# Universal Healthcare – Making it a Reality

Universal healthcare is one of the primary tools for public good. Access to healthcare in India remains far from universal and the funds committed to it show the grim picture. Public expenditure remains below 1%, while the global mean is 5%. The situation isn't expected to change in the coming years, as even the HLEG report admits that, "the transformation of India's health system to become an effective platform for UHC is an evolutionary process that will span several years". Today there are innovative strategies which are needed to improve the number of the people who can access healthcare.

## Objective & Strategies

The objective of this brief is to understand how we could increase healthcare access in India. The strategy we have seen to be successful is involvement of the private sector for employing innovative tools like Mobile healthcare units, high volume units and tele-medicine.

## What are various instruments to improve access?


## Instrument 1: Mobile Vans

The government norms stipulate

- 1 sub-centre for every 5000 people
- 1 PHC for every 30,000 people
- 1 CHC for every 120,000 people

And based on these norms, the public healthcare system has a shortfall of 76% (Planning Commission). That leaves a huge number of population vulnerable to fatal diseases such as enteric, malaria and influenza. The mobile vans could also serve as the tools for information dissemination. With digital advertising quickly becoming one of the prominent modes of advertising, short videos, text graphics could be used on medical health-vans educating people about healthier practices. They could also become a vehicle to educate people about government schemes pertaining to healthcare.

**Mobile Medical Units in Assam**

The Governement of Assam launched Mobile Medical Unit(MMU) programme to improve access to healthcare in remote areas. The Programme was started in 2007 in 10 districts of Assam. An MMU consist of a car for the staff and two buses with latest medical equipment and medicines. It has an inbuilt OPD, Laboratory, and other diagnostic facilities. The MMU medical team consists of 2 medical officers, 2 nurses, a lab technician, a radiographer and a pharmacist. There is also provision for audio-video publicity in the units.

The District Health Society prepares monthly camp plans with higher priority to hilly and remote areas in the beginning of every month, with the objective of organizing 20-25 camps per month, and visit the same location once in 3 months. The Village health committees and local NGOs help in informing the villagers about the medical camps. Services provided by MMUs include- curative services, reproductive and child health services, family planning counseling, and diagnostic facilities. The program is funded under National Rural Health Mission and is supported by Govt of India.

The intervention has been a great success. At present, it is functional in all 27 districts and 23 sub-divisions of Assam. From 183 camps being held in 2007-08 covering 40,304 patients, the number improved to 4866 camps in 2010-11 covering 6,80,064 patients, to 9058 camps covering 10,63,166 patients in 2012-13.

## Instrument 2: High Volume dispensaries

According to the Planning Commission, there are 0.45 physicians that are present for every 1000 people . While, that itself is a metric which raises concern, but that hides the more graver problem of specialists in the country. The rural population needs to wait for months to get an appointment in specialist facilities in the urban cities. The private options are largely out of reach for such specialist facilities. To provide a solution for this challenge, several private organisations (Not for profit?) have started operating high volume facilities providing specialist care. Narayan Hrudayala and Shankara Eye care are two primary examples which show an immense opportunity for scalability. With their lean operations, they have been able to perform 19 Open heart surgeries every day, which is 8 times higher than an average hospital. By keeping doctors salaries in check, they are able to serve financially constrained people as well.

**Narayan Hrudayala, Bangalore**

It was founded in 2001 by Dr. Devi Shetty. It focused on the concept of “volumes” to provide affordable medical treatment to the poor. The hospital performs 19 Open Heart Surgeries and 25 Catherization procedures every day, almost 8 times the average at other Indian hospitals. IT runs 500 blood tests on a machine every day, compared to other hospitals, which run 2. The deals with suppliers of machines are also negotiated and no long term contracts are signed. The hospital has a management software which helps maintain minimum inventory and quicker processing of tests. The drugs used are generic which are 80% cheaper than the market rate. Amount spent on staff salaries is only 22% of the hospital’s revenue. Moreover, the doctors charge fix salaries and not the % of revenue.

50% of patients at the hospital are from Economically Weaker Sections. Narayan Hrudayala is modeled as a social enterprise rather than a corporate. The model has got recognition globally, with Cayman Islands government inviting Narayan Hrudayala to set up a health city.

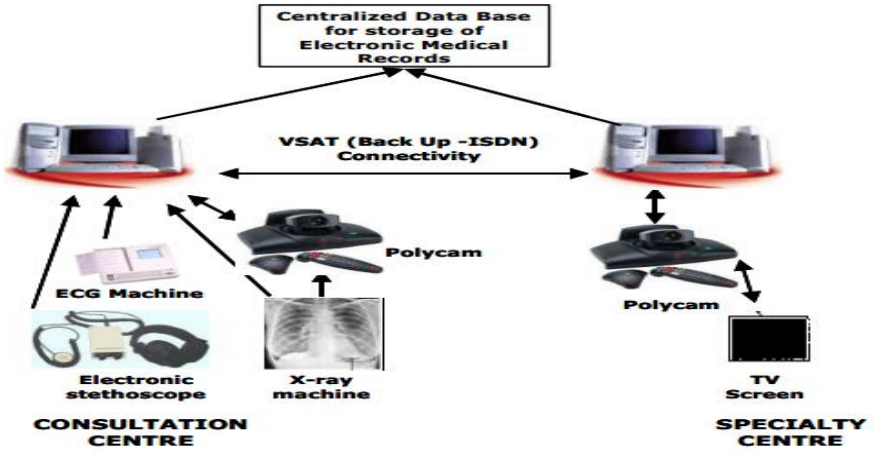
## Instrument 3: Using tools of Information Technology (IT)

With the infrastructure impediments on the front of doctors, nurses, PHC's, laboratories – one of the viable instruments that is up-coming is that of tele-medicine. With the mobile penetration in India reaching to 26% and rapidly increasing internet connectivity, the dream of universal healthcare seems closer to home. The network providers (such as Airtel, Idea) have a host of tools available at their helm to be used for improving the efficiency of already constrained infrastructure to use. Recently, Airtel tied-up with Healthfore and Fortis Healthcare as the knowledge consultants to offer medical services over telephone appropriately called "Mediphone" to its customers. This allowed people to dial-in for gaining access to basic medical queries on non-emergency health problems. There are various non-traditional private players who are involved in changing the face of healthcare. General Electric's innovative low-cost ECG machines can take digital images which could be emailed to cardiologists in any part of the world . These measures address not only the access problem but the subsequent quality of healthcare as well.

**Telemedicine in Aaragonda, Andhra Pradesh**

Telemedicine is rapid access to remote medical expertise through telecommunication and information technology. It reduces the cost of service delivery and also increases access. Apollo Telemedicine Enterprises Ltd. Was established in 1999 as a non-profit organization. It specializes in giving remote consultation and second opinion to both patients and doctors for whom access to quality health care is difficult due to distance and spiraling costs. It started a Telemedicine project in Aaragonda, a small village in Chittoor district in Andhra Pradesh, to demonstrate the use of telemedicine for general practitioners.

The Aaragonda project comprises of a specialty center and a consultation center linked to each other. A specialty center is a well-equipped room where a specialist can converse with a Registerd Medical Practitioner(RMP) in a remote area. The equipment required are a high-resolution video camera (polycam), web camera, document camera, microscope, PC, microphone, speaker, telephones, facsimile machines and a modem. While specialty centers were set up in Chennai and Hyderabad, the consultation center was set up in Aragonda.




Patient details called EMR (electronic medical records) are transferred from consultancy center to the specialty center through a desktop version of software called Emedscope developed by GEMSIT (General Electric Medical Software Information Technology). This is a software which is available in the market and can be used by any doctor and not specific to Apollo. In this software each patient's records are identified and retrieved by a UHID (unique health identification number) given to every patient who uses the Apollo hospital services.

## Available Resources

| Schemes | Name of the scheme | Description |
|---|---|---|
| **Central Schemes** | NRHM- Mobile Medical Unit Component (Rashtriya Mobile Medical Unit) | For North East States, Himachal Pradesh and J&K- Assistance of Rs 28 lakh per Diagnostic Van. For other states- Rs 24 lakhs. |
| | National Rural Telemedicine Network, NRHM | State grants of 19.83 crore were released to all States/U.Ts in 2007-08 and 2008-09.Since 2011, various States are being supported under NRHM for telemedicine activities. In 2012-13, Rs 2591 lakhs was allocated to 7 States/U.Ts( H.P, Maharashtra, Punjab, W.B, Dadra & Nagar Haveli, Assam, Tripura). |
| | Rashtriya Swasthya Bima Yojana | Provides annual hospitalization cover up to Rs 30,000 for a BPL family of 5 members. |
| **Key Resource People** | Chairman, Zila Parishad/ District Collector | Heads District Health Mission/Society, responsible for implementing NRHM |
| | Rogi Kalyan Samitis(RKS) | Management and Monitoring of Health Facilities. Elected representatives are members of the RKS. |