food at home. Cancer treatment takes forever to complete. Radiation and chemotherapy take anywhere from two to six months, after which is the time taken to recover from fatigue and side effects. Not to mention the fact that patients have to keep coming back regularly for follow ups. So, by the time treatment is over, almost a year has gone by. This becomes a big barrier for patients completing treatment.

Measures undertaken to overcome the barriers:

1. The Cachar hospital had to put in place a number of measures, from providing adhoc employment to the patients when they are on treatment, to making home visits, to making phone calls, to reducing costs every time they came to the hospital. At the hospital they had a fixed charge of Rs.100 per month, and a patient could make numerous visits within the month at no extra cost. But the challenging part is that they need to visit frequently and shelling out Rs. 100 every month was unaffordable for them. The team at Cachar understood this and introduced a one-time payment of Rs. 500 for the patients after which they did not have to pay for life.
2. A policy decision was taken to not have dual charges at the hospital and that everybody pays the same cost for treatment. As they treat poor people, they ensure that the whole environment is poor friendly. From the décor to the office staff everything is kept to a bare minimum at the hospital and at all points they strive to keep their costs as low as possible. All their staff multitask.
3. They also realized that there is a sizeable margin in the pharmacy, where one could buy a cancer chemotherapeutic drug for Rs 3000, whose cost in the market would be anywhere between Rs.14000 to Rs.15000. They decided that they would buy drugs directly. Even for purchasing in bulk they had a challenge getting drugs at stock rate. When they bought the drug at Rs. 3000 the only additional charge they built in was a 20% charge for the pharmacist's salary and they sell the drug for Rs.3600 instead of Rs. 14,000. Thus, wherever possible they try and reduce the cost of treatment and all their services are deliberately priced low.
4. Today the state funded insurance pays for part of the treatment, sometimes the entire cost of treatment. There are several NGOs such as the Indian Cancer Society, N M Budhrani Trust and several other organizations who come forward and help them in treating the poor patients.

5. With Corporate Social Responsibility coming up in a big way they are able to apply for CSR grants and have companies help them put the infrastructure for the hospital in place.
6. Engaging the community by promoting healthy behaviors to make an impact in the long run is essential. Cancer is caused by tobacco, alcohol, poor diet, lack of exercise and untreated infection. If one looks at cardiovascular diseases, stroke, hypertension, diabetes etc., they are all caused by tobacco, alcohol, lack of proper diet, lack of exercise. If we deal with these common conditions in the community, we will prevent not just cancer but a whole lot of other diseases. In other words, cancer prevention is health promotion and that is a national responsibility. Hence, engaging with the community through ASHA workers and frontline health staff through different projects and agencies is a must.

Today even a disease like cancer can be treated at a low cost. Poor patients can be treated well, and the treating organization kept afloat. The goal is to be self-sustaining through a variety of channels for the operating expenses of the hospital.

In cancer, unlike other specialties, the volumes are low. The results are often uncertain, and a certain percentage of people will not recover from the cancer and will eventually die of the disease. The treatment is not quick; it is often prolonged and expensive. All these factors make cancer care a different ballgame.

But even under these circumstances one can ensure that we practice equitably. And for that to happen one of the key things is for whole team that you work with to be aligned with your mission; everybody must be focused on being pro poor. Every activity that the hospital staff undertakes should be one where the primary objective of the organization is kept above all else.

Being open to suggestions and working collaboratively with other organizations in healthcare and especially with the government is important. It is necessary to be a 'friend-raiser along with being a fundraiser' because there is strength in working together.

Science is advancing very rapidly, and if the products of science are not made available to all in the community, then that progress clearly is not worth it. We need to ensure that everything that is new and beneficial in healthcare must reach the end user.

In cancer treatment one has to have the wisdom in choosing patients because one cannot go about using top end molecules for everybody without thinking whether they will eventually benefit the patient or not. Hence, only when we choose our patients, the technology and the treatment wisely will we actually end up saving money as we move forward.

Dr. Roshine Mary Koshy

Medical Superintendent

Makunda Christian Leprosy & General Hospital

It was in 2013 that Dr. Koshy moved to a very needy part of the country, Palamu district, which is in Jharkhand. She worked in this difficult, Naxal infested place for a year, which was an eye opener for her. It made her ask a lot of questions regarding the challenges that the poor man has in terms of healthcare.

From there she moved to Makunda Hospital in Assam and continues to work there till date. Here she was mentored by two visionaries: Dr. Vijay Anand, who is a pediatric surgeon and Dr Ann Miriam, who is an anesthesiologist. They had come to this hospital in 1993, when it was totally rundown and over the last 27 years have turned it into a thriving community. It is a 200-bed hospital and is a secondary level facility that is valued by the community.

Being able to see role models at work has shaped Dr. Koshy's views and since then she has not found a reason to move out of Makunda. She has always wanted to work in a health facility where the focus is on the poor and the marginalized and where every step and every decision made favors the poor. However, she did not know how it could actually be achieved until she studied the Makunda model. Their healthcare delivery model has a bias towards the poor. They preferentially serve the poor.

She quotes a study by Muhammad Yunus a Bangladeshi social entrepreneur, banker, economist, and civil society leader who was awarded the Nobel Peace Prize for founding the Grameen Bank. He studied many NGOs in Bangladesh, and in his book 'Banker to the Poor' his observations are that all the NGOs that worked for the poor, at some point, added facilities for people who had the capacity to pay, and towards the end the poor get edged out.

The pioneers of the Makunda model took a conscious decision that they would not have different quality or standard of care within the same campus and this has made them really focus on the poor. There are no private wards, the poor and the rich man stand in the same queue, see the same doctor and get the same medicine. When a poor man comes to the hospital, he is not treated differently because of his inability to pay. The fact that the poor man is welcome in their health facility and he looks forward to receiving care from them is what adds value to this model.

Makunda a self-sustaining organization and all their revenues come from their patients. Their volumes help them cover all operational expenses and also save some for new developments. Over the past three years, they have spent around 15% of their income on charity, around Rs. 3.3 crores for the treatment of poor patients. Their donor dependency is less than 1%. Hence, this model is scalable and a viable option for people who want to set up healthcare facilities in rural areas.

Steps to be put in place that can shift the mindset of young doctors to serve in rural India:

1. We need to get students who are studying in medical colleges, the undergraduates and postgraduates, to visit rural India and see the need there. This will help them understand the reality of healthcare for the poor in our country. People dying of preventable illnesses is just not acceptable in this day and age. The students need to understand how the medical profession has failed to cater to the needs of the people who are in desperate need of the same. The Indian Government can make a policy change in this matter and ensure that every student has a rural stint in their academic years. But at the end of the day, it is a personal choice.
2. The training that we get does not necessarily make us good clinicians. In rural areas one does not have the support of all the lab investigations or other support systems available in the urban hospitals to fall back on. That is when doctors find it difficult to cope, because they are not clinically confident of managing patients who come in rural areas.
3. People choose convenience and remuneration while taking career decisions and we know that life in rural areas is far from convenient and lucrative. Healthcare workers who work in rural areas are very likeminded, think a little more about purpose of life and do not believe that remuneration and convenience is all there is to life.
4. There is a misconception that you cannot academically excel when you are in a rural place. In Makunda or in Palamu, there are so many areas where one can ask relevant research questions and work to address those. And working in a place where you do not have a backup makes you want to think of innovative ways of trying to address these issues.

Challenges to providing equitable healthcare:

1. Human resources will be an ongoing challenge and a bottleneck for resource poor areas. Finding people who are like minded and who are willing to think from the poor man's perspective is an arduous task. They should also be willing to put their own personal wants aside and only look at catering to what the community needs.
2. There are numerous benchmarks set by accrediting organizations. For example, the Clinical Establishment Act is very strictly followed in Assam. This Act states that a hospital conducting deliveries, a physician, an obstetrician and an anesthetist need to be present. Statistically speaking the country does not produce so many consultants. The criteria used in city hospitals where there are sufficient resources available cannot be applied to resource poor settings. In resource poor settings there has to be some amount of flexibility that should be shown by quality councils. And they should acknowledge the fact that the organizations which work in these settings have their own model, their own business plan, and that is how they have managed to be sustainable. The one size fits all approach will hamper people and organizations who have innovative ideas; the Government needs to look into this aspect very seriously.

People should start talking about the challenges of the poor, about the opportunities that are available, and the benefits that one gets by working in rural and backward setups. Challenging people with realities is the way forward to bring them into the fold of providing equitable healthcare.