Urban Primary Healthcare and Private Sector in India-

A brief analysis of Kriti, Swasth India and Viva Sehat

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Primary health care in India is often associated with rural health services as the public health system there is more structured. The government's investments in infrastructure and human resources have been focused on rural areas with about 69 percent (Census, 2011) of the Indian population residing in rural areas. In the process, the urban poor have in many places been overlooked. In India 377 million[1] people live in urban places, out of which an estimated 97 million people live in urban poverty. Rapid urbanization and the significant growth of urban poor population in absolute numbers already have new demands on the available infrastructure and service delivery mechanisms. The urban poor are a mix of people living in slums and the homeless. Urban poverty is characterized by food insecurity, varied morbidity pattern, poor access to drinking water and sanitation, high costs of living and job insecurity. All these aspects affect the health seeking behavior of the urban poor and in general the health.

The primary care in urban areas, is dominated by the single practitioner clinics and unqualified practitioners. The markets where these providers operate are fragmented and unregulated. The quality of care is also questionable. In a recent study of private providers in Delhi revealed that the quality of care is low in the poorer neighborhoods. The care differed with difference in incentives (income and reputation) and competencies amongst the providers.[2] It was also noted that rich availed the services of the more competent doctors and the poor had access to lower quality of doctors.

Though the urban poor are not restricted geographically in accessing these health facilities, lack of money is a barrier to care. The recent government sponsored health financing schemes, such as Rashtriya Swasthya Bima Yojana (RSBY)[3], have shown some respite to people but it is still too early to comment on the impact of the schemes and these generally do not cover the level of primary care where most diseases are treated.

In the recent years, there has been an attempt to reduce fragmentation of the private providers in health and improve access to good quality affordable care. The health care delivery of three such initiatives are presented and discussed in this paper. The organizations are Kriti clinics (Hyderabad), Swasth India (Mumbai) and Viva Sehat (Andhra Pradesh)[4].

Service delivery and primary care

The definition of primary care and the importance was detailed by the Alma Ata declaration of the United Nations and the Bhore committee recommendations for India (1946). It includes a wide

[1] Census 2011

[2] Das, Jishnu and Hammer Jeffrey S., Money for Nothing: The Dire Straits of Medical Practice in Delhi, India (July 2005). World Bank Policy Research Working Paper No 3669. Available at SSRN: http://ssrn.com/abstract=779077 or doi:10.2139/ssrn.770977

[3] RSBY is a government-run health insurance scheme for the Indian poor which provides for cashless insurance for hospitalization in public as well private hospitals

[4] Annexure 1 for comparative matrix

range of services such as preventive, curative, promotive and rehabilitative care. Several national disease programs, family planning programs and other centrally sponsored programs are all part of this. The government established a system to ensure access to the fundamental primary care services at primary health centers. Each center covers a population of 30,000 in the rural areas. The health workers[5] working in these centers are required to deliver curative care, fulfill the targets of the national program and also supervise the activities of their subordinates. The multitude of activities and focus on national programs has diluted the focus on comprehensive primary care services. The chronic absenteeism of doctors has further disrupted the services. People often relate primary health centers to the many vertical programs such as immunization, tuberculosis, malaria and others. For curative care, they usually access the private practitioners[6]. An urban post is the urban equivalent for primary care. Some of them were created with the World Bank funds from India Population Project V and VIII in six cities. Though the service delivery improved, the services at these centers are inadequate with a lack of human resources (National Urban Health Mission – Draft report). The poor either end up visiting a non-qualified practitioner (quack)close to their home or a chemist and in severe instance a general physician. This means that most often than not, a preventable condition becomes complicated requiring more resources. Recognizing this need for basic curative services, organizations like Kriti, Viva Sehat (formerly Razi) and Swasth India have designed models in the attempt to address it.

Kriti did not begin with the objective of providing healthcare for the slum population. Neither did Swasth and Viva Sehat. The founders of Kriti wanted to improve the lives of the slum dwellers of Hyderabad but did not know where to begin. They carried out a detailed market research that helped them narrow down their focus of health, education and livelihood.

A Singapore based investment firm was scouting for investment opportunities in the Indian healthcare sector but found none that suited their interests. They had the experience of incubating a company for affordable schools (establishing new schools and taking over existing schools). This experience inspired them to adopt similar strategy for healthcare. They carried out market research to understand current health seeking behavior and expenditure. They used the information to develop a business model for a chain of urban primary care clinics - Viva Sehat. This company was then incubated by the investment firm.

For Swasth India, the story differed a little. One of the founders was working at a consulting firm researching comprehensive health care including insurance, preventive care, out-patient care. End of the work, the research remained a report. Itching to do something about the challenges and opportunities identified, he quit the firm to test the concept and started Swasth India along with a friend in 2008. They spent a few months meeting various stakeholders in western and southern India understanding what people understood by comprehensive care. From these they concluded wanted insurance providing cashless services for hospitalization, out-patient care at up to 50 percent discount and preventive services. Partnering with a local NGO in rural Maharashtra, they tested this concept. They partnered with hospitals for cashless services, with doctors who agreed to provide discounts on consultation and diagnostics and have procured a distribution license for drugs. But the prevention side was challenging as this involved changing the attitude towards health seeking behavior. They engaged health workers for preventive care and who also doubled up as health

[5] Includes doctors, paramedics and community based health worker

[6] WHO Country Office for India, Not enough here, too many there: Health Workforce in India. 2007 (p42)

insurance policy agents. The health workers were not able to assume the dual role and a separate cadre called network facilitator for insurance had to be created. Swasth did a number of changes based on their experiences from the pilots but they were unable to scale the model. This was because the local NGO was not sufficiently committed as they also provided other non-health services and had capacity for only so much. Health was not their primary focus. This was a challenge, as the consumers did not know Swasth. Swasth decided to mitigate the risk of working through an intermediary, to be involved in the entire chain of services and hence decided to shift base to Mumbai slums. They still needed to gain people's confidence and this they decided to do by creating primary care clinics in 2011. The clinics were the need of the hour and Swasth saw this as an opportunity to serve people, gain their trust and build the brand of the organization in the community.

Kriti, a Hyderabad based NGO first started its clinic in a notified slum in 2009. The market research[7] conducted helped them design their health delivery system. A basic clinic with a physician, pharmacy shop and tie up for blood tests formed the base. This is similar to Swasth India (2011), and Viva Sehat (2009). All three clinics employ a doctor who functions as a family practitioner (single doctor for all ailments) and a nurse. None of the clinics has in-patient facility. They only dispense generic drugs, have computerized health management information system and work with the government authorities to facilitate national health programs such as immunization (Swasth and Kriti). For the diagnostics, Kriti and Viva Sehat have tied up with private laboratory services and the clinics act as a collection point. The nurse in the clinic is trained to draw blood and collect other samples. Swasth has their own technician for basic diagnostics who and tied up with laboratories for other tests. They have some rapid tests at the clinic itself. All the clinics are uniformly branded for easy recognition and kept clean.

The location of clinics operated by Kriti and Swasth are within easy access to the slum dwellers. Viva Sehat clinics are not targeting the poorest but the lower middle income population and the clinic are located in highly densely populated areas. All three organizations cite a need of 30 patients per day, on average, to break even. The location becomes crucial to ensure the needed patient volumes. Kriti's first clinic was located in a highly populated slum but on a street that did not have many people passing through. The clinic did not receive the needed volumes of patients and Kriti had to relocate the clinic to a more accessible place. Swasth recognized a clinic close to a market place or bus-stop would attract patients and they carefully choose the locations. The clinics of Kriti and Swasth cater to an average population of 30,000, similar to that of a primary health center in the rural areas.

All the three organizations' network of clinics provides holistic outpatient care without any focus on any specific disease. Kriti has trained community based health workers to create awareness among woman and child health. Swasth plans to include screening services for non communicable diseases such as hypertension and diabetes. Swasth has one bed for day care such as intravenous administration and charges close to one US dollar as bed charges. A pharmacist is present in Viva Sehat and Kriti but at Swasth it is a doctor who dispenses medicines. All three organizations have tie-ups with specialists that visit the clinics on a fixed day basis. For any kind of inpatient care, the

[7] Refer Annexure 1 for highlights of the research

patients need to avail the external facilities. There is no specific referral system designed. Kriti has identified a few hospitals but the first preference in most cases is the public hospital.

Quality is ensured by developing protocols for treatment and other administrative activities. Uniform standard of protocols are not only good to check for quality but also useful for scaling. Of the three, Viva Sehat currently is the only clinic that has clinical protocols with an advanced system of capturing patient data uniform across its clinics. Both Kriti and Swasth are developing clinical protocols. All three organizations consider the selection of staff to be an important quality measure and they are careful when selecting doctors and other staff. Kriti has engaged experts to develop content that is used to train the community based workers. Swasth has an IT system that helps in capturing the patient data and also of all cash transaction. In addition they have a system of obtaining customer feedback over the phone. The database of electronic patient records and the customer feedback are the two sources of information used to monitor the services and ensure quality of care.

Demand generation activities

All the clinics have been set up with aim of self sustainability. For Swasth and Kriti the cost of setting up the clinic was in the range of INR 100,000 to INR 150,000 while for Viva Sehat it was nearly five times that cost. This could be attributed to the fact that the population it caters to is not from the slums and hence the clinics are designed to attract the middle class clientele. The location of the clinics could also contribute to higher rentals. The monthly operating expenses for Viva are not known but for the Kriti and Viva Sehat it is in the range of INR 45,000 to INR 50,000 per month. To break even an average of 30 patients per day would be required for Kriti and Swasth. But the 30 patients per day is not an easy task. It is difficult to compete with the already existing practitioners (qualified and unqualified). These providers gained the community's confidence and built their reputation over a period of time. The acceptance of a new player takes time. In Kriti's case, the unqualified healthcare providers were preferred as they charged as per the patient's ability to pay. Also indiscriminate use of high antibiotic doses and steroids brought immediate relief when compared to a doctor treating with appropriate drugs which took a longer time. The people of the community did not understand the harmful effects of the steroids and a delay in cure was perceived as poor quality of care. The existing practitioners would charge according to the ailment and bundle the cost of the medicines into it. But at the Kriti clinic, the consultation remained the same irrespective of the ailment and medicines had to be purchased separately. This was something the slum people were unused to.

All the clinics faced the challenge of generating the needed volumes of patients. The challenge was most commonly due to unavailability of a good doctor but also due to lack of awareness of these clinics. For awareness creation Viva advertised about the clinics using media. For Kriti it was health awareness camps and vouchers. Swasth introduced a pre paid health card that entitled patients to a further discount on consultation fees and medicines. These strategies have helped them to attract patients but the biggest attraction is the popularity of the doctor and it takes time to build the needed trust in the community.

Affordable care

One of the major barriers in accessing care for the poor has been money. Good affordable care especially in primary health is scarce. Many doctors are aware that the patients would not turn up for a follow up visit nor take the medicines prescribed. Most of them consult a doctor only when the condition has worsened and is affecting their daily work. Most people consult unqualified healthcare workers, as Kriti has found in their experience, and people are only seeking qualified providers when the situation is severe. People also go by the recommendations by the unqualified providers and there are nexus between doctors and these referral points. These nexuses are difficult for new healthcare provides to break and just competing on quality and cost is not always enough.

Services at these clinics are priced at least 30 to 40 percent less than the comparable market rates with those of qualified practitioner stand alone clinics. The consultation fee is a dollar or less. Swasth has found that a patient on an average spends INR 80 for all services together. Most of the medicines at the clinics are generic in nature. Both Kriti and Swasth procure their own medicine and sell it at least 20 to 30 percent less than the market. Swasth found that by buying their own reagent and providing basic laboratory tests, they could further reduce their price by 40 percent. In addition, they have negotiated with local laboratories and have requested them to pass off the usual referral fees given to the hospitals as discounts to their patients.

It is a tight rope walk when a facility wants to keep the services affordable and yet be sustainable. This is possible if the costs of operations are kept low. In all the clinics, the employees multitask. The nurse doubles up as phlebotomist and a receptionist in Viva Sehat and Swasth. In Swasth, the doctor also dispenses medicines. By regularly keeping track of expenses and inventory, redundancy is reduced. All the clinics have their own procurement system which allows them to purchase in bulk and reduce some costs. The pricing is usually benchmarked against comparable branded or market prices and then discounted.

Conclusion

Network of clinics for primary care at affordable prices is relatively new in India. These organizations try to reduce fragmentation in the market and create a platform by means of which standardized services can be provided. And to the patient it means lesser waiting time, cleaner clinics to visit and assurance on quality of care. Their main challenge remains recruiting and retaining doctors and maintaining the patient volume. A doctor not perceived as a good provider by the community is the downfall of such a venture. The right doctor brings in the patient load. Swasth learnt this from one of their clinics which had constant change of doctors. Any amount of standardization or branding could not compete with the aspect of continuity of the medical personnel. It is also a fact that India as a country has only 0.6 doctors to 1,000 population and doctors have many competing job offers. This is certainly one of the main challenges for low cost clinics for primary care. With such ratios, it is important to think about innovation in form of nurse practitioner clinics or adopt Indian System of Practitioners clinics. That can both reduce the cost of care and ensure better availability. These practitioners would however need training and gaining the trust from the community gets more difficult.

Scale is another aspect that these organizations struggle with and financial sustainability the key. Also, the clinics need to maintain the quality and address the needs of the community. Organizations like Kriti would benefit from financial backing. The managerial capacity would also require strengthening if they were to operate a vast number of clinics. Recruiting good managers is a similar

challenge as to recruiting good doctors; these organizations are facing competition with many higher paying companies looking for good managers. Viva Sehat is considering setting up clinics in corporate companies and residential colonies. By end of 2012, they are aiming for 100 clinics with 50 in the state of Andhra Pradesh and other 50 in state of Tamil Nadu and Karnataka. Swasth, by end of two years (2014) is aiming to treat 100,000 patients. Kriti is planning to have four clinics end of this year (2012) and post that focus on streamlining and standardizing protocols. Such platforms, if operated efficiently, will prove beneficial for quality improvement programs on a large scale and accreditation.

Organizations	Kriti	Swasth	Viva Sehat
Nature of establishment	Trust	Forprofit	For profit
Location	Hyderabad	Mumbai	Andhra Pradesh - start in Hyderabad
Launched	2009	2011	2009
Catchment population	Urban Slums	Urban Slums	Lower Middle income
Number of clinics	4 (the 4th clinic is being set up)	3	31*
Services			
Consultation	Yes	Yes	Yes
Laboratory tests	Collection centre	Collection centre and rapid tests	Collection centre
Pharmacy	Own including procurement	Own including procurement	Own including procurement
Day care beds	0	1 (INR 50)	0
Preventive care	MCH	To initiate - Diabetes, HT	General awareness and screening
Staff			
Doctor	MBBS with visiting specialists	MBBS	MBBS/MD
Nurse	Auxiliary Nurse Midwife	Auxiliary Nurse Midwife	Auxiliary Nurse Midwife
Lab Technician	None	Yes	None
Pharmacist	Doctor dispensing	Doctor dispensing	Yes
Management Information System (provider)	Manual	Computerized (in house) including patient records	Computerized (TATA consultancy Services)#including patient records
Equipment	Stethoscope, Blood Pressure Apparatus	Stethoscope, Blood Pressure Apparatus, Automatic Blood Analyzer, Rapid tests diagnostics	NA
Facility Size			
Initial capital	Grant Funded	Group of well wishers invested as equity	Venture Capital Company-Richard Chandler Corporation
Cost			
Capital	INR 100000	INR 150000	INR 500000 – 700000*
Mothly expenses (Salaries and Rental)-INR	30000	45000	NA
Price (INR)			
Consultation	30	30	75*
Medicine (Average)	35 (40% less than market)	30 to 40% less than market	NA
Lab tests	NA	40% less with tie ups. Their own lab- 1/10th of the price	NA
Avg. cost to the patient per visit-INR	65 (Consultation + medicine)	80 (Consultation + medicine + diagnostic)	NA
Footfalls for breakeven - patients	30	30	NA
Average patient per day		100 (all 3 clinics inclusive)	NA
Patients treated as on today		6246$	70000#

Table 1: Comparative matrix of Kriti, Swasth and Viva Sehat Source (2011 data): For Kriti and Swasth – Interviews with the founders. For Viva Sehat – Print media and a visit to a clinic
*http://www.thehindubusinessline.com/companies/article2012905.ece, #http://business-standard.com/india/news/razi-healthcare-to-open-50-clinics-by-dec-/452202/,
$ http://www.swasthindia.in/status.php

Annexure 2

Kriti market research highlights

1. Most of the households on an average had 4 to 6 members. A man is the head of the family irrespective of his employment status and the woman manages the house with whatever money is available.
2. Only 47 percent of the population has undergone formal education. About 49 percent of the men are employed either as unskilled laborers or workers (cooks, waiters, watchmen etc.) The women generally prefer part time work as they need to be home to take care of the children / family. About 63 percent of the women are unemployed which resulted in negligible surplus of income.
3. The children are encouraged to go to schools and have good access to public and private schools.
4. It was noted that 67 percent of the population owns houses of which 56 percent are semi pucca houses. 61 percent of the population is from outside Hyderabad.
5. The slums have access to electricity (subsidized) and roads but water and sanitation are a challenge.
6. Private care is expensive and in case of Filmnagar there is no affordable care within accessible distance for secondary or tertiary care. Public facilities are inadequate. Unqualified health provider is the preferred source of health provider for primary care. A family spends INR 150 for a visit to a private practitioner.
7. The general attitude of people also did not seem to very positive.