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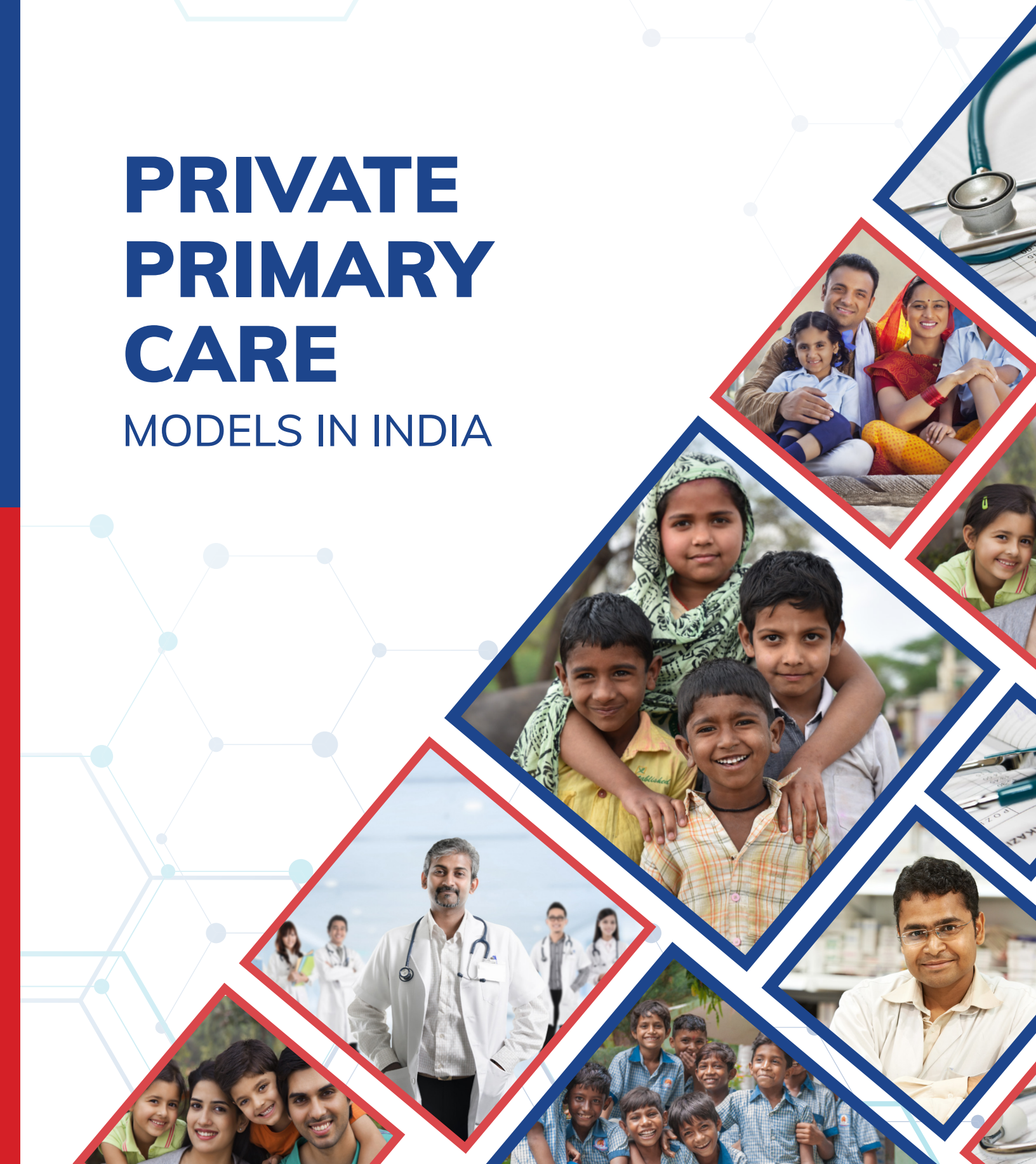
PRIVATE PRIMARY CARE

MODELS IN INDIA



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BACKGROUND

There is a growing global consensus on the importance of primary care to build a sustainable health system that enables universal health coverage. Primary health care goes beyond simply treating diseases or conditions. It is essential to improving patient outcomes and experience, lowering mortality and morbidity and reducing costs.

India ranks 145th among 195 countries in terms of quality and accessibility of healthcare, behind its neighbors like China, Bangladesh, Sri Lanka and Bhutan, according to a Lancet Study. The population faces a lack of access to quality and affordable healthcare. India spends just over 1% of its Gross Domestic Product (GDP) on public healthcare. Even with growing policy and project focus there is a lack of adequate infrastructure and a significant shortage of qualified workforce in public health systems. India is also grappling with a growing dual disease burden with the rise in non-communicable diseases (NCDs) such as asthma, hypertension and diabetes. NCDs are a significant threat to lower socio-economic populations, imposing substantial financial burden, productivity loss and employment loss.

Health systems are further weakened by rural-urban disparities as well as intra-urban disparities. As per a PwC report, 70% of India's healthcare infrastructure is in the top 20 cities.[1] With rapid and unplanned urbanization, India's urban population has increased to 450mn and is expected to reach 583mn by 2030[2]. Most rely on private health care that is fragmented and unorganized. And they face significant financial burden with more than 70% of health expenses financed out-of-pocket.

At PAHAL (Partnerships for Affordable Healthcare Access and Longevity) - USAID and IPE Global's flagship innovation platform, we seek to catalyze social enterprises that have the potential to improve access to affordable and quality healthcare for the underserved population. In this report, we analyze private sector models in primary care in India to generate insights around creating a sustainable primary care health system. We highlight the challenges faced by enterprises engaged in the primary health care sector and some key factors to be considered for operating a successful private primary care model in India.

[1]https://www.pwc.in/assets/pdfs/publications/2017/funding-indian-healthcare catalysing-the-next-wave-of-growth.pdf
[2]McKinsey Global Institute

HEALTH SCENARIO IN INDIA

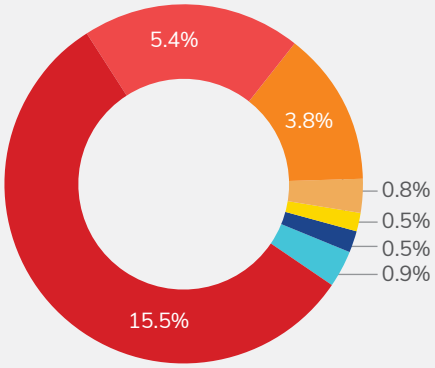
Inadequate infrastructure with epidemiological and demographic transition

India is experiencing a demographic as well as an epidemiological transition. The population faces a dual disease burden - rates of non-communicable diseases (NCDs) are rising rapidly while health systems are still trying to manage the burden of communicable diseases. NCDs are no longer 'diseases of affluence' with increasing prevalence amongst the poor as also the rural population. NCDs accounted for 47% of all deaths while communicable, maternal, neonatal and nutritional diseases (CMNNDs) together accounted for 30% in rural India[3]. As India's population ages (close to 300 million over 60 years by 2050[4]), these 'lifestyle diseases' also pose serious challenges in terms of high volume and complexity of ongoing health care needs expected in the elderly.

[3]https://idronline.org/rural-india-is-facing-an-epidemic-of-non-communicable-diseases,
[4]India Ageing Report, United Nations Population Fund (UNFPA)

CMNNDs % contribution, death rates per 100,000, India, 2016

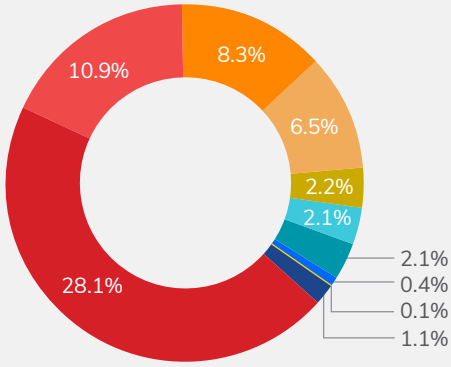
∑ = 27.5% or 2.69 million



- Diarrhoea, lower respiratory, other common infections
- HIV/AIDS, TB
- Neonatal
- Neglected tropical and malaria
- Maternal
- Nutritional deficiencies
- Others

NCDs % contribution, death rates per 100,000, India, 2016

∑ = 61.8% or 6.05 million



- Cardiovascular
- Chronic respiratory
- Neoplasms
- Diabetes, urogenital, blood, and endocrine
- Digestive
- Cirrhosis and other chronic liver
- Neurological
- Mental and substance use
- Musculoskeletal
- Others

Source: Global Burden of Disease Study; Institute for Health Metrics and Evaluation

Due to their chronic nature and potential for significant disability and premature death, NCDs cause long-term expenditure on health and worsen poverty. With a large working-age population in India, loss of productivity and purchasing capacity caused by NCDs slows down economic growth and development. It is estimated that India is likely to lose 4.58 trillion USD before 2030 due to NCDs[5].

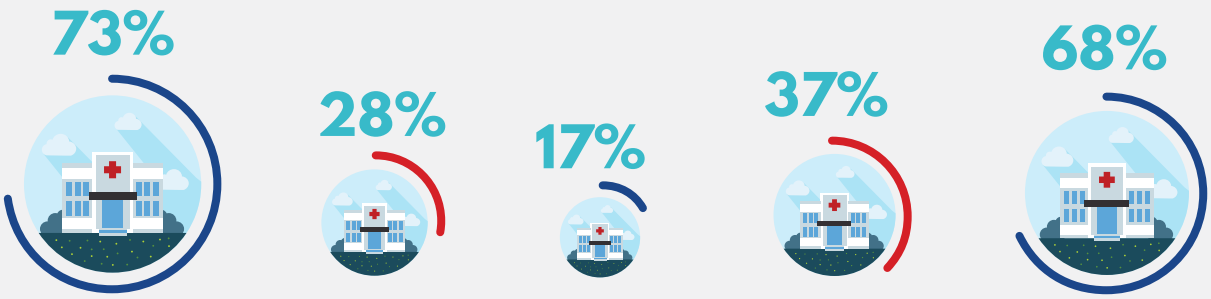
There is a compelling case for strengthening the primary health care (PHC) system in India. Managing this shift in disease burden and population profile at specialist levels leads to high costs and poorer health outcomes.

Poor infrastructure

The public health expenditure in India has remained around 1.1% of GDP, far less than the world average of 6%[6]. This amounts to just INR 3 per day spent by the government per Indian citizen on healthcare. On the supply side, Government hospitals do offer universal healthcare services, free treatment and essential drugs, however they are grossly understaffed and inadequately stocked. This results in more than 70% of the population relying on the private health care system that is fragmented and unorganized[7]. And often patients in vulnerable groups, who highly value convenience and affordability, turn to unqualified medical practitioners even at the risk of adverse health outcomes.

[5]World Economic Forum
[6]Ministry of Health and Family Welfare
[7]National Family Health Survey

Sub-centers which are at the forefront in providing primary healthcare are in a poor state



Sub-centers more than 3 km from the remotest village	Sub-centers not accessible by public transport	Unhygienic sub-centers	Rural population with access to IPD facilities within a 5 km distance	Rural population with access to OPD facilities

Absence of qualified medical professionals

India has very low physician density at less than 8 doctors per 10,000 people[8]. The number of medical professionals estimated to graduate from medical and nursing schools are not nearly enough to meet the needs of the burgeoning population. Moreover, specialists earn significantly higher incomes and enjoy better standard-of-living, status among peers than do primary care physicians.

[8]World Health Organization

Rural-urban and intra-urban disparities

75% of dispensaries, 60% of hospitals and 80% doctors are in urban areas, serving only 28% of India[9]. This inequity has resulted in policy interventions having a predominant rural focus.

Who are the urban poor?

Employed in informal sector, low wages and no job security

Overcrowded, unrecognised, settlements,unsanitary living conditions

Migrants on urban periphery,unfamiliar with available systems

No health insurance, >80% health expenses financed out of pocket by patients

The urban advantage in health in India does not hold true for the 'urban poor'. It is estimated that by 2030 about 583 million Indians will live in cities, which is almost twice the US population today[10]. Around 40-50% of this urban population or c. 200mn people are classified as 'urban poor' living with <8-9 USD to spend a day[11]. Health indicators remain consistently inferior for the urban poor compared to the urban non-poor.

Out-of-Pocket-Expenditure (OOPE)

The unavailability of preventive and primary care at the last mile and affordable financing solutions results in high OOPE. Drugs and diagnostics play a significant role in high OOPEs - possibly due to the fragmented market and supplier-induced demand. As per the National Sample Survey data, health related expenditure pushes nearly 55 million people into poverty every year. Thus, the ability to pay becomes a key determinant of health seeking behavior as personal income and savings meet bulk of OOPE.

[9]Report on healthcare access initiatives, KPMG

[10]McKinsey Global Institute

[11]https://shodhganga.inflibnet.ac.in/bitstream/10603/97367/11/11_ chapter-3.pdf

PRIMARY HEALTH CARE

Putting people at the center of healthcare

There has been a steady transition in healthcare from a narrow focus on disease-oriented etiologies, towards primary care systems that consider the interacting influences of factors rooted in culture, policy, ethnicity and environment, in order to meet the health needs of all.

What is primary health care?

1

Provides a comprehensive range of services and care, including but not limited to vaccination, screenings, prevention and control, management of noncommunicable and communicable diseases, care and services that promote, maintain and improve maternal, newborn, child and adolescent health, mental, sexual and reproductive health

2

It is accessible, equitable, safe, of high quality, comprehensive, efficient, acceptable, available and affordable and will deliver continuous, integrated services that are people centered and gender sensitive

3

It strives to avoid fragmentation and ensures a functional referral system between primary and other levels of care

There is a distinct role for different levels of care within the health spectrum – primary, secondary and tertiary. Each level is assigned different kinds of medical personnel and resources. Primary care denotes the first level of contact between individuals and families with the health system. While secondary and tertiary care refer to increasing levels of specialty and complexity in health care. According to the World Bank almost 90% of all health needs can be met at the primary health care level. A robust primary care system with optimal referral linkages makes the best use of resource investments made in health care. Catching and treating health issues earlier is not only cheaper but also more prudent than treating severe or advanced illness. For e.g. India fares worse than Lower Middle-Income Country (LMIC) average on deaths attributable to preventable WaSH risk factors (1.36x death rate in India vs. LMIC average)[12]

	Population that can be addressed	Complexity and specialization	Point of delivery	Services
Primary	75%-85%	● ○ ○ ○ ○	Primary Health Centre, Sub-Centre	E.g. preventive, general medicine, obs/gynae, paedriatrics
Secondary	10%-12%	● ● ● ○ ○	District hospitals, Community Health Centres	E.g. cardiologists, urologists, dermatologists
Tertiary	5%-10%	● ● ● ● ●	E.g. large teaching hospitals, medical research institutes	E.g. complex medical, surgical interventions, oncolony, trauma

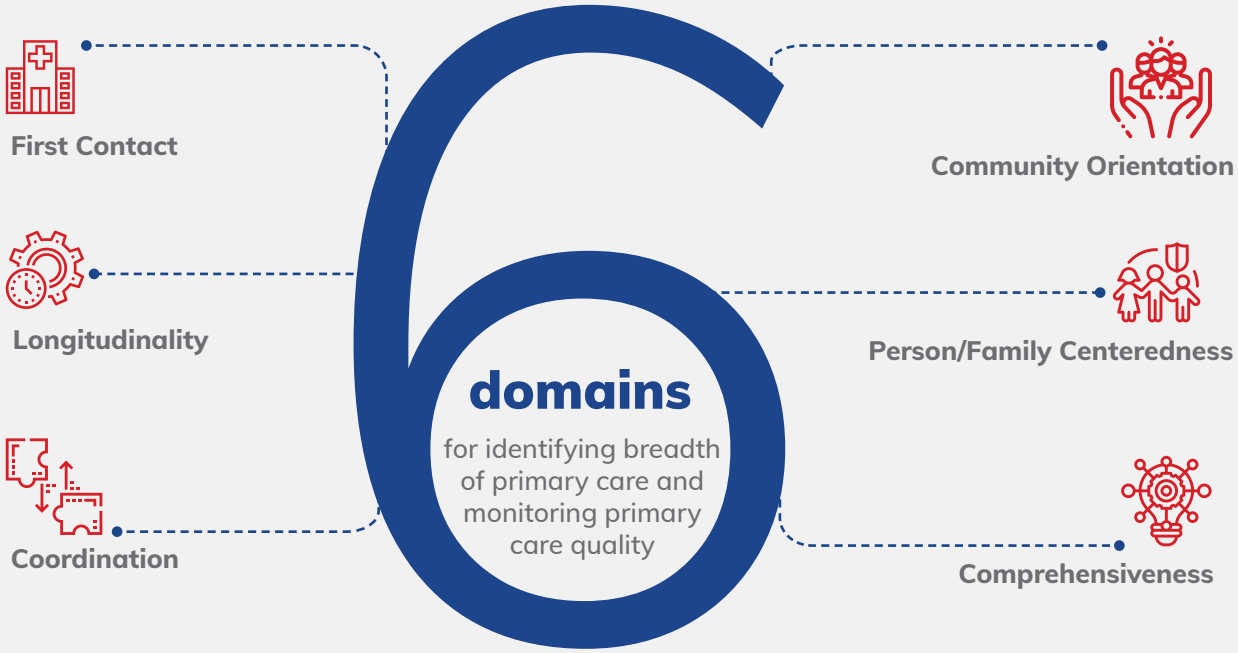
Source: Shi L. The impact of primary care: a focused review

[12]World Bank

GLOBAL HEALTH AND DEVELOPMENT AGENDAS

Re-orienting health systems towards primary health care has been recognized as key to attainment of 'health for all'

The historical 1978 Alma-Ata declaration at the International Conference on PHC was considered ground-breaking as it combined a rights-based approach and achieved global consensus on the strategy towards 'health for all'. It was agreed that governments and international organizations should work towards the social target of a level of health for all people that allows them to lead productive lives. Primary health care was recognized as key to attaining this target.



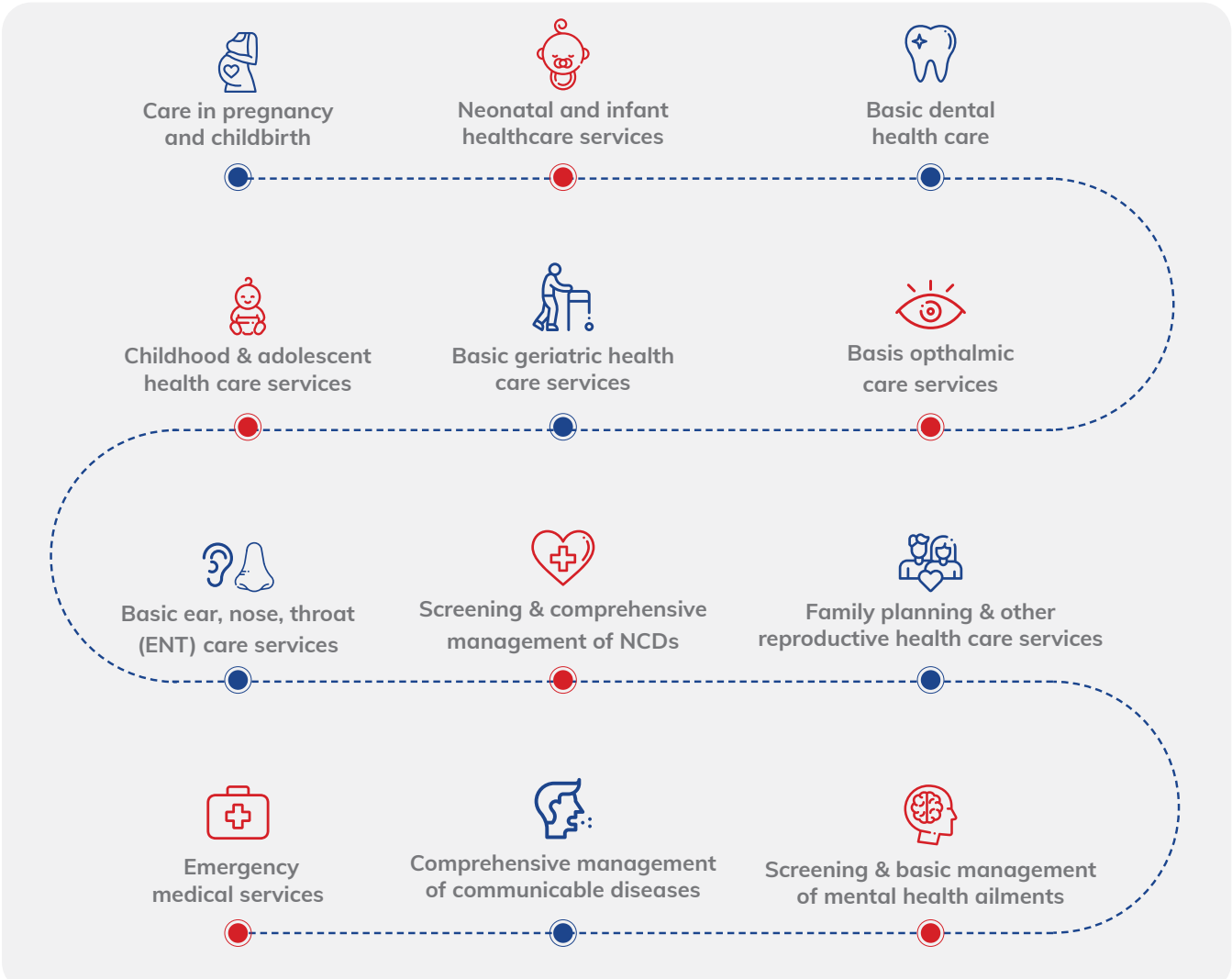
Forty years later world leaders, with the declaration of Astana in 2018, acknowledged that disparities in health outcomes continue to adversely affect those in the most vulnerable groups. Inefficient and inadequate financing and reimbursement systems expose the people to financial burden owing to the use of health services. There is a strong need to reallocate resources and reduce barriers to strengthen primary care systems. It is also crucial to provide adequate incentives to physicians and allied medical professionals to enter and remain in the primary care system. Additionally, improving linkages to social service organizations, telehealth services and encouraging full participation of communities can help expand the reach of these systems. Appropriate compensation, education, training and retention of community health workers also helps address people's health needs in a timely manner.

Astana Conference laid emphasis on:

- **Large out-of-pocket-expense; growing drug/ vaccine costs**
- **Crucial importance of health promotion and disease prevention**
- **Fragmented, unsafe or poor-quality care**
- **Shortage and uneven distribution of health workers**

Advances in information systems and the role of technologies to improve accessibility, high-quality data collection, continuity of information, disease monitoring and transparency were noted. And also that, it is crucial for all stakeholders apart from health professionals like academia, patients, agencies and funds, and the private sector to align with national policies and strategies and take joint actions to build stronger PHC.

In India, through the vision for setting up 1.5 lakh Health and Wellness Centres (HWCs) by 2022 under Ayushman Bharat, there has been a steady policy shift from a selective healthcare approach to a comprehensive primary health care (CPHC) paradigm. This follows India's 2017 National health policy's stated objectives of achieving universal health coverage (UHC) by covering all aspects such as health financing, health service delivery, health workforce, and health infrastructure and quality assurance mechanism. The government is recognizing the Public-Private-Partnership (PPP) model as one of the key ways of achieving these UHC targets with some notable examples of successful PPP-led health and wellness models already being run in the states of Andhra Pradesh, Maharashtra, Karnataka, Rajasthan, Odisha and Madhya Pradesh. CPHC is now being envisioned to include an expanded range of services as shown below:



ASSESSING QUALITY OF PHC SYSTEMS AND INVESTING IN PHC

Health care's structure and incentives are driven by financial and resource constraints and do not focus on effective disease prevention and health promotion

A strong primary care system allows for the integration of all health services; benefiting communities and improving health outcomes for all. It is based on patient-centeredness and comprehensive care that goes beyond disease-specific measures of performance and quality. Primary care guidelines, however, are often considered in well-resourced contexts and dangerously oversimplify needs in resource-constrained settings.

Aspects of primary health care

Ease of access, clinical quality of care, interpersonal aspects of care, continuity, and coordination have been identified as important elements to consider when assessing primary care[13]. Ease of access is typically affected by availability factors such as after-hours care, length of wait time, travel time to an appointment, and flexibility in selecting a clinic. Level of access to primary care impacts other elements of quality as well, such as continuity of care and has a significant impact on health-seeking behavior among the vulnerable and underserved.

Assessing the quality of primary health care

Ease of access

Elimination of barriers posed by geography, administrative hurdles, financing, culture, and language

Benefits

Lower nonurgent and urgent hospitalization rates, improved continuity of care, reductions in cost over long time periods, reduced mortality rates

Clinical quality of care

Effective, evidence-based care focusing on the interaction between health-care providers and patients and ways in which inputs are transformed into health outcomes.

Benefits

Improved patient outcomes, better patient experience of clinical treatment and chances of treatment continuance

Interpersonal aspects of care

First-contact experience - provider knowledge, professionalism, compassion and attitude

Benefits

Patient satisfaction and involvement, continuity of care, improved diagnosis with better disclosure from patient

Continuity and coordination

Management, informational, and relational continuity based on patient circumstances

Benefits

Better patient-provider relationship, increased patient satisfaction, improved uptake of preventive care, enhanced adherence to treatment, reduced healthcare use and costs

[13]The Impact of Primary Care: A Focused Review, Leiyu Shi

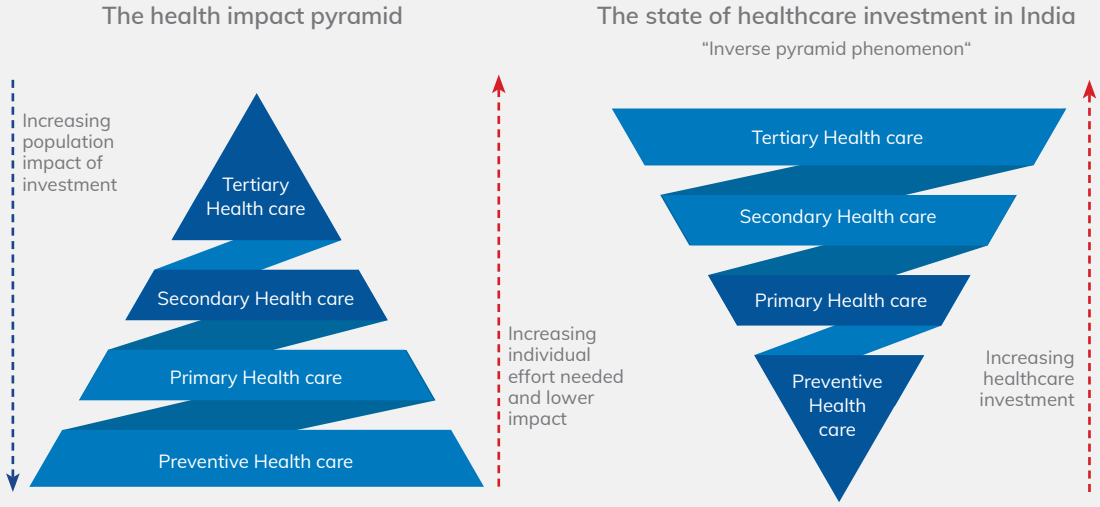
Investments focusing on lower levels of the health impact pyramid tend to be more effective because they reach broader segments of society and require less individual effort. For E.g. nonadherence is especially problematic for chronic conditions such as hypertension, high cholesterol and diabetes. Primary care that promotes health education and is designed around socio-economic factors brings about the maximum population-wide impact in improving adherence. Interventions at the top levels of the pyramid, on the other hand, are designed to help individuals instead of entire populations.

Higher investment in PHC systems is associated with a reduction in costs, a rise in patient satisfaction, fewer hospitalizations and emergency department visits, and lower mortality. Unfortunately, healthcare investments in India exhibit an inverse pyramid phenomenon with much higher investment directed at secondary and tertiary health care levels.

Primary care continues to be a grossly underfunded investment area in India. Low public expenditure in primary healthcare inhibits access to the most marginalized populations. As per PwC, apart from increasing public expenditure on healthcare in India, the government can act as a catalyst by focusing on universal health care driven by private sector participation, providing national priority status to the healthcare sector, providing fiscal incentives for setting up healthcare facilities in tier 3 cities or rural areas.

The private hospital sector in India has expanded rapidly for e.g. more than 70% of new beds were added by the private sector from 2002 to 2010[14]. And private hospitals provide the majority of outpatient and inpatient care in India. Unfortunately, investment in primary health care has still fallen short.

Investment in primary health care is a cost-effective but underfunded investment area



[14]Inspiring Possibilities, Challenging Journey (McKinsey and Co., Jan. 2012)

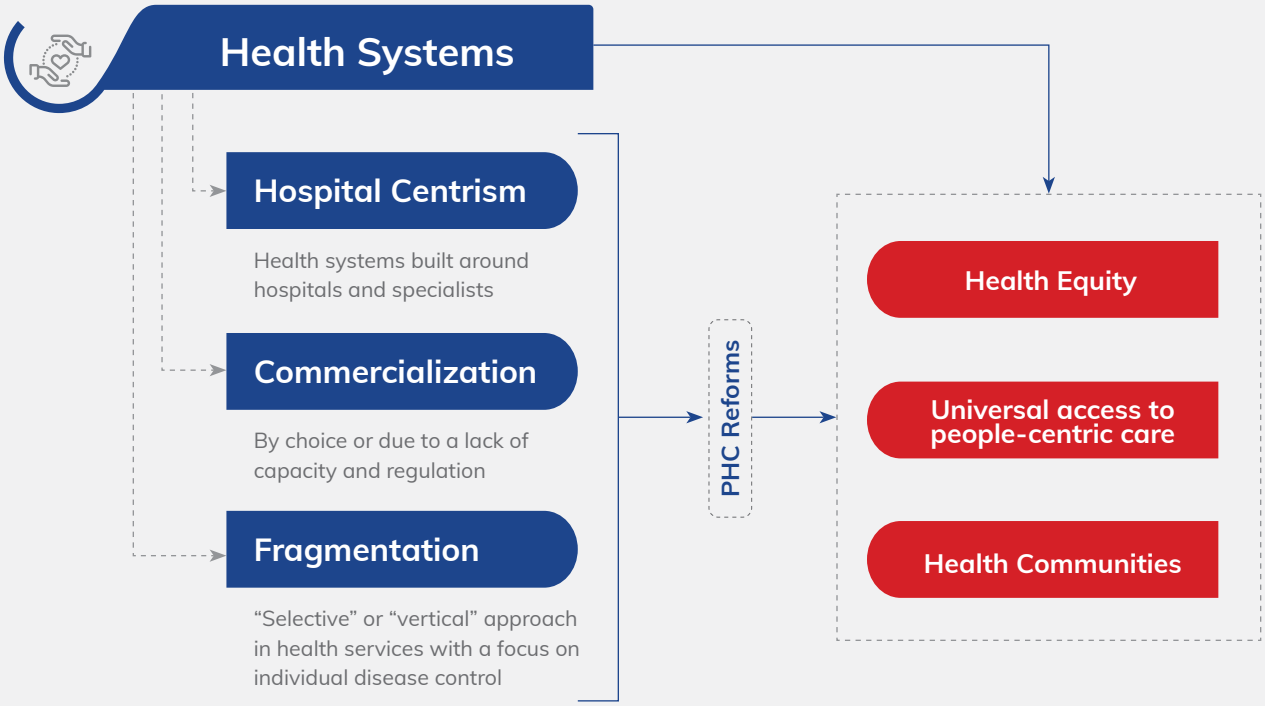
CHALLENGES TO BUILDING A STRONG PHC SYSTEM

How health systems get diverted from core primary healthcare values

In the absence of strong policies and political will, health systems often get diverted from their intended direction, especially as they are influenced by forces of commercialisation, fragmentation and an excessive focus on the 'hospital' as opposed to the patient. High

consumer demand, the incentive structure in the medical profession and the medico-industrial complex creates a disproportionate resource flow towards specialized hospital care to the detriment of investment in primary care. This hospital centrism increases unnecessary medical costs and promotes inefficient ways of addressing disease burden instead of more effective ways such as health promotion and prevention. A focus on single-disease control hampers efforts for 'health for all' in severely resource-constrained circumstances as service delivery continues to focus on specific diseases particularly those with higher funding focus.

Health systems get diverted from core primary healthcare values



Deterrents to PHC in India

- India features one of the lowest investments in healthcare globally; just over 1% of GDP, which is 80% lower than the world average. There has been increasing policy focus on the gaps in the Indian health care system, but policies often fail to consider the sociocultural context especially for rural or underserved areas and fall short of targets. Also, weak governance mechanisms reduce the effectiveness of health systems- as per WHO's 2008 World Health Report, within developing countries improved local governance can help produce 75 years or more of life expectancy while with poor urban governance we could find life expectancy as low as 35 years.

- There is an acute shortage of qualified medical personnel. India's medical colleges do not produce nearly enough professionals to eliminate the shortage of PHC personnel. Specialists earn significantly higher incomes and enjoy better standard-of-living, status among peers than primary care physicians. Shortage of well-stocked facilities and medical supplies cause further deterioration in the quality of health care delivery

- A large part of India's population is employed in the unorganized sector and lives in slums which lack durable housing, access to clean water or sanitation and are disproportionately exposed to pollution, employment hazards, violence, and accidents. Their health-seeking behaviour is strongly affected by the potential of livelihood loss as well as the cultural and social barriers they face.

- More than 60% of the Indian population is without health insurance[15] and India features one of the highest proportions of out-of-pocket-expenditure. Many insurance companies pay for hospital-based complex diagnostic and invasive procedures but not for routine preventive visits and consultations. Lack of budgetary support, a fragmented private healthcare system combined with a lack of pooling mechanisms in health finance leads to a disproportionate share of health financing burden falling on the population. This adversely affects health-seeking behaviour with those in vulnerable groups often turning to quacks or unqualified medical professionals.

[15]National Health Profile 2019

Strengthening India's primary care system

While the Indian healthcare delivery infrastructure has expanded remarkably in the last few decades it has not been able to keep pace with the population's rise nor has it been able to address its specific contextual needs. In most cases patients do not have access to affordable, quality health care and when they do the gaps in health care delivery break the continuum of care leading to poorer health outcomes.

Key focus areas that need to be tackled by private primary care models

01

Healthcare Delivery

Lack of quality and access in the current public as well as private health delivery system. Our PHC systems also have to evolve to address the epidemiological and demographic transition in India.

02

Engaging the Community

Community centric measures often play a key role in improving awareness as well as in overcoming geographic and cultural barriers that negatively affect health seeking behavior

03

Policy Support

Unclear policies and regulations plus weak governance mechanisms hinder the effectiveness and performance of health systems

04

Cost of Accessing Healthcare

Large out-of-pocket-expenditures negatively impact the utilization of healthcare services and also lead to impoverishing or catastrophic expenses for patients

PRIMARY HEALTH CARE MODELS ACROSS THE GLOBE

Reforms in primary care systems built around context specific objectives

Addressing the challenges of achieving a strong primary health care system

Thailand

- Thailand achieved Universal Health Coverage in 2002 and Out-of-pocket expense was down to 12%
- Key changes implemented were decentralization in the health system, establishment of National Health Security Office responsible for UHC, and development of district health systems, primary care clusters and family care teams
- To address the shortage of physicians in rural areas, government incentivized rural physicians with 10-15% premium over urban, non-private physician salaries

Liberia

- Country's health infrastructure was devastated after long running violence and only 50 doctors remained for 4 million+ people
- **Last Mile Health** - recruits, trains, equips, manages and pays community health workers to provide lifesaving health services
- Designed a nationwide community health workforce that was critical in containing the Ebola epidemic
- 3016 CHWs deployed, 707585 people served so far

Kenya

- Child and Family Wellness (CFW) franchise system was built by the HSF - Health Store Foundation in 1997
- CFW franchisees operate clinics run by qualified nurses with a business incentive to comply with a predefined set of standards in exchange for access to a cost-effective drug and medical equipment supply chain
- The average price for basic consultation at a CFW clinic (approx. US$3–3.5)

Brazil

- Access to healthcare expanded through the Unified Health System (SUS) – largest, universal, free public health system globally (c. 160 million people covered)
- Family Health Strategy (FHS) - Family health teams composed of one physician, nurse, nurse aide and 4-12 full-time community health workers responsible for up to 1000 families, or 3500–4500 people
- Lack of quality, economic crises and fragmented private healthcare space, create opportunities for enterprises such as Dr. Consulta & Clinica SiM

[16] 30 years after Alma-Ata: has primary health care worked in countries?

[17] Last Mile Health (as of 2018)

[18] The impact of the Brazilian family health on selected primary care sensitive conditions: A systematic review

Thailand

Universal Health Coverage was achieved in 2002 with a comprehensive benefits package with free care at the point of service delivery and very little co-payment. The significant improvements were achieved on the back of a dominant public-sector role. Thailand was ranked first amongst the top ten achievers of millennium development goals (MDGs) for MDG 4 – reduction in under five mortality[19]. The focus has been on the district level and below health delivery infrastructure and on training and incentivising the health workforce in rural and underserved areas.

Liberia

Significant strides in reforming the country's health sector were made after the establishment of peace and stability. Basic Package of Health Services (BPHS) that emphasizes primary care is the cornerstone of Liberia's national health care strategy. The focus has been on greater equity of access to health services especially at peripheral levels of the health system, progressive decentralisation of management of health services and on building closer ties with local communities and partners.

Kenya

The CFW franchise system built by the HSF lets franchisees operate small CFW drug shops or clinics strategically located to improve access to essential drugs. The majority of CFW Shop franchisees are trained and experienced nurses who comply with CFW drug handling and administration regulations. They conduct outreach events such as health screenings, sanitation and water purification trainings.

Brazil

Community Health Workers (CHW) have been at the core of Brazil's primary health care policy since 1994 with a maximum of 150 families managed by a CHW. They provide comprehensive primary care support including clinical triage, chronic disease management immunizations, health promotion. CHWs completely integrated with the primary care physician and nurses. They are highly respected resulting in low turnover. Scaling of FHS is incentivised as municipalities only receive full payment for primary care if their service model aligns with the strategy

[19]Millenium Development Goals Report Card, Overseas Development Institute

PRIVATE PHC MODELS IN INDIA

Unique models with different focus areas, target populations, degrees of use of community linkages and technology

Glocal Healthcare

Founded: 2010

Headquarters: Kolkata, West Bengal

Founder: Sabahat Azim

Glocal Healthcare is a social enterprise that seeks to bring quality healthcare to the underserved population in India through an integrated model of comprehensive primary & secondary care hospitals, digital dispensaries and technology

- Proprietary decision support system and a web-based teleconsultation platform
- Nine 100 bedded hospitals with low cost OPD, IPD and acute care. 170+ Digital Dispensaries (DDs) providing primary healthcare in remote areas
- 600K patients served, 75% patients Below Poverty Line

Locations / Geographic Spread

9 hospitals, 170 Digital Dispensaries across Odisha, Rajasthan, Gujarat and other states

Target Population

Low and middle income

Pricing

₹250 (including consultation, basic tests and medicines)

Facilities / Premises

Each Dispensary, manned by a set of qualified nurses, lab technician and pharmacist, caters to a population of about 50,000-60,000

Doctor Profile

MBBS / MD

Additional Services

Vitals are measured and basic laboratory investigations. Generic medicines are prescribed which are then collected through an automatic dispensing equipment LitmusRX

Use of Tech

Telemedicine suite connecting doctors to patients through video conferencing. LitmusDX: A Sematic Algorithm based suite allows doctors to make differential diagnoses, titrate dosages, check investigations interpret them real time, check for treatment protocols and titrate

Healthspring

Founded: 2011

Headquarters: Mumbai, Maharashtra

Founder: Professor Gautam Sen, Kaushik Sen

Healthspring aims to improve the health delivery system in India at the primary care level with its chain of high-quality health centers with all services under one roof

- Focus on the entire spectrum - individuals, families, communities, corporate houses and industrial complexes
- Team of 200+ doctors, 500+ health experts including nutritionists, physiotherapists, nurses & pharmacists
- Have delivered care to 600,000+ patients, tie up with 200 corporate clients, and conducted 300,000 health checks

Locations / Geographic Spread

Mumbai and Pune

Target Population

Middle and upper middle class

Pricing

OPD - ₹400-600, subscription- Tier 1 ₹ 2000 (single)/year, family of 4 - ₹6000/ year; tier 2 - ₹ 5000; tier 3 - ₹ 8000 (Diabetic and hypertension case), senior Care – ₹9000 (4 Doctor Visits, 4 nursing visit)

Facilities / Premises

Each center approx. 1000 Sq. feet

Doctor Profile

5 Doctors per facility (3 GPs +1Pediatrician/ Gynaecologist+ 1 dentist); typically MBBS

Additional Services

Limited in-house pharmacy, basic diagnostics - X-ray, Ultrasound, ambulance. Physiotherapy, nutrition advice; strong pathology business

Use of Tech

The Healthspring model uses telehealth for consultation and for the referral. Doctors conduct triage by telephone

Focus on community engagement and tertiary linkages

In case of an emergency, the network hospitals are called to ensure the availability of a bed. To save time, the patient's medical history and three preferences for hospitals are stored in a database

iKure

Founded: 2009

Headquarters: Kolkata, West Bengal

Founder: Sujay Santra

iKure is a social enterprise catering to primary and preventive healthcare across the rural, semi urban & urban population

- Hub and spoke clinic set up where a core medical team is stationed at hub clinic and visits spoke clinics on a regular basis
- Population of 25 million served, 1500 community health workers (CHWs) trained, 1 million health cards distributed

Locations / Geographic Spread

West Bengal, Jharkhand, Karnataka, Assam, Odisha

Target Population

Low income

Pricing

OPD - ₹50 (GP)

Facilities / Premises

Hub (with GP, Lab, Pharmacy) and spoke (GP only)

Doctor Profile

1 doctor per facility; typically, MBBS / BHMS / BAMS for GP; MD for specialty; Monthly Fixed Pay (Salary)

Additional Services

Pathology laboratory, registered pharmacy, insurance facility, an optometrist at the hub, spectacle prescription and sale

Use of Tech

Proprietary software, Wireless Health Incident Monitoring System (WHIMS) for health screening, early detection, and monitoring of diseases

Focus on community engagement and tertiary linkages

- CHWs are given PoC devices and training in MCH. They also deliver spectacles, nutraceuticals, sanitary pads, etc.
- Partnership with local NGOs for ground mobilization, hospitals for secondary & tertiary care

Karma Healthcare

Founded: 2014

Headquarters: Udaipur, Rajasthan

Founder: Jagdeep Gambhir

Karma Healthcare is a social enterprise that aims to harness digital connectivity to provide affordable quality healthcare to rural and semi-urban India

- Assisted e-health business model aiming to combine low delivery cost with a human touch for patients
- 'e-Doctor' clinics – online consultations by qualified doctors with assistance from a nurse at clinic.
- Has completed 73000+ consultations, population of over 350,000 covered

Locations / Geographic Spread

Rajasthan, Udaipur -10 clinics, Haryana 9 clinics

Target Population

Low to mid income

Pricing

OPD - ₹80 (GP), ₹140 (specialist)

Facilities / Premises

Standalone Tele clinic with audio and video conferencing set up, PoC diagnostic devices, 1 bed, prescription printing facility and medicine dispensation facility at select locations

Doctor Profile

Variable number of doctors per facility depending on walk-ins; typically MBBS for GP; MD for specialty; Per hour Fixed Pay (Salary)

Additional Services

Basic tests performed using PoC devices, partnership with the neighboring pharmacy for basic stock of medicines

Use of Tech

For GP and specialist consultation and patient record management, data capture, storage and analysis, business visualization

Focus on community engagement and tertiary linkages

- Outreach worker for marketing and lead generation
- Referral services to secondary and tertiary care facilities in nearby cities

Merrygold Hospital

Founded: 2007

Headquarters: Noida, Uttar Pradesh

Founder: Franchisor – Hindustan Latex Family Planning Promotion Trust (HLFPPT)

Largest asset-light social franchising network with a focus on providing Maternal, Child Health/ Family Planning services at affordable prices to urban poor

- "Franchisee (hospital) pays annual franchising fee to the franchisor (HLFPPT) and offers health service linked to standards and protocols.
- The network provides training, marketing and branding support to the franchisees.
- 500+ hospitals & clinics spread across 150+ districts in 5 states
- Facilitated more than 2 million Antenatal Check-ups, 300000 Institutional Deliveries and 1 million Postnatal Services through its network

Locations / Geographic Spread

Uttar Pradesh, Rajasthan, Bihar, Odisha and Uttarakhand

Target Population

Urban/peri-urban - urban poor and lower middle class

Pricing

OPD – ₹ 200-500 (GP)

Facilities / Premises

Hub and spoke design with (hub) Level 1 franchisee at district levels and (spoke) level 2, 3 at subdivision and block level. 5-50 beds facilities with 1-3 doctors per facility

Doctor Profile

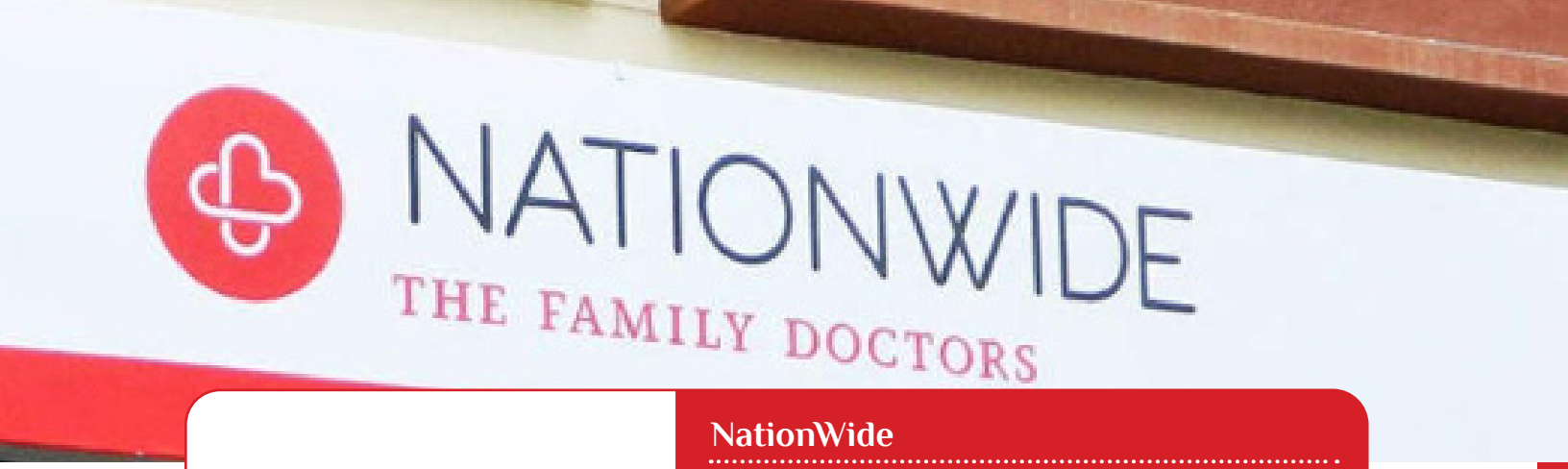
MD doctors in Level 1 hospitals and MBBS in Level 2 Hospitals / Clinics of the franchise network

Additional Services

Tie up with diagnostic chain Metropolis Health Services, drugs from nearby standalone pharmacies

Focus on community engagement and tertiary linkages

Strong community engagement – over 12000 community health workers (CHWs) or MerryTarang workers. CHWs strong link between communities and health facilities - initiating adoption of health seeking behaviors amongst the communities



NationWide

Founded: 2010

Headquarters: Bengaluru, Karnataka

Founder: Dr. Santanu Chattopadhyay

NationWide was built with an aim to revolutionize the way primary care is delivered in India via the family doctor model

- Focus on bringing back the Family Doctor concept in India
- Had 40-member team, including several Board-Certified Family Medicine Specialists and GPs from the UK and USA, who had relocated back to India
- Focus is on bridging the gap between general practitioner (GP) services and highly expensive super- specialist hospital care

Locations / Geographic Spread

Bengaluru, NCR Region, Pune, Hyderabad and Kolkata

Target Population

Urban middle class (Annual income 500k-1000k)

Pricing

OPD-₹ 400-600 for GP Consultation, psychologist (₹ 1000 per session)

Facilities / Premises

2 consulting rooms, approx. 200-400 sq. ft. (some larger up to 3000 sq. ft). High focus on branding within facilities

Doctor Profile

Typically, two doctors per facility with MD/MRCGP/DNB qualifications; GP salary ₹ 50 K + incentive/ month, Dentist ₹ 25K/ month, dental assistant ₹10K/ month, also had revenue sharing

Additional Services

Sample collection facility, tie-up with an external lab, internal pharmacy. Offered corporate services and health plans

Use of Tech

Practice Assist, a WhatsApp based mobile app for a virtual consultation, maintained proprietary EHR in the cloud

Focus on community engagement and tertiary linkages

Partnered with tertiary-care hospitals to provide their customers with preferential benefits and “continuity of care” referrals

Sugha Vazhvu

Founded: 2008

Headquarters: Thanjavur, Tamil Nadu

Founder: Zeena Johar, Nachiket Mor

Sugha Vazhvu was a network of clinics focused on primary care delivery for the inaccessible rural Indian population

- Trained nurses used technology to capture the patient's medical history and recommend diagnostic tests. If the diagnosis was confirmed, the treatment recommended was validated by a doctor and administered.
- Reached 200,000 population and treated 50,000 patients
- Collaborated with academia to develop evidence-based guidelines for care and to train health workers

Locations / Geographic Spread

7 facilities/outlets in Tamil Nadu

Target Population

Rural

Pricing

OPD ₹ 10 - 15 (GP)

Facilities / Premises

The doctor-supervised Rural Micro Health Centre (RMHC) catering to approx. 10,000 people within a 3-4 km radius, a central diagnostic hub, community engagement platform and, 4) community-based risk screening & 5) subscription-based disease management

Doctor Profile

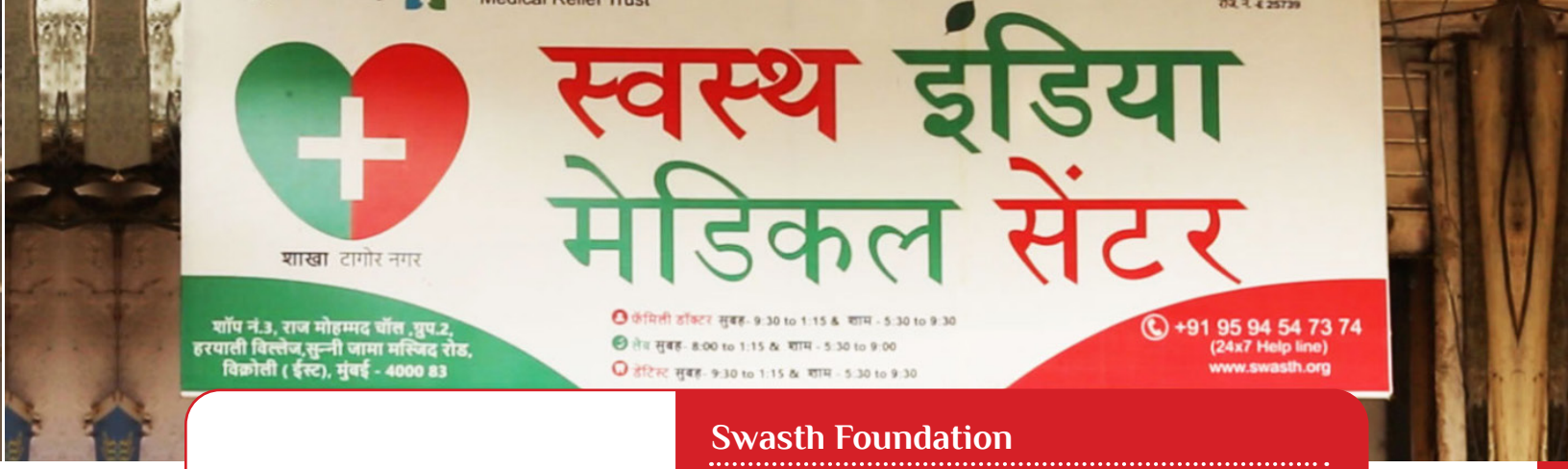
1 doctor + 1 health worker attendant per facility.
AYUSH physicians

Additional Services

cloud-hosted application built on an open source platform for patient data, enrolment, inventory and supply chain management, human resource management and training. Modules such as monitoring and evaluation, clinical audit, clinical data analysis and community disease mapping aided by geo-visualization

Focus on community engagement and tertiary linkages

Large community engagement platform that undertook population risk profiling and offered affordable disease management alternatives



Swasth Foundation

Founded: 2008

Headquarters: Mumbai, Maharashtra

Founder: Sundeep Kapila

Swasth is a non-profit social enterprise committed to providing a range of affordable and high-quality primary-preventive health services

- Strong focus on reducing the financial burden due to over-prescription, over-treatment, travel cost, wage loss, hospitalization
- Enables 40% reduction in the cost of delivery by using network of self-sustaining “one stop shops”, vertical integration of drug supply chain and pathology lab and incorporating staff incentives on patient outcomes
- Has managed 821374 patient visits through patient-centric care for e.g. warranty on lab reports, 3-year warranty on dental treatment

Locations / Geographic Spread

Mumbai and Ahmedabad

Target Population

Slum residents or in low-income housing, with a daily income of approx. ₹ 70-250

Pricing

OPD – ₹90 (GP), ₹ 300 (Dental)

Facilities / Premises

300 square feet: 3 rooms- 2 for consultation, 1 for the reception and a toilet, 2 beds for stabilizing patients. Each center caters to 100,000 population catchment area

Doctor Profile

Aayush Doctors (BAMS/BUMS), salary ₹ 25K/month; MBBS- salary ₹ 40K/month. 1 Doctor, 1 dentist and 3 Attendants per facility

Additional Services

Nutrition counseling and daycare; centralized - diagnostics lab, medicine warehouse (own procurement)

Use of Tech

Use of technology to integrate all network activities. Including standard protocols, referrals, stock management, reports, and patient history

Focus on community engagement and tertiary linkages

- Door-to-door follow-ups via CHWs.
- Swasth doctors make referrals without commissions. The Commission is passed on as a discount to the patient.

Razi Clinics

Founded: 2009

Headquarters: Hyderabad

Founder: Dr. Snehal Patel, Shwetank Verma

Razi clinics was a chain of 60+ primary care clinics aiming to provide affordable healthcare and revive the 'family clinic' concept in India

- Strong focus on standardization of clinical as well as non-clinical protocols across clinics and on reducing health expenses for patients.
- Significant reduction in costs for e.g. prescription of generics as opposed to branded drugs
- Focus on the selection of clinic location to keep control over rents and also maintain the quality of patient experience

Locations / Geographic Spread

Andhra Pradesh

Target Population

Low or middle income

Pricing

OPD – ₹150

Facilities / Premises

700 square foot: 1 GP room, 1 pharmacy and 1 nurse cum reception area, the entire clinic set-up cost close to ₹ 7 lakhs. Each clinic staffed by a nurse, a pharmacist and a doctor

Doctor Profile

MBBS, salary ₹ 28K-40k/ month depending on experience

Additional Services

Tie ups with pathology and radiology facilities. Clinics had sample collection facility

Use of Tech

Proprietary electronic medical records platform. Cloud-computing used to ensure that all patients receive the same standard of medical services, irrespective of their location

Focus on community engagement and tertiary linkages

Doctors made referrals without commissions and any commission were passed on as discount to the patient

CONCLUSIONS AND KEY TAKEAWAYS

The way forward for a strong primary health care system in India

We have chosen three scenarios below to represent the unique challenges faced by private primary healthcare enterprises in India. The analysis below focuses on unit economics and considers typical estimated revenue and cost figures for these representative models:

I. While CAPEX, OPEX as well as OPD charges are low in this brick and mortar model success is strongly affected by its ability to influence health-seeking habits in the target low-income population

II. Any telemedicine model usually succeeds in a rural or peri-urban setting where access to quality medical care is a challenge. However, a low required footfall as shown below still remains hard to achieve given the socio-economic context of these areas

III. This model features relatively higher CAPEX and OPEX. OPD charges are also higher with the middle and upper-middle class as the target population. Patient footfalls to break-even remain a barrier as it encounters greater competition from established players in the catchment area

Primary Care Unit Economics

	Brick and mortar / Low-income	Telemedicine / Low income	Brick and mortar/ Middle income
Revenue / Patient	₹ 180	₹ 250	₹ 550
CAPEX	₹ 10,00,000	₹ 12,00,000	₹ 20,00,000
Fixed Doctor Cost/month	₹ 50,000	-	₹ 1,00,000
Fixed OPEX/month	₹ 40,000	₹ 40,000	₹ 1,80,000
Variable Cost / Patient	₹ 40	₹ 135	₹ 100
Revenue per day	₹ 5,400	₹ 5,250	₹ 13,750
Patients/day required for cashflow break-even	26	14	25

(Note: Representative models, names hidden for confidentiality)

Improved primary care has a positive correlation with the equitable distribution of health services in a population. Unfortunately, several supply-side and demand-side factors hamper the PHC system in India. A large part of the country's population stays deprived of basic healthcare services while the state-of-the-art tertiary and quaternary services continue to promote India's status as a 'medical-tourism' destination.

Supply Side

1 High overhead costs

Overheads are higher for organized chains. It is challenging to deploy quality medical and paramedical staff and develop the brand. Building volumes and achieving break-even takes time

3 Competition

High barriers to entry due to existing quacks / medical practitioners / hospitals in the operational areas with established patient base and goodwill within the community. Also with free of cost government healthcare services customers are highly value conscious

5 Lack of comprehensive Services

Patients highly value convenience offered by comprehensive/'one-stop-shop' solutions featuring doctor consultations, wide coverage of diseases, basic diagnostics, medications, financing options and referral if required. A partial solution reduces the probability of success

7 Shortage of qualified personnel

India has a very low density of qualified medical professionals compared to WHO guidelines. The situation is further exacerbated due to social stereotypes and financial constraints that work against primary care physicians

Demand Side

2 Poor health-seeking behavior (HSB)

Poor HSB due to high OOPE, lack of accessibility to quality healthcare. A large population subsists on daily wages and avoid loss of one day's earnings till health situation becomes critical. HSB also affected by awareness, unsympathetic attitude of staff and non-availability of medicines

4 Lack of contextual application

Many primary care models fail to consider the diversity and unique needs of the community/population they are catering to. For e.g. educational status, type of employment, place of residence, gender or caste

6 Lower than expected volumes

Underlying assumption of getting a progressively higher number of patients for primary care business models becomes unachievable or slower than estimated. Cashflows can be made more predictable using a subscription model but come with inherent risks.

8 Emphasis on doctor reputation over brand

Patient volumes and repeat visits to the facility are often strongly driven by doctor reputation. Doctor attrition at a center causes a sharp drop in patient volumes

Key factors to consider for a private PHC model

Achieving patient footfalls needed for a sustainable PHC model is difficult given the underlying health seeking behaviour. It is also affected by a lack of models that provide 'one-stop' solutions to healthcare needs. Sustainability becomes even more challenging when we incorporate customer acquisition costs.

While an established brand may command the required customer loyalty, given the nascent state of private PHC delivery in India the brand is often overshadowed by the reputation of the doctors leading to higher than the desired correlation between doctor attrition and patient volumes. Certain models have also unsuccessfully attempted to bring predictability in cash-flows through subscription-based models.

Patient break-even numbers may look achievable as standalone numbers, however entrenched health-seeking habits prevent models from becoming sustainable. Leveraging the community has been a catalyst in counteracting barriers due to gender, caste and other socioeconomic factors.

Customer-pay models take a long period of time to achieve sustainability and employing a third-party payments models be it from the government, insurers or others can prevent the premature failure of PHC models. Aggregation can also help bring down costs and employ economies of scale. For e.g. certain models have focused on providing primary health care for employees in corporate establishments

The digitization of healthcare processes reduces unnecessary overhead costs, brings cost transparency and improves process quality and system control. Its positive impact on care quality ultimately reflects in patient experience and ensures recurring patient footfalls.

Admittedly lack of sufficiently interconnected IT systems has affected the uptake of digital solutions by healthcare enterprises. However, the sharp rise in internet penetration, rising disposable incomes and higher health awareness has given a boost to patient-centric solutions that leverage technology.

Learnings from various private primary care models in India have helped bring forth the following insights around the key factors that build sustainability of such models. These factors address both the supply-side issues such as high costs, comprehensiveness of services as well as demand-side issues that affect health-seeking habits of the population.

Sustainability of private primary care models is affected by a number of factors

Patient Volumes

Strongly affected by **health-seeking behavior, perception of value provided** by health service, barriers due to social and economic factors.

One-Stop Solution

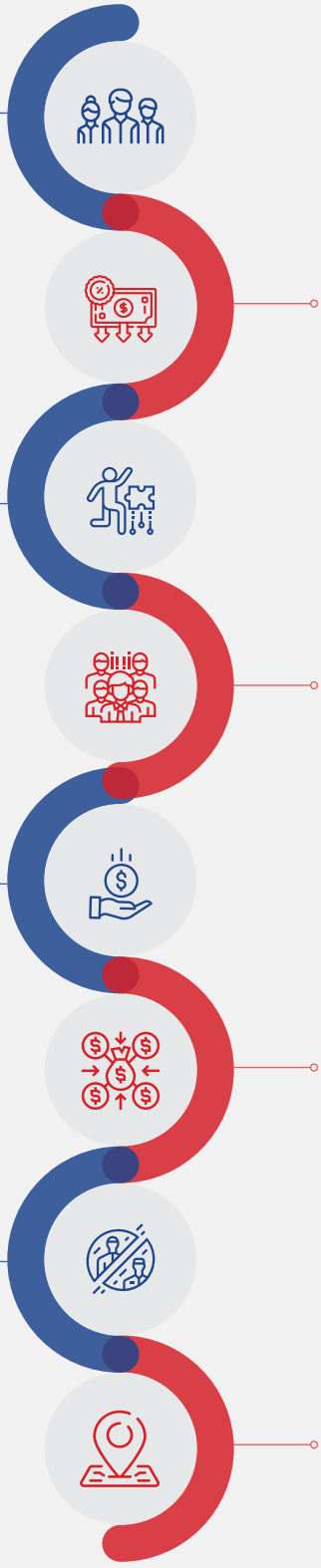
Comprehensive services provided add to overall convenience for the patient and improve continuity of care

Financing for Patients

Third-party payments through the government or insurance firms

Competition

Crucial to create a **differentiated model** to mitigate the impact of competition



OPEX

Lowering operating expenses meaningfully without compromising on the quality of health care delivery. (For e.g. use of tech to increase efficiency)

Manpower

Essential to **deploy, incentivize as well as retain qualified physicians,** outreach staff and community health workers

Revenue Streams

A **diversified revenue stream** including pathology, pharmacy, complementary products

Location

Placement of health facility keeping in mind **accessibility and visibility**

Pahal
Partnerships for Affordable Healthcare Access and Longevity

USAID's Urban Health Project

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