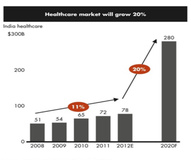
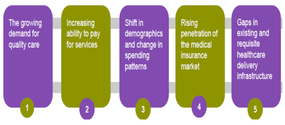
An Analysis of Level of Patients Compliance To Advised Ultra Sonography Investigations

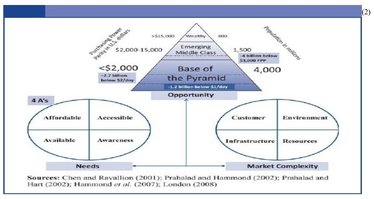
INTRODUCTION:

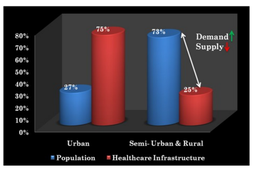
Health care has become one of the country's largest sectors, both in terms of revenue and employment – and its growth is slated to continue.(1) But healthcare facilities are extremely fragmented, According to a report by UN,75% of health infrastructure in India including doctors and specialist and other health resources-is concentrated in urban areas where only 27% of population lives. This creates a huge demand-supply gap in semi-urban and rural areas. So, access to high quality and affordable basic healthcare services is one of the **key challenges** that rural and semi-urban population faces. This need presents significant opportunities for the private sector and sound business model enterprises to innovate and scale. (I.e. making profits but at the same time making a significant social impact)



Sources: India Brand Equity Foundation; WorldBank







"MAJOR NEED = MAJOR BUSINESS OPPORTUNITIES"

'SPOKE AND HUB MODEL':(3)

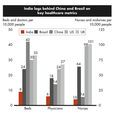
It is a concept of central hospital with ambulatory care offshoots. In order to reach the masses of people in need of care, Indian hospitals create hubs in semi-urban areas and open smaller clinics in more rural areas which feed patients to the main hospitals. This tightly coordinated web cut the cost significantly by concentrating the most expensive equipments and expertise in the hub rather than duplicating it in every village. Moreover performing high volumes of focused procedures creates a wealth of skill human resource that will improve quality.

- Offers services and facilities to the wider community.
- Links smaller less cost effective schemes to a larger network of resource making them more sustainable (both in terms of shared cost but also in providing a full range of services)

'CAPACITY BUILDING AND TASK-SHIFTING': (3)

"Necessity is the mother of invention"

Since India is dealing with chronic shortage of doctors, nurses and paramedical staff.(1) This shortage increases by multiple times in rural counterpart making the healthcare delivery in rural areas crippled.(4) With widespread nurse shortages, treatment cannot be monitored, waiting times for any treatment are prolonged, patient education is not delivered and patients wait in crowded rooms or sleep on floors. So there is a need to come up with a strategy to address the



Bulletin on Rural Health Statistics, (BRHS) of the Ministry of Health and Family Welfare, there are out of March 2008).

CAPACITY BUILDING/LOCAL ENGAGEMENT MODEL:

Refers for building necessary skills, in-house training programmes for training locals as nurses and paramedical staff i.e. engagement of local community in carrying a business operations, thus, also helps in building a long-term relationship with the community.

- Cost-effective
- Provides employment to locals
- Builds trust and transparency
- Healthcare awareness ecosystem which will lead to preventive healthcare

TASK SHIFTING:

Task Shifting involves the rational redistribution of tasks among health workforce teams. Specific tasks are moved, where appropriate, from highly qualified health workers to health workers with shorter training and fewer qualifications in order to make more efficient use of the available human resources for health.
For Example:
When doctors are in short supply, a qualified nurse could often prescribe and dispense healthcare services. Further, community workers can potentially deliver a wide range of healthcare services, thus freeing the time of qualified nurse

However, task-shifting alone is not expected to resolve the health workforce crisis, it should be implemented along side other efforts to increase the number of skilled health workers.

- Has increased health workforce capacity at the speed necessary to respond to the increased healthcare services needs
- Positive contribution to overall health system strengthening.

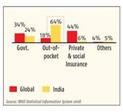
The above two innovations are jointly used by several organizations as a cost effective way to meet the health work force crisis in rural areas. After shifting tasks from doctors to nurse practitioners and nurses, several hospitals have even created a lower tier of paramedic workers with two years training after high school to perform the most routine medical jobs.

"RSBY" AND "COMMUNITY BASED HEALTH INSURANCE":

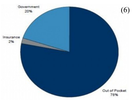
Indian health sector faces severe resource crunch and the government health spending is very less, resulting Out of pocket health expenditure is as high as 78%.(6)

Roughly 39million (3.9%) falls below poverty line due to high medical bills. (7)

Around 30% (2004) in rural India didn't go for any treatment for financial constraints. In urban areas, 20% of ailments were untreated for financial problems the same year.(7)



Source: WHO Statistical Information System 2006



RASHTRIYA SWASTHYA BIMA YOJANA:(8)

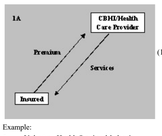
Introduced on 1st April 2008 by ministry of labour and employment, GOI, the scheme provides health insurance to BPL households. Beneficiaries under RSBY pay a premium of Rs.30/- as registration fee and are entitled to hospitalization coverage of up to Rs. 30,000/- for most of the diseases.

Unique features:

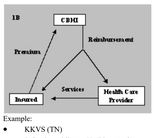
- **Empowering the beneficiary:** provides participating BPL household with freedom of choice b/w public and private hospitals.
- **Cashless and paperless transactions:** a beneficiary of RSBY gets cashless benefits in any of the empanelled hospitals. For participating providers it is a paperless scheme as they do not need to send all the papers related to treatment to the insurer.
- **Portability:** beneficiary who has been enrolled in a particular district will be able to use his/her smart card in any RSBY empanelled hospital across India.
- **Safe and pool proof:** the use of biometric enabled smart card and key management system makes this scheme safe and pool-proof.
- **Information technology intensive:** for the 1dt time, IT application are being used for social sector scheme on such a large scale.
- **Business model for all stakeholder:**
- **Robust monitoring and evaluation:**

COMMUNITY BASED HEALTH INSURANCE:

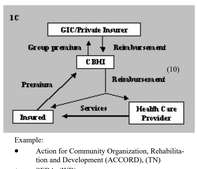
It is a mechanism that allows for pooling of resources to cover cost of future and unpredictable health related events. Targeted community is involved in defining contribution levels, collecting mechanism and content of benefit packages.



Example:
- Voluntary Health Service, Madurai (TN)



Example:
- KKVS (TN)
- Raigarh Ambikapur Health Associa-



Example:
- Action for Community Organization, Rehabilitation and Development (ACCORD), (TN)
- SEBA, (WB)
- SEWA (GJ)
-

Considerations:

- Diversity: (in terms of health & wealth, size and growth of member population) to optimize risk sharing, diversity is preferred so that there is cross subsidization of re -imbursement (increases financial sustainability)
- Potential return per rupee of premium paid.
- The maximum amount reimbursed for hospitalization in absolute terms.
- Inclusion of maximum diseases.
- Scheme should provide reimbursement during the utilization of services.
- Credibility of organization, so that there is increase faith, trust and participation of community members.

Factors underlying failure :

- Insurance scheme provide insurance for fixed amount, cost above which have to be bear by insured
- Most of the scheme provide the re-imbursement only after the insured has paid the hospital out of pocket
- Lack of awareness and knowledge about the insurance scheme that an insured has
- Poorest of the poor do not join the CBHI because they will not be able to afford premium.

"WE CAN REDUCE COST NOT BY PROVIDING LESS BUT PROVIDING MORE, MORE EFFICIENTLY"

NO-FRILL APPROACH AND LEAN ORGANIZATION STRUCTURE:(3)

No-Frill Business operates on the principle that by removing luxurious additions, customers may be offered lower prices.
So, this approach is used to reduce non-core expenditure on hospital infrastructure set-up like,

- Locations in semi-urban cheaper areas
- Having building on lease
- Building ultra low-cost facilities i.e. strip out air-conditioning, ventilation through large windows, having rooms with only essential items, having equipments on rent.
- Short term agreement with suppliers
- Outsourcing of allied activities.

Lean organization is committed to its customers, aims to refine processes, reduce waste and deliver value to customers.

- Minimum administrative involvement of specialist.
- Girls trained as nurses & Para-medical staff and Task shifting.
- Extended working hours of doctors and extended availability of OT's.
- Training visitors for post-operative care.
- Investments are carefully considered and only made when it is clear that a long-term financial advantage exists in doing so.
- Experimentation and continuous focus on technology and innovations.

ASSEMBLY LINE APPROACH:(3)

It reduces the time of surgery and increases the number of surgeries. As you do more numbers, results get better and cost goes down.
It has done this by using nurses and paramedical staff for the preparatory and post-operative work on each patient and by restricting surgeon's job to surgery and not the patient entire process.
EXAMPLE: (From: Aravind eye care)
To boost patients throughout, Aravind's surgeons would need to also boost efficiency. They devised an 'assembly-line' approach to surgery, delegating ancillary tasks so surgeons gets in, operates and get out.

There'll probably be 10 gurneys lined up outside the operation theatre. Someone will wash the eyes, someone will put in the eye drops. And the patient is then led into the operating room, where nurses do all preparations. Around 5 surgeons would move back and forth between the 10 or so operating tables. They finish one and the next patient is set up.

STANDARDIZATION OF PROCESSES:(3)

Standardize everything-systems, departments, equipments, services etc.

EXAMPLE: (From Vatsalya Healthcare)

All 5 hospitals of vatsalya healthcare have the same equipments, services, processes which means higher interchangeably and easier maintainance.

When machine break down, parts can be transferred from one hospital to another. Technicians can handle equipments iat any of these hospitals. Nurses can be transferred and fit right in because everything is standardised.

CONCLUSION:

"Never restrict demand, Build your capacity to meet the demand".
As India advances its healthcare delivery system to create a wider delivery base, we need many more such models.
However, the healthcare services organizations displayed the common intent, objective and passion of creating and ecosystem to deliver the inclusive healthcare services to the poor. The key aspect which was found missing and needed attention was that most of these successful business ventures were operating individually. Considering the complexity and magnitude of health services required, it would be better to integrate the individual healthcare organization into a uniform network. This development of integrated ecosystem of inclusive healthcare is required to maximise the reach & impact and resolve the scalability limitation.

KEYWORDS:

- Base of the pyramid
- inequitable demand supply gap
- emerging market, opportunities
- innovative self-sustainable business models,
- inclusive healthcare services
- shared value

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