According to the World Health Organization (WHO), 285 million people are visually impaired globally and nearly 40 million are blind. Alarmingly, 90% of these individuals reside in developing countries. While many of these cases—as much as 80%—can be prevented or cured, high prices and low availability of eye care services transform mild impairments into irreversible blindness. But there may be light at the end of the proverbial tunnel. The WHO has actually noted a decrease in the prevalence of infectious disease-related vision impairment in the last 20 years, and numerous innovative programs are joining the fight against avoidable blindness and transforming eye care for the poor in remarkable ways.

It is impossible to talk about innovations in pro-poor eye care without mentioning the Aravind Eye Care System. Its history has recently been chronicled in a book, *Infinite Vision*, cowritten by the grandniece of Aravind’s founder, Dr. Venkataswamy. The much lauded India-based hospital chain is the largest supplier of eye care in the world, performing about 1,000 surgeries a day and restoring sight to 12 million people since its founding in 1976. What’s more, while the non-profit model earns enough revenue to be self-sustaining, the vast majority—approximately 70%—of its patients receive care for free. Aravind may be the grandfather of eye care innovation, and indeed it is one of the oldest innovative models profiled in the CHMI database, but it is operating in good company. CHMI profiles 36 programs improving the accessibility and quality of eye care in the developing world. An overview of these programs’ basic characteristics is displayed in the chart below.

**Reducing the cost of care through higher volumes and cross-subsidization.**

Pioneered by Aravind and others, a significant number of eye care facilities are employing the standardized high-volume operational model to lower the cost of services. LV Prasad and Sadguru Netra Chikitsalaya in India, the new SalaUno clinics in Mexico, and the Lumbini Eye Institute in Nepal all provide services through
the low-cost, high patient volume model. For example, staff at Lumbini’s 125-bed hospital performs up to 170 eye surgeries daily, accounting for 25% of all sight-restoring surgeries in Nepal. But the high-volume model alone does not make care affordable to the very poor. Complementing it are a variety of cross-subsidization schemes, quite common among pro-poor eye care programs, that charge full fees to patients able to pay in order to cover the cost of care to the poor. Of the eye care programs profiled by CHMI, at least 30% employ some form of cross-subsidization to cater to those unable to pay. Pakistan’s Al-Shifa Trust Eye Hospitals, for example, have treated 70% of their patients free of cost. Meanwhile, paying patients at Sadguru Netra Chikitsalaya—just about half of the total patients are charged fees based on a sliding scale—allow the hospital to provide free services to the poor.

Improving the availability of care through mobile outreach.

While affordable eye care is becoming increasingly available to the urban poor through large hospitals or chains of clinics, services are still slow to reach rural and remote areas. To mitigate this problem, a number of hospitals are sending ophthalmologists into hard-to-reach areas through mobile outreach programs. In Bangladesh, Chittagong Eye Infirmary & Training Complex has organized hundreds of mobile eye camps which have treated over 7.5 million people. India’s Pushpagiri Eye Institute, a facility dedicated to treating various forms of preventable eye diseases with a special focus on diabetic, childhood, and corneal blindness in Andhra Pradesh, organizes outreach clinics, approximately 10 per month, and treatment camps in the state’s rural areas. Several independent programs—those not operated by base hospitals—are also helping to provide care to the rural poor. In Kenya, LIHEAL operates mobile eye units that run fifteen eye camps a year. The units screen for diabetic retinopathy and provide eye examinations, follow-up care, and laser treatment at an affordable rate.

Earning a profit while serving the poor.

Although eye care is a significant problem afflicting the world’s poor, it has never been a donor darling, particularly when communicable diseases continue to kill millions of people each year. In light of the relatively low influx of donor funds, a number of organizations—both non-profits such as Aravind as well as for-profit groups—have developed innovative revenue-based cost-recovery models, all the while providing care to those unable to pay. Several for-profit eye care chains are now catering to those willing to pay a small sum to receive quality care and avoid the long-lines and variable service quality customary of public hospitals. In Guatemala, Visualiza’s three hospitals offer eye care at an affordable rate to the poor, focusing on preventable blindness, cataracts and ametropia. Although it charges fees about one third of the market rate by utilizing a high-volume model and employing other operational efficiencies, Mexico’s SalaUno is also catering to those not able
to pay by partnering with a local cinema to provide 100 free surgeries per month. The company currently operates one pilot clinic and plans to open three more in 2012.

These programs are just a subset of the innovative eye care models operating globally and large-scale initiatives such as Vision2020 are aiming to prevent the estimated doubling of avoidable vision impairment by 2020. As we gather more data about the universe of health market innovations, we will continue to track trends and highlight new insights gleaned from analysis of the aggregate.

Caveat to these preliminary conclusions: CHMI’s data collection methodology and relationships with partner organizations in specific countries may result in data collection biases. Furthermore, CHMI uses the “eye care” tag only for programs that have a particular focus on eye care services. We acknowledge that many programs provide eye care as part of their general primary, secondary, and tertiary health care services. Finally, CHMI cannot attest to the efficacy or impact of individual models.

*Photo at top: Patient waits for cataract cake with SalaUno, Mexico. Photo credit: SalaUno