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Innovations in Rural Healthcare Delivery: Exploring New Synergies

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An initiative by

MART Knowledge Centre

MART Knowledge Centre organised Roundtable on 'Innovation in Rural Healthcare Delivery' on 25th November 2011 in New Delhi.

Rural India accounts for 67% of the Country's population but has only 25% of the healthcare Centres. 80% doctors, 75% dispensaries and 60% hospitals being located in urban areas catering to only 33% of the population. The first rural health sub centre is located at 5000 population (only 3% of villages have more than 5000 population); it means 97% of the villages do not have any health care facility. The first doctor is available only at Primary Health Centre in a 30,000 population town. Studies reveal that 30% of rural population travels more than 30 kms to seek health services. The expenditure on travel to access healthcare alone amounts to 30% of the total health care expenses.

Till now government was the predominant health service provider in rural areas. But with rising rural incomes and ability to spend more on better health care, this opens up a new business opportunity for the private sector to meet this growing demand for rural health care in India.

Objectives

- Share and learn from innovations undertaken in rural health care delivery
- Explore horizons for collaboration to innovate for quality rural healthcare services

Mr. Pradeep Kashyap, CEO, MART delivering the keynote address highlighted a few important pointers about the rural economy. As is well known the Indian economy shall grow to about USD 4 bn by 2020 making it the third largest economy of the world. A significant part of the growth will come from the rural sector. He stressed the fact that with rising income levels and prosperity of hinterland India, the much talked about pyramid with a flat base would change shape and character to become a diamond with more people in the middle. Presently there are 400 million people at the base of the pyramid with income less than USD 1 per day; 350 million moderate income segment population lying in the USD 1-5 per capita per day and 50 million high income people having more than USD 5 per day. The poor will shrink to 250 million and the middle income segment will expand to 500 million and finally 150 million to rich segment. As the income level rises, demographically these consumers start demanding more aspirational products and services which need completely new processes and skills by the private sector. This would mean a complete transformation from present levels of 80% health services provided by the government and 20% by the private sector to about 20% by government and 80% private. The rural healthcare sector will grow 128% over the next decade.

Mr. Kashyap outlined three key challenges – Affordability, Skilled man power and leveraging existing social infrastructure. He advocates the need to find solutions through a process of community co-creation.

Rural Healthcare: Structure & Challenges

Dr. Tarun Sheen, a career bureaucrat and who till recently had been on deputation to the PHFI tried to give a governmental perspective to expectations from the National Rural Livelihoods Mission (NRHM). The NRHM has been developed as a broad spectrum reform agenda and not as a simple project with a start and an end line, is designated to work on a community needs assessment approach and works with on a mission mode. Explaining the NRHM expectations of a 3-dimensional plane, Dr. Sheen said that the X-axis focuses on entitlement and not just inputs or infrastructure; the intersectorality on the Y-axis that offers convergence, and decentralisation on the Z-axis. These three coordinates define the big picture expectations from the NRHM on various dimentions.

Ms. Sheena Chhabra, Team Leader, at USAID highlighted access as the critical issue for developing a sustainable rural healthcare delivery model. Quoting the latest round of the National Family Healthcare Survey she said deterrents like large distance to the healthcare facility, unavailability of transport or lack of healthcare providers and drug availability forces nearly half of the rural population remain out of the healthcare network. As a result there exists only one Primary Healthcare Center (PHC) for every 30,000 residents or only one of five villages has a PHCs. Rural population has to either depend on the semi-skilled Rural Medical Practitioners (RMPs) for minor ailments or the private nursing homes in town and cities for major health ailments. This is an incomplete and irrational business oriented approach to healthcare rather than providing a holistic healthcare approach with an underlying business value proposition at play in the health sector. Outlining the major challenges for providing affordable quality healthcare she stressed on the need of a changed mindset of planners looking for increased integration of various policies at the central and state level and leveraging the already existing network of healthcare professionals like the ASHA worker to deliver healthcare program.

Ms. Sumedha Sen, Director, HOSMAC India Pvt. Ltd, highlighted how in absence of the desired level of health infrastructure the rural population has to bear about one and a half times more expenditure on healthcare. Dilapidated state of infrastructure, poor supply of drugs & equipments and rampant employee absenteeism (national average is 40%) in governmental healthcare setup is a major reason for rural people to look for more expensive options leading to overall poverty. To improve the situation, she suggested a ‘wish-list’ of the government investing in facilities where the private sector is unwilling to venture given its urban bias and to introduce short term vocational courses dealing in primary healthcare to create a new cadre of technically qualified village based healthcare professionals.

Challenges in Quality Health Service Delivery (Affordability & Accessibility)

Mr. Daljit Singh, President, Fortis Healthcare, speaking on the topic of 'Sustaining quality healthcare services for BoP consumer segments' in his capacity as Managing Director of the largely small town focused Fortis Healthcare also stressed on the triangle of affordability, accessibility and availability paradigm needing to converge operating either in an upmarket Delhi or an interior Kanpur Dehat market. On an earlier raised issue of the commercial players' urban bias, Mr. Singh observed that the absence of adequate living quality infrastructure that restricts most corporate initiatives to penetrate the hinterland territories. As a group with a rural India focus Fortis has been consciously trying to provide its personnel with decent living standards to allow them work in the remote locations. Healthcare is still a new space for private players unlike other domains like consumer goods. But with increasing maturity of the market, the big players would gradually start moving into the Tier 3 and Tier 4 towns and villages. Mr. Singh outlined four key challenges: the first challenge is a less than perfect understanding about rural India and its needs. For a large group like Fortis, it means a difference of disease profile of the people – while the urban sector (from where corporate groups come) require largely tertiary care support involving huge investments, rural sector primarily need basic healthcare like vaccination, paediatric and curative care facilities. Second, availability of skilled manpower is crucial for which Fortis tries to develop local resources with less dependence on outside supply. Transporting existing manpower from cities to towns has been historically more expensive as people need to be compensated adequately enough for relocation. The third challenge is about standardising processes to make them sustainable and scalable across locations.

Mr Singh emphasized that the fourth critical aspect is about maintaining minimum quality standards as the sector is extremely fragmented with small hospitals and nursing homes operating with less than 30 beds which has sprung up in a very unregulated manner. The fifth challenge is about building adequate infrastructure that not only allows the big players to remain competitive but also ensure low cost. A lot of intelligent planning can help in this regard like relocating the phasing out equipment and technology from cities to towns, appropriate layout designing etc.

Mrs. Rashmi Asif, Director, JHPIEGO speaking on the issues of challenges of quality health service delivery brought attention of the participants to a new dimension – knowledge management of upgrading skills for the paramedic staff like the ANM midwife and the ASHA worker. Inspite of the availability of a large support staff at the village level, the health indicators have not improved in line with the Millennium Development Goals (MDGs. This made the government frame new technical upgradation and skill building courses and modules, but unfortunately tied up in red tape and biting dust either at Ministry level or the district Chief Medical Officers' level and not reaching the technical providers for whom they are actually meant. Thus, there is no dearth of information but getting it to action is something which is lacking. During

implementation of the training program it was further found there is no correlation between training material and actual practice leaving the users like ANMs with only theoretical knowledge. This challenge was addressed through an initiative of Indian Nursing Council with support from USAID and Jhpiego. The initiative was to strengthen pre-service education of nursing and midwifery in India, by building capacities of ANM trainers according to the new roles and skill requirements for maternal, new born and child healthcare. This capacity building focused on clinical practice under supervision before they passed out.

Mr. Navin Bhatia, Executive Director of Navkar spoke on the convergence of the micro and macro scenario of the health sector from a learning perspective by concentrating on 4 Ps: People, Policy Advocacy, Profits and Partnerships. With a fast growing economy and majority young population needing jobs, the country faces serious skill challenge for its employable population including the health sector. There is lack of occupational quality standards in the healthcare sector. There is also a need for Policy Advocacy for creating a cadre of healthcare professionals that would bring in a lot of respectability and aspirational content to the job of trainer and reduce the shortage of quality trainers. Much of the buoyancy of the Indian economy is fuelled by the entrepreneurial and risk taking ability of the rural youth and needs to be leveraged upon for creating a viable business model. Lastly, given the scale of the skill challenge, no single corporate group can alone meet up the challenge and requires partnership among the existing players to reach the figures. The health sector can learn from the mobile telephony experience.

Innovations in Health Service Delivery

Speaking about the GE experience, a major equipment provider, Mr. Ravi Kaushik, Director, GE Healthcare shared the GE transformation story from a large equipment, high margin, small volume and big city paradigm to simplified equipment, less expensive, large volumes targeting small cities mindset. Using the same engineers who built the expensive machines and new consumer insights in association with MART, GE is unlearning and re-learning new ways of doing business and exploring new synergies. While it initially concentrated on de-featuring products to sell in rural India, it is now finding ways to be at least 15 percent less expensive to the actual service user than existing options to create win-win. So while GE innovates with latest technology, policy advocacy for better technology usage to improve health parameters and quality training of the paramedic staff is done in partnership with local resource partners.

Mr. Saroj Mohanta, Partner, MART, shared the Arogya Parivar, a ‘last mile’ health service delivery model to reach rural health consumers, a model co-created by MART for Novartis Healthcare. He related the success of the program to making available reliable and quality healthcare services for treatment of tuberculosis, at

an affordable price to the patients. The model ensured that the patients completed their treatment and got fully cured. The program created a network of qualified healthcare providers in the private sector, under the Arogya Parivar, to offer the healthcare services. This was necessary as qualified doctors, diagnostic centers and chemist stores, available in rural are limited. The handholding and monitoring of the patients is managed by a battery of 'health educators' (HE), rural youth trained by company to become the 'last mile connect' for the program. The HE is an entrepreneur who earns from sale of medicines in his territory. The company has created a new business vertical and earns from additional sales.

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