" TO STUDY THE EFFECTIVENESS OF HS 20/20 PILOT PROJECT CLINIC MODEL AS AN ALTERNATIVE MEAN OF AFFORDABLE, ACCESSIBLE AND QUALITY HEALTH CARE FOR POOR AND MARGINALIZED SLUM DWELLERS"

A dissertation submitted in partial fulfilment of the requirements
for the award of

Post-Graduate Diploma in Health and Hospital Management

by

Dr Sheenu Chaudhary

International Institute of Health Management Research
New Delhi -110075

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Certificate of Approval

The following dissertation titled "To study the effectiveness of HS 20/20 pilot project clinic model as an alternative mean of affordable, accessible and quality healthcare for poor and marginalized slum dwellers" is hereby approved as a certified study in management carried out and presented in a manner satisfactory to warrant its acceptance as a prerequisite for the award of **Post- Graduate Diploma in Health and Hospital Management** for which it has been submitted. It is understood that by this approval the undersigned do not necessarily endorse or approve any statement made, opinion expressed or conclusion drawn therein but approve the dissertation only for the purpose it is submitted.

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PRAGYA T. GUPTA	
Kirti Udaya.	

Certificate of Internship Completion

TO WHOM IT MAY CONCERN

This is to certify that Dr. Sheenu Chaudhary has successfully completed her 3 months internship in our organization from December 19, 2011 to March 19, 2012. During this intern she has worked under the guidance of me and my team at Deloitte, Nehru Place, New Delhi.

We wish him/her good luck for his/her future assignments.

(Signature)
VIKAS DAGUR (Name)
PROJECT MANAGER Designation

Certificate from Dissertation Advisory Committee

This is to certify that **Dr. Sheenu Chaudhary**, a graduate student of the **Post- Graduate Diploma in Health and Hospital Management**, has worked under our guidance and supervision. She is submitting this dissertation titled **" To study the effectiveness of HS 20/20 pilot project clinic model as an alternative mean of affordable, accessible and quality health care for poor and marginalized slum dwellers"** in partial fulfillment of the requirements for the award of the **Post- Graduate Diploma in Health and Hospital Management**.

This dissertation has the requisite standard and to the best of our knowledge no part of it has been reproduced from any other dissertation, monograph, report or book.

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INTERNSHIP REPORT

ABOUT THE ORGANISATION

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- Designing and implementing pension and social safety systems to improve the lives of populations
- Implementing USG and other donor programs in emerging market settings for over 20 years.

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Financing healthcare is a critical component of a functioning healthcare system. Out-of-pocket spending by households accounts for more than half of total health financing in many developing countries.[1] Budgets and resources are not aligned to results. Ineffective health insurance mechanisms do not properly pool financial risks. Lack of transparent, efficient financial management systems contribute to poor resource mobilization, lack of transparency, and ineffective planning and decision making. These challenges greatly impede access, quality, efficiency and sustainability of healthcare services.

Deloitte helps countries across the spectrum of health financing issues, supporting regional, national and international stakeholders in strengthening health financing strategies and programs. Our specific areas of specialization include:

- Risk pooling and health insurance
- Resource mobilization
- Resource tracking and National Health Accounts
- Results-based financing
- Costing

Health Financing – Risk Pooling and Health Insurance

- In many developing countries, out-of-pocket spending accounts for a significant portion of total health expenditures. This regressive form of health financing can affect utilization rates, reduce equity in access to care, and push families deeper into poverty. Risk-pooling is one mechanism that can be used to help spread the costs of healthcare over a population group in an effort to reduce the catastrophic implications of out-of-pocket expenditures.
- Deloitte understands the social, political and infrastructural factors that need to be considered when designing, implementing or strengthening health insurance initiatives. For health insurance implementation to be successful, it is critical to pay close attention to the details of the design, operationalization, and execution. We help countries navigate

the details and multiple dimensions of successful health insurance, including the regulatory environment, benefit package design, financing, provider payment mechanisms, enrollment procedures, and other operational requirements of an insurance scheme. Our work has helped countries expand and strengthen health insurance to improve equitable access to healthcare.

DELOITTE WORK IN INDIA

Deloitte has worked in India for many years to help strengthen health insurance. When the insurance industry was opened up to the private sector, Deloitte was selected to provide comprehensive technical assistance to the IRDA to help build its institutional capacity in insurance supervision, help it supervise and enforce compliance of the insurance laws and regulation, bring international "best practices" to the industry, and help increase transparency and efficiency in allocation and mobilization of resources.

Since 2009, Deloitte under the flagship of USAID , working on Health Systems 20/20 and providing technical assistance to the Government of Delhi's Mission Convergence has had the dual aim of facilitating greater access to health insurance and financial risk protection for the urban poor and ensuring that public health system extends to these hard-to-reach populations to meet their unique healthcare needs. The Delhi Government sponsors a number of health schemes targeted at this marginalized population. The schemes, one of which is to extend financial risk protection against hospital expenses, seek to reduce infant mortality, maternal mortality and out-of-pocket expenditure on health. However, a survey of households conducted by the Health Systems 20/20 project in 2010 revealed telling information about actual use of these schemes by those they are intended to serve. The survey indicated that the population's limited knowledge of government-sponsored insurance options available to them and the low practice of preventive health care all impede vulnerable households' access to quality and affordable healthcare. High out-of-pocket expenditures for health, despite coverage with insurance, continue to mark the health system with which the poor interact. Therefore, sub-optimal

use of the financial risk protection afforded by the government health system results in many missed opportunities to positively impact health outcomes of the poor.

Bearing this in mind, USAID's Health Systems 20/20 program worked closely with the Mission Convergence to address the implementation challenges faced when providing health insurance for vulnerable families as a means to extend final risk protection against the shock of catastrophic health events. The project collaborated with its network of selected Gender Resource Centers (GRCs), the implementation arm of Mission Convergence in communities, to demonstrate strategies that can make a significant difference in how the poor interact with the health system. Health Systems 20/20's inclusive approach sought to shed light on the different facets of the health system – from health insurance mechanisms to public and private providers to community organizations to public health managers – all which are linked and must work in concert to affect the behaviors of the poor. Health Systems 20/20 strategies were designed to encourage more efficiencies within the Delhi health system to ensure that its components complement one another and make the desired impact on the health outcomes of poor households and households' ability to confront personal health shocks without sinking deeper into poverty.

PART 2- DISSERTATION REPORT

CHAPTER 1 – INTRODUCTION

1.1HEALTH SYSTEMS 20/20

Since 2009, Health Systems 20/20 technical assistance to the Government of Delhi's Mission Convergence has had the dual aim of facilitating greater access to health insurance and financial risk protection for the urban poor and ensuring that public health system extends to these hard-to-reach populations to meet their unique healthcare needs. The Delhi Government sponsors a number of health schemes targeted at this marginalized population. The schemes, one of which is to extend financial risk protection against hospital expenses, seek to reduce infant mortality, maternal mortality and out-of-pocket expenditure on health. However, a survey of households conducted by the Health Systems 20/20 project in 2010 revealed telling information about actual use of these schemes by those they are intended to serve. The survey indicated that the population's limited knowledge of government-sponsored insurance options available to them and the low practice of preventive health care all impede vulnerable households' access to quality and affordable healthcare. High out-of-pocket expenditures for health, despite coverage with insurance, continue to mark the health system with which the poor interact. Therefore, sub-optimal use of the financial risk protection afforded by the government health system results in many missed opportunities to positively impact health outcomes of the poor.

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1.2Swasth Foundation

Swasth Foundation started an evening clinic in Udyog Nagar slum area of North West Delhi in July 16th 2011, as part of HS20/20 project on improving access to healthcare. This clinic provides quality affordable care – at Rs 5 / consultation, drugs at 50% discount, and linkages with diagnostics providers for discounted rates. The model has evolved to providing services at 2 locations, 3 days a week at each location.

1.3Socio-economic status of the catchment area:

Udyog Nagar slum area which is a part of Mangolpuri mainly consist of "Jhuggi Jhopdi" clusters. No of households is 1200 with approx. 6000 population.

According to HS 20/20 baseline survey and CNA report :

More than half the households surveyed have a Scheduled Caste / Scheduled Tribe /Other Backward class status (78% in Mangolpuri).

41% of households have BPL cards.

Religion: More than 85% of households are Hindu, with the rest primarily being Muslim.

Education:

1. Higher education levels are low – with only 2-4% of household holds atleast being a graduate. Standard of education is better assessed through the levels of primary and secondary education.
2. Mangolpuri, being close to Mangolpuri industrial area, has 68% of household heads educated to primary or higher.

Occupation:

1. Occupation types were divided into 3 categories – Not working, Irregular (includes domestic labour, hawkers, untrained construction workers), Regular (includes working in a small scale industry or a company, and trained construction workers), and Selfemployed.
2. 7-10% of household heads do not work – which is a high level of unemployment. Most of the household heads work in an irregular or regular kind of job.
3. Mangolpuri, by virtue of proximity of industries in Mangolpuri industrial area, has 44% of household heads working a regular job
4. Irregular jobs are more common in slums.

1. Raghubir Nagar and Mangolpuri both have government and private providers widely present.
2. **There are enough private providers** -- 5-11 nursing homes and 30-60 OPD doctors in the area. Most of the nursing homes 5-30 bed setup run by a single qualified doctor, with a few other specialists as consultants. OPD doctors are predominantly BAMS / BHMS / BUMS, some RMPs, and a few MBBS. RMPs and BAMS / BAMS / BUMS doctors are usually within a short walking distance from most of the catchment area. Additionally, there are adequate number of multispeciality trust hospitals nearby that people avail the services of.
3. **People usually do not appreciate the difference between doctor qualification levels** (those who do usually disregard it) – they prefer going to private unqualified doctors a few times, and escalating to an MBBS doctor only when the situation does not improve in a few visits.

4. There are **NGOs working on a vertical health issue** in the catchment area, usually running a center locally offering counseling / follow up care on the theme. These centers will be a part of a bigger Delhi wide project. There are very few targeting overall health. Two of these health NGOs in the area are Worldvision (drug deaddiction) and Savera (HIV / STDs).

1.4PROBLEM STATEMENT:

Development efforts in India have mostly been rural focused. Although living in proximity to good health facilities, urban poor are often unable to access them, because of unequal distribution of health services, heavy patient load corresponding to long waiting hours, ineffective outreach and weak referral system. In such situations vulnerable community often get attracted by local healers and quacks, available within the slums and are friendly and flexible in mode of payment. Social exclusion and lack of information also plays an important role.

The lack of economic resources restricts their access to available private facilities. Further, the lack of standards and norms for the urban health care delivery system when contrasted with rural network makes the urban poor more vulnerable and worse off than their counterpart**.**

The health statistics of the urban poor are worse than the urban average. This may be consequence of living in degraded environment, inaccessibility to health care, irregular employment, widespread illiteracy.

Thus inaccessibility to quality healthcare services, unaffordability and unequal distribution of health care services affects the health seeking behavior of people resulting in reliability on unqualified medical practitioners, degraded health conditions and increased out of pocket expenditure of urban poor.

1.4.1JUSTIFICATION OF THE PROBLEM STATEMENT

The following data is taken from community need assessment report done by Swasth Foundation, which suggests that there high incidence of illness of acute and chronic diseases, casual health seeking behavior, increase in wage loss due to illness in Udyog Nagar community.

1.4.1.1Acute illnesses

1. High prevalence of fungal infections (resulting in skin infections, or vaginal discharge amongst women – white discharge cases are common at GRC's OPD clinics), water borne diseases (diarrhoea, hepatitis), and air borne diseases (ARI).

2. **Illnesses amongst men seem almost as common as those amongst women**. HS20/20 baseline data indicated 54% of chronic conditions as coming from men (46% amongst women).

3. **People prefer to consult an unqualified doctor and carry on with their work when ill** – unless the condition worsens. In the latter case, they consult a qualified doctor – and may end up skipping work. People didn't lose any working days in 717 of the 839 cases reported – these would be in the first category of conditions that were handled with an unqualified doctor. However, the other 122 conditions saw an average working day loss of 8 days.

4. Cases of water supply pipe leakage were noticed in Raghubir Nagar, indicating high level of water contamination and thus **high incidence of water borne diseases**.

Mangolpuri is closer to the industrial area and susceptible to a higher level of industrial air pollution. Data corroborates this –17% diarrhoea and 22% ARI incidence respectively in Mangolpuri. Furthermore, **the poor health status in slum regions of Mangolpuri (Udyog Nagar) is also reconfirmed by 10% higher chronic condition incidence than resettlement areas.**

1.4.1.2Health Seeking behaviour

1. People have a **casual attitude to most illnesses**. Common early signs, such as weakness, pain, headache or fever, are usually ignored – people either ignore it, go for self medication, or see a local unqualified practitioner, and go about their regular work. **Qualified doctor's consultation is sought when the condition worsens (20-30% of conditions) - by which time, the condition is bad enough for people to take leave from work (1 in 6 conditions average,resulting in average 8 days off work).**

2. **Underdiagnosis of common chronic conditions**, like hypertension, diabetes and anaemia, results from the casual attitude to most illnesses. Most unqualified doctors are not equipped with basic diagnosis – and these conditions thus continue to be undiagnosed.

3. Community is **largely uninformed about causes of illnesses**, or basic prevention around it. For example, people believe that if water looks clear, it is fit to drink. Only visual impurities are taken as sign of unclean water – and when it is seen in supplied water, it is drained till it becomes clear again. Water filters are not common. Worse, community strongly holds onto these beliefs, and needs persuasive tools to change.

4. **Handling of illnesses is largely thought of as curative**, and lifestyle changes to preventthem are ignored. Hypertension, diabetes and anaemic patients have been given drugs and advised on lifestyle / eating habit changes to handle their conditions. When followed up,they consumed the medication offered – but eating / lifestyle changes advised were not followed.

5. Even when cost is not an barrier (eg for RSBY members), there is **perceptable bias against surgical procedures** esp amongst the elderly. We encountered various RSBY card holders in need of cataract and gall bladder stones surgery that were reluctant to go ahead with it.

6. **Unhealthy habits** are responsible for much of incidence, esp chronic conditions. Tobacco, alcohol consumption and smoking are high overall, and there are pockets of drug abuse. The health mela in B-2 JJ cluster (in Raghubir Nagar) identified various at risk for oral and lung cancer, caused by tobacco and smoking.

7. **Those with chronic illness consumed alcohol twice more frequently** than those without, suggesting the reverse causality. The incidences of people with 2 or 3 chronic conditions is also quite high – also hinting their illnesses as caused by their unhealthy habits.

8. **Home delivery rates are high**, esp in slum areas – and reason cited by people revolved around the perceived lack of need for institutional delivery. HS20/20survery indicated home deliveries at 52% and 44% in slum areas of Raghubir Nagar and Mangolpuri respectively (as opposed to 20% in resettlement areas).

9. Another indicator of low health situation awareness is **delayed breastfeeding** of infants – 36% infants are first breast-fed after 1 hr of delivery (goes up to 49% and 43% in slums of Mangolpuri and Raghubir Nagar respectively).

1.4.1.3Areas of Work

Based on the above study, improving the health situation will require 3 broad categories of intervention:

1. Increase awareness:

1. Educating about government dispensaries, ASHAs, ANMs – their locations and services, health financial assistance schemes, such as RSBY, JSY, MAMTA, and various vertical programs that offer health services such as mobile vans, chlorine supply, ORS, etc at the field level. This will be aimed at redirecting people towards availing these services and reducing their spend in private sector.
2. Changing community perceptions about safe drinking water, importance of sanitation in a persuasive manner.
3. Steering people away from high levels of tobacco / alcohol consumption and smoking, linking it to chronic conditions it puts people at risk to.
4. Sensitizing people on importance of behavioral / lifestyle / habit changes to handle common conditions such as hypertension, blood pressure, anaemia

2. Increase access to diagnosis and improved primary care services

1. Increased detection of common chronic conditions such as hypertension, diabetes, cancer – and management of these conditions. This includes supplementing primary care services, including those run by GRCs, with additional diagnostics to increase detection and making some simple diagnostics available on the field, with community volunteers and ASHAs.

2. Bridging the **community linkage gap due to fewer ASHAs in Mangolpuri with health volunteers.**

3. Improve compliance of treatment and surgeries through followup. These include working with existing local NGOs working on vertical health themes, involving them in handling the conditions diagnosed.

4. Linking with programs that offer treatment for various conditions, or financial assistance for them, even those outside of RSBY. These include Delhi Blindness control society (DBCS)'s treatment for cataract, MAMTA for deliveries and NGO run DOTS centers.

5. Reducing the cost of outpatient care by targeting the cost of drugs.

3. Facilitate access to secondary / tertiary services by:

1. Assisting patients in logistics and paperwork involved in getting benefits under JSY and
MAMTA

2. Ensure that RSBY patients get promised treatment at the empanelled hospitals

Accessibility and availability of health care is important for ensuring a community's general health status and reflects the reach and coverage of health facilities.

1.5 RATIONALE OF THE STUDY

The poor health conditions among slum dwellers, comprising large section of growing urban population needs to be addressed as the already underserved urban poor are at risk of becoming even more vulnerable because population growth outstrips the meager services that exist.

If primary health care services are provided at the doorstep of the poor and vulnerable community it can lead to

- Healthy lifestyle among slum dwellers
- Better primary health care needs addressed at local level
- Reduced chances of secondary and tertiary health complications
- Reduced out of pocket expenditure
- Decreased burdon on the tertiary healthcare providers

Rational of the study is to investigate alternative health care model for hard to reach areas and poor and marginalized population in urban slums which provides affordable, quality services and act as a referral health care unit, so that if primary health care services are provided at the doorstep of the poor and vulnerable community it can lead to reduced out of pocket expenditure, comprehensive healthcare and decreased burdon on the tertiary healthcare providers.

CHAPTER 2 - LITERATURE REVIEW

Y Balarajan, S Selvaraj and S V Subramanian(2011) discusses that in India, despite improvements in access to health care, inequalities are related to socioeconomic status, geography, and gender, and are compounded by high out-of-pocket expenditures, with more than three-quarters of the increasing financial burden of health care being met by households. Health-care expenditures exacerbate poverty, with about 39 million additional people falling into poverty every year as a result of such expenditures. We identify key challenges for the achievement of equity in service provision, and equity in financing and financial risk protection in India. These challenges include an imbalance in resource allocation, inadequate physical access to high-quality health services and human resources for health, high out-of-pocket health expenditures, inflation in health spending, and behavioral factors that affect the demand for appropriate health care.

Substantial socioeconomic inequalities exist in access to health care in India. In 2005–06, national immunization coverage was 44%, whereas the coverage was 64% for children of mothers with more than 5 years of education, and 26% for children of mothers with no education. Similarly, even though rates of delivery in institutions have increased with time, only 40% of women in India report giving birth in a health facility for their previous birth in 2005–06, with women in the richest quintile six times more likely to deliver in an institution than those in the poorest quintile. Between 1986–87 and 2004, the absolute expenditures per outpatient visit and inpatient visit in rural and urban areas increased, particularly affecting the ability of the poorest individuals to access services. Although costs have increased in the public and private sectors, the increase has been much faster (>100%) in the private sector. Expenditures for drugs, which represent 70–80% of out-of-pocket expenditures for outpatients, have been increasing with time at a rate that is at least twice as fast as the general price increase.

A cogent moral, social, and economic argument exists for investment in the achievement of health-care equity for Indian people. Recent rapid economic growth provides a unique opportunity to increase financial commitments to support the public health system and

health-systems research. India can also draw from its booming technology sector to innovate and strengthen the development of health information systems, which has already begun. Improved water and sanitation, food security, poverty reduction, and changes to other structural factors, complemented by an equitable health system, will help ensure greater equity in health for more than 1 billion people.

Kamla Gupta, Fred Arnold, and H. Lhungdim (2009) discuss the report that analyzes health and living conditions in eight large Indian cities (Chennai, Delhi, Hyderabad, Indore, Kolkata, Meerut, Mumbai, and Nagpur). The report is based on data from India's 2005-06 National Family Health Survey (NFHS-3). A special feature of NFHS-3 is that the sample was designed to allow separate estimates of population, health, and nutrition indicators to be generated for each of these eight cities, as well as for the residents of slum and non-slum areas in these cities. In addition, a wealth index was constructed for households in urban India as a whole, using NFHS-3 data on household assets and housing characteristics. For the purposes of this report, the urban poor population is defined as those persons belonging to the lowest quartile on this wealth index.

The study examines the living environment, socioeconomic characteristics of households and the population, children's living arrangements, children's work, the health and nutrition of children and adults, fertility and family planning, utilization of maternal health services, knowledge of HIV/AIDS, attitudes of adults toward schools providing family life education for children, and other important aspects of urban life for the eight cities by slum/non-slum residence and for the urban poor

The analysis shows that more than half of the population in Mumbai lives in slums, whereas the slum population varies widely in the other seven cities. Major differences in the estimation of the size of the slum population are found depending on how slum areas are defined (according to the 2001 Census designation or observation of the area by the NFHS-3 team supervisor at the time of the fieldwork). The poor population in these cities varies within a narrower range, from 7 percent in Mumbai to 20 percent in Nagpur. The analysis finds that a substantial proportion of the poor population does not

live in slums and that a substantial proportion of slum dwellers are not poor (that is, they do not fall into the bottom quartile on the NFHS-3 wealth index). In some cities, the poor are mostly concentrated in slum areas, whereas the reverse is true in other cities.

Although slum dwellers are generally worse off than non-slum dwellers, this pattern is not consistently true for all indicators in every city, and the differentials are quite small in some cases. However, there are large disparities in health and living conditions between the poor and the non-poor in these cities. Although there is an obvious need to improve living conditions and the health of slum dwellers, it is equally apparent that programs that focus solely on slum areas will not be able to address the urgent needs of the large poor population not living in slums.

John Wakerman (2008) discusses that one third of all Australians live outside of its major cities. Access to health services and health outcomes are generally poorer in rural and remote areas relative to metropolitan areas. In order to improve access to services, many new programs and models of service delivery have been trialed since the first National Rural Health Strategy in 1994. Inadequate evaluation of these initiatives has resulted in failure to garner knowledge, which would facilitate the establishment of evidence-based service models, sustain and systematize them over time and facilitate transfer of successful programs. This is the first study to systematically review the available published literature describing innovative models of comprehensive primary health care (PHC) in rural and remote Australia since the development of the first National Rural Health Strategy (1993–2006). The studies aimed to describe what health service models were reported to work, where they worked and why.

A reference group of experts in rural health assisted in the development and implementation

of the study. Peer-reviewed publications were identified from the relevant electronic databases. 'Grey' literature was identified pragmatically from works known to the researchers, reference lists and from relevant websites. Data were extracted and synthesized from papers meeting inclusion criteria.

A total of 5391 abstracts were reviewed. Data were extracted finally from 76 'rural' and 17 'remote' papers. Synthesis of extracted data resulted in a typology of models with five

broad groupings: discrete services, integrated services, comprehensive PHC, outreach models and virtual outreach models. Different model types assume prominence with increasing remoteness and decreasing population density. Whilst different models suit different locations, a number of 'environmental enablers' and 'essential service requirements' are common across all model types.

Synthesized data suggest that, moving away from Australian coastal population centres, sustainable models are able to address diseconomies of scale which result from large distances and small dispersed populations. Based on the service requirements and enablers derived from analysis of reported successful PHC service models, we have developed a conceptual framework that is particularly useful in underpinning the development of sustainable PHC models in rural and remote communities.

Thomas Crowley (2009) discusses the report that analyzed the rural implications of statewide health reform proposals being considered by the Governor's Transformation Taskforce and the Legislative Commission on Health Care Access. The report included recommendations for ensuring that policy proposals are relevant to rural Minnesota. One recommendation was to improve the quality and safety of health care by "designing and supporting a rural health care delivery model (e.g., health care home) in which chronic and acute care is seamless" (Minnesota Department of Health, 2007).

The Rural Health Advisory Committee (RHAC) is a statewide forum for rural health interests. The committee, appointed by the Governor, is composed of 15 members representing licensed health care professionals, higher education, legislative officials and consumers. The RHAC advises the commissioner of health and leaders in other state agencies on rural health issues. After examining health care access and delivery trends (including potential changes due to proposed health reform), the RHAC determined a thoughtful discussion around a new model for rural health care delivery was needed.

The New Rural Health Care Delivery Model Work Group was formed to examine the influence

health reform legislation may have on rural health delivery, and how rural providers and

consumers may directly benefit from improvements to the current health care system. The group
consisted of RHAC members and additional stakeholders of the rural health care delivery system. The charge of the work group was to examine primary care and other essential health services in rural Minnesota and to identify the challenges and benefits associated with primary care becoming the foundation for a new health care delivery model. This report documents the efforts of the work group, leading to policy recommendations supportive of establishing primary care, integrated health systems and interdisciplinary teams as a new model of rural health care delivery.

A comprehensive redesign of the health care delivery system will mean a new way of providing and experiencing health care services in Minnesota. It is important that the recommendations and issues identified in this report are carefully considered for successful changes in future health care delivery models and in health care reform initiatives. This work provides a step toward envisioning what a new model of health care delivery may look like.

Taken together, the recommendations lead to notable progress in stabilizing and improving rural health care systems and positions rural health providers to make the contributions needed to successfully meet health reform goals and provide citizens with the health care improvements they expect and need.

CHAPTER -3

HEALTH STATUS OF URBAN POOR IN INDIA AND DELHI

Who are urban poor?

In 2002, the United Nations operationally defined slums as communities characterized by insecure residential status, poor structural quality of housing, overcrowding, and inadequate access to safe water, sanitation, and other infrastructure (United Nations Human Settlements Program, 2003).

After China, India has the largest urban population in the world[1].

India has undergone rapid urbanization over the past fifty years. As per the 2001 Census (Office of the Registrar General and Census Commissioner, 2001), 28 percent of the population of India was living in urban areas.

Four of these cities (Mumbai, Kolkata, Delhi, and Chennai) feature among the 20 largest cities in the world. The growth rates of most of these big cities have remained higher than the average growth rates of the urban population as a whole. According to the medium range projections of the United Nations, 41 percent of India's population will live in urban areas by 2030 (United Nations, 2005).

The size of the country's urban population is projected to increase to nearly 586 million by 2030. It is estimated that urban population growth will account for over two-thirds of total population growth in India in the first quarter of the 21st Century. Slums remain the fastest growing segment of the urban population, with almost double the overall growth of the urban population.

The health statistics of the urban poor are worse than the urban average. This may be consequence of living in degraded environment, inaccessibility to health care, irregular employment, widespread illiteracy.

[1] Urban health report

The urban poor suffer from adverse health outcomes which do not get reflected in the commonly available health statistics.

For instance ,Under five mortalities among the urban poor (112.5) are nearly three times higher than that for the urban high income groups(39.4). As per NFHS-2 data, among children 12-23 months of age, belonging to the urban poor only 43% are fully immunized. The proportion of severely under weight children among the urban poor (23%) is five times higher than that of urban income group (4.5%).[2]

PROBLEMS LEADING TO DEGRADED HEALTH OF URBAN POOR

Growth rate in rural areas of India have declined while growth rate in urban areas have grown steeper. The urban population is expected to increase to 35.7 crore in 2011 and 43.2 crore in 2021. Growth is not accounted for by **higher birth rates** alone, but significantly draws from **migration and population mobility** as well. It is estimated that in future, great majority of India's population growth will be coming from its urban areas. While 30% of India's people live in urban areas today, estimates tell us that India will be 50% urban within two decades Owing to rapid growth the already underserved urban poor are at risk of becoming even more underserved as the population growth outstrips the meager services that exist Urban growth has led to rapid increase in number of urban poor population, many of whom live in slums and squatter settlement. This is putting greater strain on the urban infrastructure which is alredy overstrechhed. [3]

The poor health conditions among slum dwellers, comprising a large section of our growing cities, needs to addressed on a priority basis.The health and productivity of this section of population are vital as they play an imperative role in the economic activities of cities which in turn contribute to the economic growth of the country.

CHAPTER 4

SWASTH CLINIC – A BRIDGING MODEL FOR QUALITY HEALTHCARE

According to HS20/20 baseline report

Expenditure on OPD Treatment for Most Recent Ailments

The itemized breakdown of the average total expenditure incurred for OPD treatment for the most recent reported ailments within the household responding. As can be seen, **four-fifth (81%) of the total expenditure was incurred on medicines and doctor's fee, with medicines accounting for the major chunk (68%). The remaining one-fifth was spent on transport & others expenses as well as investigations such as laboratory testing (10% and 9%, respectively).**

A comparative analysis of the itemized breakdown of the total average expenditure incurred at Government facilities, private facilities and unauthorized medical practitioners is presented in Table, below. As expected, the average expenditure at private facility is much higher than expenditure at Government facility or with an unauthorized medicial practitioner. While the private facilities are twice as expensive as the Government facility, they are four times as expensive as an unauthorized medicial practitioner. Further, treatment by umauthorized medicial practitioner is half as expensive as the treatment at Government facilities.

Also notable is the proportion of total expenditure that medicines comprise. These account for a minimum of 59% at private facility and maximum of 87% for unauthorized medicial practitioners. Surprisingly, in the case of Government hospitals, four-fifth (79%) of the total expenditure was incurred on medicines, indicating that they were prescribed to be bought from outside.

It is also interesting to note that while the percent share of expenditure on medicines at private facilities (59%) is much smaller than that for the Government facilities (79%) or unauthorized medical practitioners (87%), in absolute terms, the amount spent on

medicines at private facilities (Rs. 459/-) is much higher than that spent at Government facilities (Rs. 318/-) or with unauthorized medicial practitioners(Rs. 187/-)

Itemized Expenditure on OPD Treatment (in Rs. and % of Total Expenditure)

Expenditure on:	**Overall (n=432)**		**Govt. Facility (n=137)**		**Pvt. Facility (n=170)**		**Unauthorized Medical Practitioners (n=125)**	
Doctor's Fees	63	(13%)	8	(2%)	145	(19%)	13	(6%)
Medicines	340	(68%)	318	(79%)	459	(59%)	187	(87%)
Investigations	42	(9%)	8	(2%)	99	(13%)	4	(2%)
Transport & Others	49	(10%)	69	(17%)	70	(9%)	11	(5%)
Total	**494**	**(100%)**	**403**	**(100%)**	**773**	**(100%)**	**214**	**(100%)**

SNAPSHOT OF PRIMARY HEALTHCARE ACCESS

As per **NSSO data**, per capita outpatient expense in Delhi is Rs 589 per year, compared to a national average of Rs 478. **Drug costs account for 60% of outpatient expense in Delhi, while other medical expenses account for 19% (largely consultation and diagnostics)**. These are higher than national

averages of 52% and 13% effectively – thus doubly adding up the burden of medical costs in Delhi.

Awareness and finance are the biggest barriers to non-treatment, not access to provider. About 15% ailments go untreated, and with the following 3 being the top reasons for lack of treatment:

1. "Ailment not serious enough": ~40%
2. "Lack of financing": ~35%
3. "Lack of access": ~2%

Our effort will thus focus on reducing the cost of consultation and drugs cost.

SWASTH CLINIC- A BRIDGING MODEL

FEATURES/ KEY ROLES :

- ***Improving access of services to the urban poor.***
- ***Enchancing the role of community mobilisers in improving health conditions through awareness and education.***
- ***Addressing the key problems of health in the community.***
- ***Awareness regarding the policies and programmes by the government.***
- ***Promoting preventive care through improved primary health care services***

Swasth Foundation started an evening clinic in Udyog Nagar slum area of North West Delhi in July 16th 2011, as part of HS20/20 project on improving access to healthcare. This clinic provides quality affordable care – at Rs 5 / consultation, drugs at 50% discount, and linkages with diagnostics providers for discounted rates. The model has evolved to providing services at 2 locations, 3 days a week at each location. Learnings on clinic and care best practices have been made over this period.

The objective is to develop and pilot a cost effective primary healthcare delivery model in the form of a clinic providing services outside of business hours. The pilot will examine the potential of this clinic to **maximize patient footfalls** while keeping the **per patient cost lower than government dispensaries**.

SERVICES PROVIDE ARE :

1. Consultation by a doctor, basic strip based tests, dispensing of most medications prescribed by him / her, and linkages with diagnositics labs / referral hospitals.
2. Thematic health awareness talks / discussions will happen on the site every week.
3. Health assistant at the clinic will also do dispensing of chlorine and health products.

Consultation and Drug fees model:

5. Consultation with a General Practitioner will be Rs 5 / visit (It will be Rs 20 for consultation with some specialists like Optometrist). Patient will be allowed free followup in 7 days.
6. Drugs will be sold at 50% discount over the MRP.
7. Common tests – eg Haemoglobin, Pregnancy, Malarial Parasite, Blood Sugar and Blood Pressure available in clinic – at half the consumable cost.
8. Linkage with diagnostic labs providing upto 50% discounts for other tests / diangostics not available at the clinic.

Specialities covered: These clinics will be manned by General Practitioner on 4 days / week, with a Gynaecologist coming once a week at each location. Monthly specialists will include Optometrist, Dermatologist, ENT specialist.

The deployed IT system in the clinic will capture patient family details, and patient's chief complaint, diagnosis and procedure on every visit. Periodic reports will identify common chief complaints and diagnosis – the required specialists maybe invited using the linkages with various hospitals.

IT Support: We have deployed Swasth India's comprehensive health IT system for the pilot. This Electronic Health record has been tracking patient demographics (family details), outpatient consultation record and drugs inventory management,. Each patient will be given a case sheet printed using the system, along with referral slips wherever applicable. Referral tracking will also be implemented in the IT system early in October.

Location & Timing: Clinic services are being provisioned in Udyog Nagar.

These are evening clinics, 5-8pm every day. Some specialist services are provided at a slightly earlier time, due to partner / service provider's timing constraint.
Based on community response, this frequency / duration maybe increased / decreased, or some of these hours can be put in a clinic closer to community as an outreach activity.

Location and timings of evening clinic are such which saves the wage loss.

Covered population: Udyog Nagar slum has 2 clusters, totaling to about 1200 households – or 7000 population.

Key Innovations

1. Sourcing of discounted high quality generics to pass on the drug discount to the beneficiaries. This cost reduction makes the treatment cost comparable to that of visiting quacks
2. Clinic timings in the evenings, so as to suit working men / women
3. Focus on providing as many services as possible through the clinic – either directly at clinic, or through linkages with labs, pharmacies and hospitals / specialists through a referral chain
4. Monitoring and control of prescription costs to keep the patient treatment cost low and manageable.

Drug cost breakup

Drug costs account for about 80% of outpatient medical costs. However, expenditure on drugs is high due to inefficiency in the supply chain, not due to high manufacturing costs of the drugs itself. The cost of manufacturing and logistics total to 20-40% of what the patient pays. The extra margin is shared

between the doctor, the pharmacy and the pharma company – largely leveraging patients / consumers unwareness about low cost options like generics. Consumers largely rely on doctors' presecription.

Therefore, to pass on the drug discounts to the consumers the model needs to have a control of the doctor's prescription – which is possible only for empanelled or employee doctors. These doctors must be backed with the supply of an alternative set of generic medications available as replacement.

CHAPTER 5

OBJECTIVES AND METHODOLOGY

5.1 OBJECTIVE:

To study the effectiveness of HS 20/20 pilot project clinic model as an alternative mean of affordable, accessible and quality health care for poor and marginalized slum dwellers.

5.2SPECIFIC OBJECTIVES:

1. To find out the number / percentage of people catering to services of this paid model.
2. Whether the needs of the people are satisfied or not?
3. Whether the problem of patients are satisfied or not ?
4. To understand the dimensions of physical accessibility
5. What is the percentage turnout of female in the clinic?
6. Is there any age or gender specific requirement by old age, females, or children?
7. To know the preference of patients while choosing a healthcare service.

5.3 Methodology:

The following methodology was adopted for the study:

5.3.1 Research/ Study design- Descriptive

5.3.2 Sample size - Following were the number of cases that were observed and contacted during the study:

- Total 150 respondants were observed regardless of Name, Age, Sex, Diagnosis etc.
- No of females(), no of males ()were selected for observation under the study.

5.3.3 Sampling technique

Random sampling technique was adopted for selection of the samples.

Data collection Plan

Following was the plan followed for the data collection exercise:

Techniques

5.3.4 Tools

Following tools were developed for the study:

1. To collect primary data pre structured close ended questionnaire was used.

2. Personal interviews of the respondants , community mobilizers and clinic staff were taken.

Analysis plan

The data was analyzed using SPSS.

Duration of the study

From- 1st January to 31st January 2012

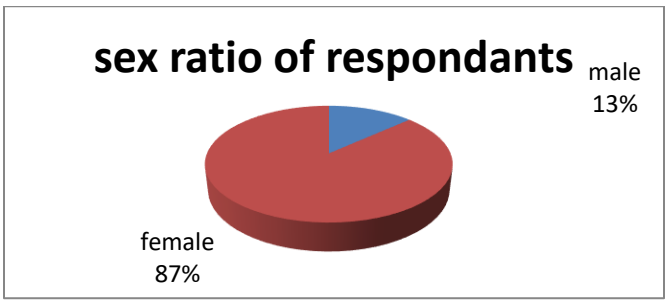
Total time period given to each respondent: 30 -45 minutes

CHAPTER -6

RESULTS AND DISCUSSION

Through a close ended questionnaire general profile of the respondents , health seeking behavior pattern was captured. Respondents were selected on random basis to see no of people who seek facility of clinic and capture the feedback of those who visited the clinic. It was tried to find out whether people find the services of clinic affordable and which services are most beneficial to them.

Graph 1:. <u>Sex ratio of respondants:</u>



During survey 87% respondents were female. It may be because of non availability of head of household or male member. It was also surveyor' focus to capture female respondents view as they are the care taker of the family. It was also found in CNA report that there is high prevalence of fungal infection (skin infections and vaginal discharge among women)

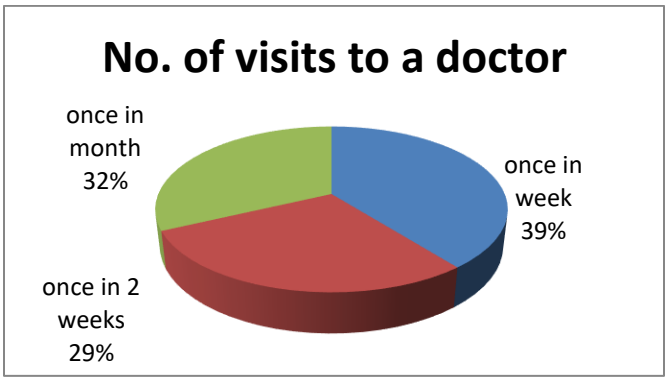
2. Distance travelled to avail health facilities

Question was divided into four categories:

1. Less than 5 kms
2. 5-10 kms
3. 10-15 kms
4. More than 15 kms

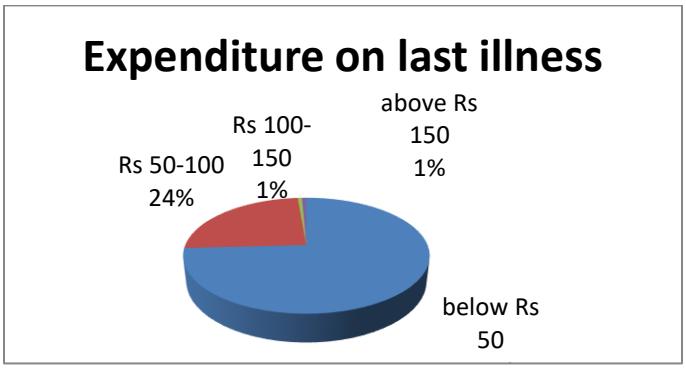
Interestingly the survey finding showed that the 100% respondents avail health facilities within 5km of radius for most of their health problems.

Graph 2.:<u>Frequency of visits to any doctor:</u>



Maximum no. of respondents said they seek help of a doctor/ health facility once in a week, around 39% which is quite high. 29% visit a health facility once in 2 weeks and 32% once in a month. This graph shows that demand side is high , but the need is not fulfilled because of the non availability of quality services.

Graph4. <u>Expenditure (single visit) on previous health facility including consultation, medicine, diagnostics, transport, wage loss etc.</u>



When data on expenditure (single visit) to health facility including consultation, medicine and wage loss etc. was analyzed 74% spent below Rs 50. Good number of people ,around 24% spent between Rs. 50-100, 1% between Rs. 100-150 and above Rs. 150.

If we correlate the above two table of frequency of visit to health facility and expenditure, it is revealed that around 40% of people visit health facility once in a week and around 74% of them spend below Rs. 50 and 24% between Rs 50-100.

Spending upto Rs. 100 once or twice in a week for the daily wage workers/construction workers/mechanic/rikshaw pullers is a matter of concern because their earnings are in the range of Rs 100-180/ day. This may further lead to poor family conditions due to heavy wage loses for health reasons.

Age was cross tabulated with expenditure using spss . Five age class interval was taken below 18, 18-25, 26-35,36-45,46-55, 55 and above to see the expenditure pattern in specific age group.

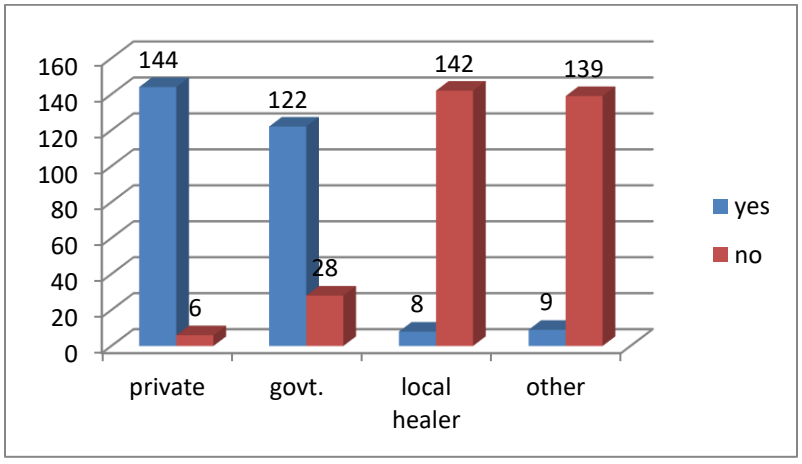
Table 1: Age.Class * Expenditure on last Illness Crosstabulation

			expenditure on last illness				
			below Rs 50	Rs 50-100	Rs 100-150	above Rs 150	Total
age.class	below 18	Count	0	1	0	0	1
		% within age.class	.0%	100.0%	.0%	.0%	100.0%
	18-25	Count	18	6	1	0	25
		% within age.class	72.0%	24.0%	4.0%	.0%	100.0%
	26-35	Count	56	14	0	1	71
		% within age.class	78.9%	19.7%	.0%	1.4%	100.0%
	36-45	Count	23	10	0	0	33
		% within age.class	69.7%	30.3%	.0%	.0%	100.0%
	46-55	Count	12	5	0	0	17
		% within age.class	70.6%	29.4%	.0%	.0%	100.0%
Total		Count	109	36	1	1	147

	% within age.class	74.1%	24.5%	.7%	.7%	100.0%

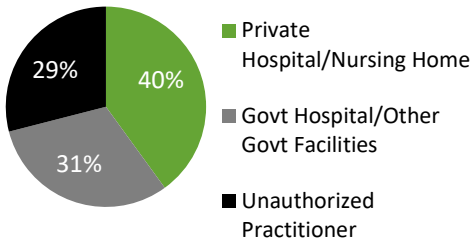
Cross tabulation results show that middle age group people between 26-45 years of age spent maximum amount below Rs50. Also spending between Rs 50-100 was second highest among the same age group. Hypothetically we can say that this age group is facing much more problem than the other age group, which may lead to further complication and increased out of pocket expenditure. This is a generic table which gives us idea of futuristic exploration.

Graph 5.Source of treatment



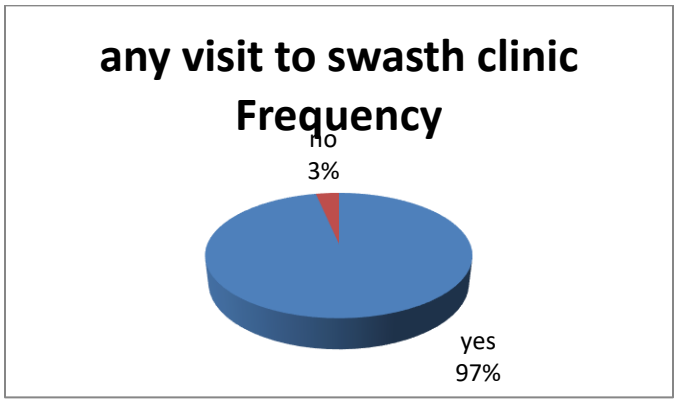
There were multiple responses, but maximum no. of respondents, 144 out of 150 said they prefer going to a private hospital or clinic, 122 to government hospital or dispensary. Only 8 people said they go to local healer. In contrast having one to one interaction with community mobilizers, it was found many people go to local healer/ quacks but they will rarely confess, they visit to local healer.

The following graph taken from HS20/20 baseline report also shows that 29% people relied on unauthorized medical practitioner for their treatment. This data was captured from 10 GRC's (around 3200 interviews).



FEEDBACK FOR SWASTH/LIFELINE CLINIC

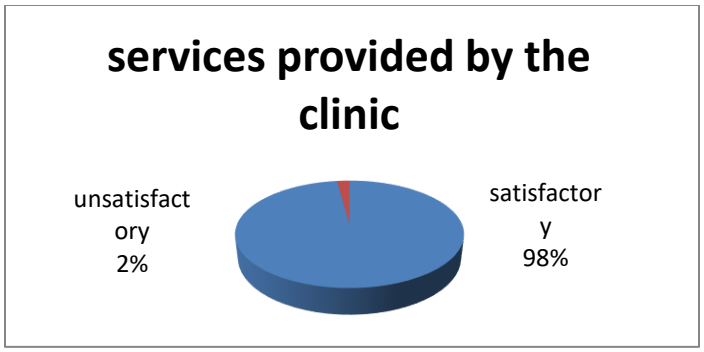
Graph6: Visit to lifeline clinic:



It was found that 97% of respondents visited the clinic which indicates the behavior of the community, that if a health facility is nearby, people will prefer to avail services, it could be a local healer or quality healthcare service. This is further supported by the fact, 99% of respondents said , less distance to clinic was the most beneficial part of the clinic.

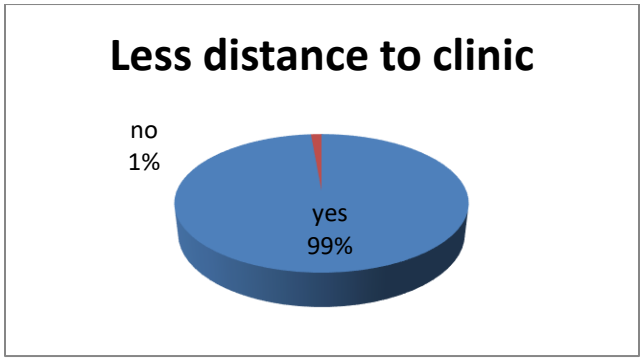
According to clinic data average number of patients seen per day are 20.

Graph 7: Satisfaction level:



98% of respondents were satisfied with the services of clinic. Follow up was done for those who were not satisfied. Reasons that came out were non affordability of diagnostics and medicines, ailment not treated by given medicines etc.

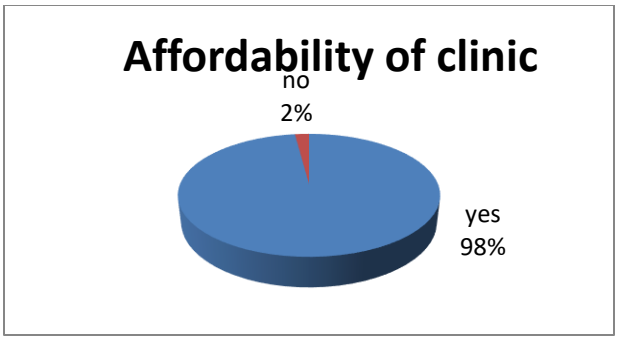
Graph 8 :Distance



When asked about the lifeline clinic, 99% of the respondents said that less distance to the clinic was one of the most beneficial part.

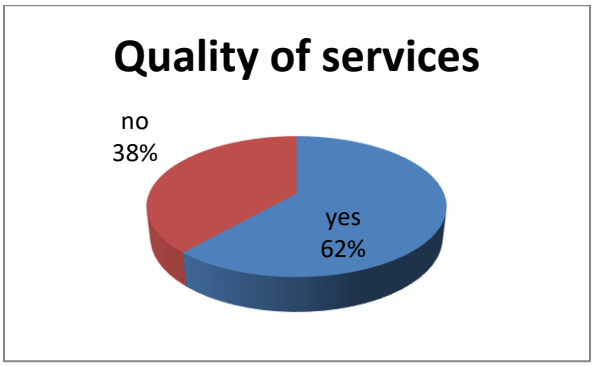
According to baseline survey also , long waiting hours(80%) and long distance to a facility(60%) were found to be major causes for not using the government facility.

Graph 9:. Affordability



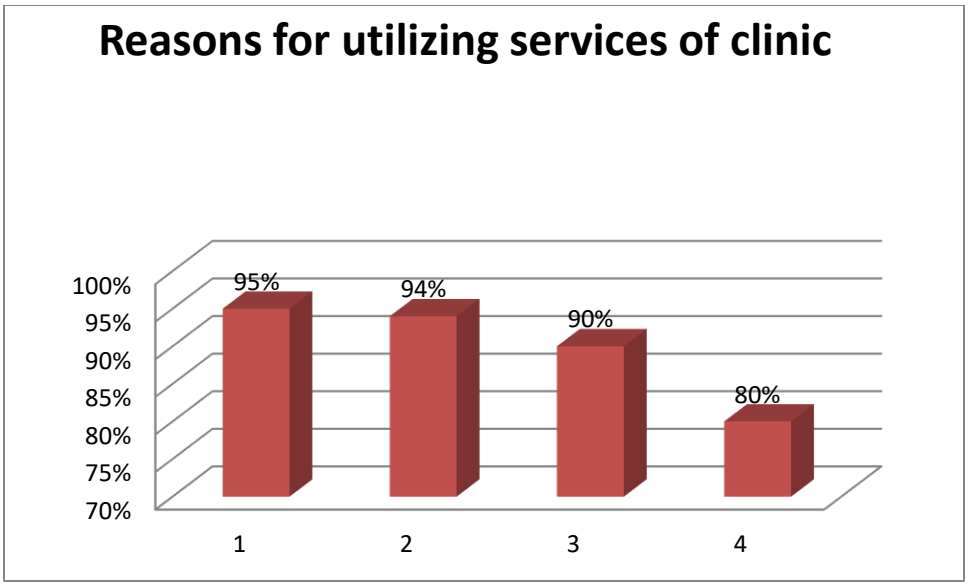
Analysis of data showed that affordability of clinic was found second most common factor, for using clinic's facility. Since the large no. of population in the catchment area falls under BPL, and 41% of them have BPL card, so affordability of clinic plays an important role.

Graph 10 :Quality of services



When probed about of quality of services provided by the clinic 62% of respondents said that the quality was good . Quality to them means affordability and less waiting time.

Graph 11: Reasons for utilizing services of clinic



1. Consultation by the doctor
2. Availability of cost effective drugs and diagnostics
3. Health schemes
4. Awareness and education by community mobilisers

Multiple responses were taken to find out what were the most beneficial services to the community, among all 95% patients were satisfied with the consultation by doctor. Some of the reasons behind were less waiting time and appropriate time given to each patients unlike government providers. Second common reason was availability of cost effective drugs and diagnostics 94%,then 90%was health schemes and 80% Awareness and education by community mobilisers.

CHAPTER 7

CONCLUSION

The survey findings showed that the objective of clinic was fulfilled up to a great extent. 90% of the respondents find the services of clinic affordable. According to HS 20/20 baseline survey report, four-fifth (81%) of the total expenditure on OPD was incurred on medicines and doctor's fee, with medicines accounting for the major chunk (68%). The remaining one-fifth was spent on transport & others expenses as well as investigations such as laboratory testing (10% and 9%, respectively)**.** Keeping this factor in mind generic drugs are provided at 50% discount, consultation Rs 5 .Even though it is a paid model but since quality drugs and diagnostics are provided at subsidized rates, people are willing to avail quality healthcare services.

It is interesting to note that 100% of the respondents prefer to avail health care services within 5 kms of their reach. Location and timings of clinic are designed in such a way to make it affordable and accessible. Since it is an evening clinic people need not be absent from their work, and the location is such that it reduces the transportation cost.99% of people said that the accessibility or less distance to the clinic was the most beneficial part of the clinic.

According to survey report 97% of respondents had visited the clinic, out of that 98% found the services of clinic satisfactory. When probed about the reasons for utilizing the services of clinic, the percentage of consultation by doctor was found quite high, 98%, reasons may be due to less waiting time and appropriate time given by consultant to each patient leading to greater satisfaction.

About the health seeking behavior of the people, majority of them prefer to avail services from provide providers. Frequency of visit to a doctor once in a week was found highest, and 74% people are spending below Rs. 50 for single visit to a health facility.

The results of above mentioned findings of the study reveals that health seeking behavior of community is affected by number of factors. For any routine problem, people may avoid going to a distant facility and prefer to consult a quack because of close proximity.

This may lead to a habit of using services of a quack as first point of health service for their future needs. Complicated situations which can not be handled immediately by local healers may only push people to secondary or tertiary care institutions. But there are chances that the case may not reach appropriate place in absence of proper primary health handling. Expenditure is a matter of concern for all sections of the community but affordable quality services on which community can rely are always preferred in long run.

The results are clear in clinic implementation that frequescy of visits or regularity of visits to clinic increased after 3 month implementation of the program because people found it reliable in terms of consultation by trained practitioner, reduced consultation, reduced drug cost and exact identification of disease so visits to clinic can be reduced. The short duration of the program do not allow to investigate the finances for a period of 12 months or more but such model can surely gain more attendance from the community for their primary health needs with reduced out of pocket expenditure if calculated annually.

CHAPTER-8

LIMITATIONS

- Duration of the clinic was less to see the impact or effectiveness on the community.
- No of respondents less due to time constraint.
- Comparative analysis on expenditure could not be done because of unavailability of data.
- Pilot project duration was ending on 31st January so exhaustive study could not be done.
- Sample size is small, results may not reflect the view of entire community.
- The short duration of the program do not allow to investigate the finances for a period of 12 months or more but such model can surely gain more attendance from the community for their primary health needs with reduced out of pocket expenditure if calculated annually

CHAPTER 9

RECOMMENDATIONS

- **Increase the clinic timings – 2 times a day**

  Clinic was providing, 6 days / week of OPD services running at two locations each offering at least 3 days of service / week, from 5-8 pm in the evening. If clinic services are provided in early morning hours also, keeping in mind that patient don't have to be absent from work.

  In this way more no. of population can be catered, thus **cost saving per patient** may be increased. Increase in patient load may be managed by dividing the patients in morning and evening hours.

- **Raise awareness about the clinic**

  To increase the utilization of clinic , awareness should be raised by adopting methods like mobilization pamphlets, health talks, and sent messages through community mobilizers.

- **Referral and linkages**

  Follow up of the referred patient should be done. Linkages with government hospitals, dispensaries, ASHA, ANM should be done, for better utilization of health schemes and to seek better secondary and tertiary care if required.

- **Reduce the cost of medication per visit**

  Instead of giving medication for 5 days or 7 days, it should be given for 2 or 3 days, and patient should be recalled, so that it reduces the cost of visit to the patient.

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ANNEXURE

QUESTIONNAIRE FOR SWASTH CLINIC

1. General profile of the respondent
    - Name
    - Age
    - Sex
    - Address

2. Frequency of visits to any doctor from your family
    - Once in a week
    - Once in 2 weeks
    - Once in a month
    - others
3. How far do you go to avail health facilities
    - Less than 5 kms
    - 5-10 kms
    - 10-15 kms
    - More than 15 kms

4. Where do you go to avail health facilities
    - Government dispensary/hospital
    - Private clinic
    - Local healer
    - Any other
5. Have you visited swasth clinic?
   If yes, no. of your card-
   If yes, according to you which option is most beneficial to you?
    - Less distance to the clinic
    - Affordability of the clinic services
    - Quality of services

6. Expenditure (single visit) on previous health facility including consultation, medicine, diagnostics, transport, wage loss etc.
    - Below Rs 50
    - Rs 50-100
    - Rs 100-150
    - Above Rs 150
7. Services provided by the clinic

- Satisfactory
- Not Satisfactory

8. If Satisfactory, tick one or more options
    - Affordable treatment
    - Less waiting time
    - Satisfactory consultation by the doctor
    - Problem resolved for which you visited the clinic
    - Appropriate time given by the doctor

9. If not satisfactory, tick the appropriate option
    - High cost of medicine
    - Proper treatment not given
    - Others

10. Which service of the clinic you find most beneficial
    - Consultation by the doctor
    - Availability of cost effective drugs and diagnostics
    - Health schemes
    - Awareness and education by community mobilisers
    - Any other