Vadu Rural Health Programme : A Unique Initiative

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Abstract: *This document is more of a fact-sheet and report than an empirical or scientific paper. The purpose is to describe the setting and throw light on the advantages and weaknesses of this model. These are based on experiences of researchers working with the VRHP and not on empirical evidence.*

Vadu Rural Health Programmeme (VRHP) is in a unique setting situated 35 km east of Pune. In this model the VRHP has dual role: as a private partner with the public sector and as a proxy to the government with 'Private' practitioners. This report intends to link some theoretical discussions with ground realities in an exemplary and one of the oldest PPPs.

There is an argument that civil society acts as a counterweight to markets, but still, promotion of such partnerships are grounded in the acceptance of neo-liberal growth strategies of economic development (Escobar 1995; Levine 2002). The public administration or management perspective looks at the characteristics of such partnerships and provides recommendations on how to establish them. A lot of literature suggests that public sector can learn from private sector in terms of efficiency, result orientation, flexibility and professionalism (Batley 2004, Bronson and Sahlin-Anderson 2000). Another perspective- more critically studied and empirically based – documents behavior and frequent failures of many partnerships. They address ideological background of PPPs assuming that all partners are equal. Studies that show how power relations shape and affect partnerships are relatively rare (Laurie 2005; Mosse 2004). This paper argues for the need of such studies.

Also there is little literature that suggests why public services should remain under the sole production/ control of the government.

The main objective of the paper is to describe the unique PPP model at VRHP and to discuss various aspects along with advantages and disadvantages of the same.

This paper also tries to argue that:

1. Efficiency of a sector is a function of incentive and market structures rather than ownerships. (5)
2. Flexibility, professionalism, freedom to take initiatives, and less number of barriers in quick decision making are the attributes of private sector that are crucial for growth and efficient operation of healthcare facilities.
3. Controlled freedom in PPPs can create environment conducive to new initiatives and innovations as it gives flexibility that is rarely seen in the public sector because of administrative structure.

Public Private Partnerships are a way to expand services without borrowing funds or raising taxes where resources (in other words – without increasing burden on government's funds) and technical/managerial expertise from both parties could be used for the greater good of community. In our observation so far, in healthcare they mostly pertain to either ultramodern, technologically or technically challenging areas or service deprived or logistically challenging sections of society. There is a huge potential to expand it to routine services as seen in the example of VRHP.

PPP at VRHP

Under the leadership of Padmabhushan Late Dr Banoo Coyaji the King Edward Memorial Hospital (KEMH) Pune tookmany insightful initiatives. VRHP was one of them. With Coyaji at the helm, the government had little doubts regarding public-service intentions and efficiency of KEMH staff. This made the government take teinitiative in proposing a model in Vadu area. 22 villages- 14 from Shirur block and 8 from Haveli block were assigned to VRHP. The purpose was to establish a highly efficient, technically robust outreach programme that would be exemplary for other PHCs. While good quality curative services would be administered through KEMH management.

In this model, outreach activities of a Primary Health Center (PHC) were to be financially (in terms of personnel, equipment and supplies) supported by government. The activities include vaccinations, family planning and welfare, school health check-ups, and other national programmes. The programmeme would carry out all activities supposed to be carried out by a Primary Health Center except that the headquarters would be run by the KEMH according to its norms.

An international philanthropic organization based in Hong Kong, 'Shamdasani Foundation' pitched in with funding to construct a building for a hospital under this programmeme and has been supporting on ad hoc basis for repairs and maintenance of building. This actually adds to the appeal of VRHP in terms of a unique PPP, where Government collaborated with an NGO, and a privately owned funding agency provided additional financial support to create a programme that would provide good quality healthcare to rural population at affordable costs. The hospital was renamed as Shirdi Saibaba KEM Hospital (SS KEMH). Historically the focus has been on Maternal and Child healthcare. It is being expanded to communicable and non-communicable diseases now.

The Medical Officer (who is usually a MBBS) is stationed at the PHC headquarters, takes care of Outpatients and primary healthcare problems along with obstetrical needs. Teams of surgeon/ anesthetist/ ophthalmologist/ other specialists visit the PHC according to rules or requirement. In SS KEM Hospital, which is run according to KEMH, Pune management norms, there is a provision for a residential Gynecologist, a Gynecology resident, a Pediatrician along with a residential Medical Officer who is a MBBS or non-allopath. All the staff would be employed by SS KEMH. From management and consumer perspectives it is a privately owned entity. In addition to this the hospital provides services of a radiologist, an ophthalmologist, a surgeon, an ENT surgeon twice a week and occasional visits (as per requirement) by laparoscopist and other skilled surgeons who commute from Pune. The fees are much lower than levied by the private sector for these services. (The laparoscopist mentioned above is different from the Government laparoscopist who visits for sterilizations which are done for free at the hospital and incentives provided to the beneficiaries as well.)

The position of Outreach Medical Officer is vacant for quite some time now but the Medical Officer is supposed to be responsible for monitoring and supervising outreach programme activities, proper delivery of national programmes and reporting to the VRHP administration. These reports in turn are sent to the District Health Office or Taluka (block level) Health Officer by the administration. There is a statistician appointed by the KEMH and he is responsible for maintaining data collected through outreach activities.

Then and Now

Situation in Vadu area has changed so drastically since the times when this partnership was forged, that the area is almost unrecognizable for older fellows who themselves have seen an era when there was a great scarcity of water, good transportation was a luxury, socio-economic status was nowhere close to what it is now and good medical care was at the mercy of handful of providers many of whom were not technically excellent or would commute from Pune. Now because of various small dams and canals for irrigating lands the farmers are in a better position. Many industrial areas have come up and these have contributed hugely in increasing economic turnover in this area. Shooting up of land prices during the economic boom days has contributed greatly towards changing the lifestyle of people.

Since last seven years there has been a change in the outlook towards the settings from KEMH management side. The emphasis is now on creating a model hospital that provides essential Maternal and Child Health care along with care from other specialties at a considerably low rate competitive to the private sector. This setting needs to be 'self reliant' for economic purposes. The incentives for specialists need to be enough to keep them engaged in such settings. In short a rural/ semi-urban corporate hospital supported by patients (in other terms the society around) with some support from government and technical guidance from competent hospital administrators.

This setting is close to but not exactly a 'cooperative' model. Routine operational costs are borne by the patients and government programmes are supported by the state. Thus financial

needs are taken care of by not 'just' the government but the population around also contributes towards them. In this model government takes care of preventive measures- in other words tries to bear the costs to prevent direct and indirect economic losses due to preventable conditions and population around pays for the curative care that it needs. In economic theories this might go as another kind of 'soft capitalistic- more socialistic' hybrid model. In our view it reflects the present mindset of our society and the current phase in socio-economic transformation. At present the hospital charges the patients fees that are much lower than those in private hospitals around. This way it is competing with the private sector for share of the patients. A small part of the fees is paid to the specialist as an incentive. Compared to fees of specialists in private sector in the area they are negligible but the volume of patients makes for it to some extent.

Governmental support requires the administration where services are provided for almost no cost to people below certain socio-economic status.

There were efforts made to experiment with low premium family health care insurance schemes but none worked for various problems.

Though the current administration in the District Health office feels the need for improvement in some areas, there is still a lot of enthusiasm and support from DHO office and other national programmes.

As it is true for all other PHCs, at VRHP too outreach workers visit the privately owned health facilities for collecting birth data and other relevant data. These figures are included in the report from VRHP area to the DHO. The government officials make sure that they include all VRHP data in their compilation and reporting of district data. It is collected by outreach programme workers and is then regularly presented to the Director of VRHP. Once approved by the VRHP administration it is sent to the DHO or THO.

What Did People Gain?

Efficiency is a function of incentives and market structures: Round the clock services of a gynecologist are a great comforting factor for population in the VRHP area. Along with the gynecologist a pediatrician, a gynecology resident, and a resident Medical Officer are present on the campus day and night. The institute has to strive hard to provide these services continuously while keeping a close eye on the costs to patient; quality of services though, is not a thing to be compromised on at VRHP. Regular turnover of specialists was a perennial problem.

VRHP has a unique appeal in that it provides an opportunity to work with the rural community while employee doctors can work in an institutional, academically oriented environment. They can be working for all sections of the society without compromising too much on their basic needs. In spite of this, till a few years back even socially inclined gynecologists would not continue for long periods; and that hampers the development of any organization. Since the 'incentive' system is introduced, there is a tendency in specialists to

continue for longer periods. Their intensity and enthusiasm in services has increased. So has the hospital's share of deliveries in the area. In late 2007 and early 2008 average number of deliveries at SS KEMH in a month was closer to 10 than 12. The average for last 6 months is more than 60. This is estimated to be more than 70% of all the deliveries occurring in the VRHP area (22 villages – 84000 population). There are 24-25 facilities that conduct deliveries in the area. One facility out of 24 taking a 70% share speaks for itself. A cursory look at average rates for normal and caesarian sections will show that rates at VRHP are around 30-40% of those in private sector. Very few cases of premature labor or underweight babies are referred to tertiary centers in Pune. A glimpse at the 'Remarks book' at VRHP tells a story about patient satisfaction at this hospital. Even small things like following daily routines for crucial procedures or keeping hospital premises maintained to provide a freshening environment are distinctly different from majority of PHC or Rural Hospital (RH) premises in the district or private facilities in the area.

Public facilities do not have the pressures to face competition with the private sector and lack of accountability, monitoring mechanisms, and conviction to medical services in present scenario among the PPs leads to practices that might be unfair to the patients or may be academically of low quality. A practice of 'performance based incentives' in the public sector may change the situation to some extent.

Efficiency and high service quality at affordable prices are supposed to be the endpoints of all efforts at VRHP. Both of these are observed to be better than solely public and solely private institutes.

Flexibility, professionalism and freedom to take (or at least express) initiatives: Flexibility and fewer hurdles in decision making can prove to be very effective in yielding to public demand. Quality of services and technical expertise of consultants was attractive to the population but many people did not want to come to the hospital because there were no special rooms even if they were willing to pay little more money. At SS KEMH the management created self-contained special wards and rooms for patients on public demand. Immediately more affording people started availing the services. This resulted in better services for other patients too. So was the case with tying up with laparoscopy surgeons and ophthalmologists. The hospital management has announced that soon there will be a dental OPD twice a week . Rarely can a rural population avail of these kinds of services and quality at such prices. The system here is definitely more quickly responsive to changes in and demands from the society around compared to public institutions.

There have been many other interesting population based studies. Some of those are:

1 Correlation of weight of placenta, low birth weight and outcomes in terms of morbidity and general health.

2 Hand washing and respiratory tract infections (ARI-Hand-washing studies) in collaboration with London School of Hygiene and Tropical Medicine.

3 Iron atta study in collaboration with Department of Bio-Technology (DBT), Government of India and St John's Hospital, Bangalore.

4 Sprinkles study in collaboration with Sick Children's Hospital, Toronto, Canada.

5 Meningococcal Vaccine project 003 and 005. In collaboration with PATH and WHO.

6 Measles Aerosol Vaccine Project. In collaboration with WHO.

7 Influenza Burden of Disease project in collaboration with ICMR, AIIMS, and CDC Atlanta.

8 Health and Demographic Surveillance System (HDSS) in collaboration with INDEPTH.

Since last seven years the programme has been conducting demographic surveillance rounds every six months under the 'HDSS'. This has resulted in compilation of longitudinal demographic data that will grow in its value with every passing year. This process of 'knowing' the base population has prompted many research activities. Any analysis where the denominator is known completely will make the researcher more comfortable than research based on estimated denominators. Such a surveillance system augurs well for conducting studies where denominator values are crucial and analyses are sensitive to these values.

Surveillance activities have enabled VRHP to have extensive interaction with the society because every household is visited in at the most 6 months.

How do these research activities benefit the population? Every research activity requires the programme to conduct community meetings where village heads are present as are senior influential people from the community. The scientific studies being designed meticulously give realistic information about disease conditions, preventive measures or sometimes just create awareness to alleviate fear and confusion.

The technical areas addressed by studies at VRHP are:

1 Diabetes and its connection to gestational period- diet, exercise, general health, etc.

2 Domestic violence and gender issues.

3 Sex and HIV awareness among teenagers.

4 Nutrition, weight of placenta and outcomes of Low Birth Weight babies.Acute Respiratory infections and Hand-washing.

5 Anemia and different strategies to address this problem

6 Various vaccine studies- Meningococcal vaccine, Measles Vaccine, H-Influenza B Vaccine, etc.

7 Influenza disease burden project

8 Ayurgenomics project- a study to explore any possible connection between 'prakruti' (concept in Ayurved) and genomic make up of the person.

These scientifically robust studies inevitably give in depth, correct, objective and up to date information to the population. These awareness creating activities make the population more inquisitive and proactive towards their health issues.

The likelihood of private sector venturing in such activities is less. In the government sector the priorities may differ according to situations and resources available. It may not be a very bold statement to say that there is a lot of inertia in the government system and epidemiologic changes in the society take a long time to have any kind of impact on policy making. The private sector rarely has the capacity nore perhaps the talent to conduct research; and, non-research government systems are not best conducive places for research activities. Fewer barriers in quick decision making are the attributes of private sector that are crucial for growth and efficient operation of healthcare facilities.

Private Practitioners and Research Projects

Since May 2009, VRHP has been involved in 'Influenza Disease Burden in Rural India' study. This study tries to assess the burden of severe influenza on medical facilities and the direct and indirect economic costs to the society. It was imperative for the study that 'all' or at least most eligible cases are recorded. A patient admitted overnight for certain problems would fit in the inclusion criteria. SS KEMH being predominantly a Maternal and Child Healthcare hospital, it was necessary that all private practitioners cooperate in data collection. This would actually mean that each case admitted in all these hospitals would be interviewed by a VRHP Field Research Assistant. This activity has many aspects to it.

VRHP acts as a proxy to the government in this area. Not too many doctors would want that a record of all admissions in their hospitals be kept by someone who is not their staff especially not if the person belongs to an institute that is a proxy to the government. In this case the topic of research was less glamorous compared to HIV-AIDS, Cardiac or Neurological problems, Neonatal conditions, Pregnancy and Obstetrical issues, diabetes, etc. The structure was didactic and more of academic interest (for short term thinkers) and results of sample testing would not affect the treatment. Direct benefit to the patient was next to negligible. The situation was challenging and stimulating. Researchers from VRHP started organizing CME sessions for private practitioners. The response was cold to start with for various reasons. Gradually person-to-person contact with all the practitioners in the area started changing the environment especially when there was an assurance that information collected from a hospital will stay with the research team only and would not be revealed to 'any' other person – not even doctors and researchers in other projects in VRHP. The fear was alleviated to some extent and all doctors showed enthusiasm in participating.

There are two other projects on-going at VRHP that require assistance from Pps. A Meningococcal vaccine trial and a Measles Aerosol Project (both are supported by WHO). In the Measles vaccine trial participating institutions include – WHO, Central Health

Ministry, India, State Health office, Maharashtra, DHO Pune, KEM Hospital Research Center, Pune and the private practitioners. Without help from PPs the study will not be scientifically robust and ethically compact.

At present all 55 but one doctors are cooperating in data collection for Influenza project. VRHP takes pride in it. Although, nobody knows how long this situation will continue. This relationship is completely dependent on willingness of the private practitioners and willingness is dependent on many factors, some of them being unknown. We argue for powers with such institutes so that such information can be collected for research and study purposes and the data collection is not dependant on variables that are not academic or factors which do not stem from public interest. State authorities have such powers especially in emergency situations. There have been movements to bring an act that would make the private practitioners report certain kinds of communicable diseases to the government.

This situation throws light on some of the factors that are responsible for the slim number of epidemiological studies being conducted in India especially given the technical areas that need to be addressed through such studies. For a population as huge as India's estimated denominators for studies on TB, HIV-AIDS, Malaria, HepB, Diabetes, CVDs, etc do not augur well for producing high quality policy decisions. Unrestrained Cooperation from the private sector is a must in this process.

From the PP's point of view, there needs to be provision for reimbursing his time, efforts and goodwill that will be used for such activities. This arguably calls for better regulation of private sector so that all cases are recorded. All treatment given is recorded along with outcomes. This would have positive economic, medical and social ramifications.

The lack of self discipline stems from a tacit general understanding that certain responsibilities are to be borne by the government only. This thinking has its roots in the Medical educational culture where there is little scope for comprehensive thinking about medical field and practice as such. People are supposed to learn these things on their own. There is little mention about economic implications of treatments and how medicine-health-economics-social attributes are interdependent as well as they form a comprehensive society. The role of a doctor in the society is not clear to the medical student.

The Curious Case of Swine Influenza in VRHP Area

As a part of Influenza study VRHP has been sending throat and nasal swabs of admitted patients who fit the eligibility criteria to NIV for testing. These samples were supposed to be tested for seasonal influenza viruses. When Swine flu epidemic started in Pune and there were surmises that it might have spread out of Pune, these same samples were tested for Swine flu if they were untypable. The first case in VRHP area was diagnosed because a Private Practitioner had a strong suspicion about his patient and his swab was collected through VRHP system. The same swab was tested and found positive for Swine flu. The patient was immediately admitted to the assigned hospital and got cured.

Being so close to Pune, the epicenter of Swine flu outbreak in India, VRHP area was supposed to find swine flu cases sooner in the epidemic than later. The media coverage spread a wave of fear and confusion among the people in this area. Private practitioners were in a state of confusion as to whom to admit and whom to refer to centers in Pune; especially because a big private hospital in Pune had to face legal issues because of a 'swine flu' death.

In Pune there was a great chaos at centers identified by the government for testing and admitting patients with swine flu. At such a crucial time, because VRHP was in a unique position to be associated with the NIV, we were collecting samples in the same manner as required for the 'swine flu' testing. Private practitioners were looking up to us to take a lead in dealing with the situation. There was a meeting in which majority of practitioners participated and expressed their views. Everyone agreed to address community meetings in villages, schools and Panchayats in the area. It was heartening to be a part of a collective effort from Government, NGO, and private sector along with support from research center like NIV.

Conclusions

Various issues have been implicitly stated in the discussion above however we want to reiterate them again here.

1 There is a need for studies that show how power relations are shaped by and affect PPPs.

2 There is a need to create a system of 'performance based incentives' in the public sector.

3 Provisions should be made so that the private practitioners are required to assist studies and research projects and cooperate in implementing national programmes as well assisting with providing data to concerned government authorities.

4 Inclusion of broader understanding of integrated nature of 'health-economics and social aspects' in the medical education curriculum; making the medical education thought provoking than didactic.

5 Practical training on ethical issues, legal aspects, and human rights during internship.

6 Extensive collaborations between private and state healthcare sectors.

References

EscobarE, A. (1995): *Encountering Development: The Making and Unmaking of the Third World.* Princeton University Press, New Jersey.

Levine, M (2002): 'Metropolitan Polarization in an Era of Affluence: Income Trends in Metropolitan Milwaukee Since 1990' University of Wisconsin-Milwaukee, Center for Economic Development (January).

Batley, R. and Larbi, G. A., (2004): *The Changing Role of Government: The Reform of Public Services in Developing Countries,* Palgrave Macmillan.

Mosse, D., (2004): 'Power Relations and Poverty Reduction', in Power, rights and poverty: concepts and connections, ed. R Alsop, The World Bank, Washington D.C., pp.51-67.

(2005): 'Incentives and the fficiency of Public Sector-outsourcing Contracts' *Journal of Economic Surveys*, Volume 19 Issue 5, pp. 767 – 787. (Published Online: 25 Nov 2005 Journal compilation © 2010 Blackwell Publishing Ltd)