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NGOs and NPISHs in Health Sector
Possibilities and Policy Options
An Expository Study in the Indian Context

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NGOs and NPISHs in health sector-Possibilities and policy options- An expository study in the Indian context

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Health services in India are the result of joint efforts by the government and the private and voluntary sectors. Of these three the government sector is by far the largest with a huge infrastructure and an annual outlay of $1328.85 million including water and sanitation projects. But unfortunately three fourths of the health budget is poured in to expensive specialist services which benefit less than one fourth of the population .The existing primary health services in rural areas, which are barely functional in some places, are totally defunct in most places. This is due to shortage of resources, lopsided priorities, the devastating pressure of family planning, target – chasing and lack of motivation among health functionaries etc. There is hardly any participation of people in health care delivery.

Pyle (1981) observes, under the Indian constitution, health is not a basic human right. Yet NGOs have used this rationale of social justice to target specific sub-population-the tribes, the Scheduled Castes, those are in slums, or those are the most poor in rural settings.NGOs and NPISHs have tried to achieve equity by identifying these disadvantaged and serving their needs.

Health care in India has a long tradition of voluntarism. For centuries, traditional healers have taken care of the health needs of their own community, as part of their social responsibility. They have used the knowledge that has passed down the generations, regarding the medicinal value of locally available herbs and plants. This tradition still continues, especially in the tribal pockets of the country.

Unfortunately, the institutionalized voluntarism that evolved during the colonial era was completely dominated by the thinking of the colonizers. They completely ignored the rich traditional systems of health care in India. After independence, till the mid sixties, voluntary effort in health care was again limited to hospital based health care by rich family charities or religious institutions. In the mid sixties, the effectiveness of the western curative model of health care in the less developed countries came under serious attack by development planners.

The Chinese experience of decentralized health care through effective use of motivated health cadres at the grassroots level, also received widespread attention. Out of this rethinking grew various models of community health programmes which emphasized decentralized curative services. In these, trained village level workers played a key role. Much more importance was given to preventive aspects, where the community plays a more effective part in their own 'health care"

According to an estimate by the Independent Commission of Health in India (VHAI 1997), there are more than 7000 NGOs working in the field of healthcare. Voluntary agencies have played a significant role in developing alternative "models", as well as providing low cost and effective health services in many parts of the country. They have been able to develop village based health cadres, educational materials and appropriate technology .They also help in filling the critical gaps that exist in government health services

The Directory of Hospitals (GOI 1998) mentions that the non-profit sector has 937 (10% of all hospitals) hospitals with 74,498 beds (13% of all beds) in the country. As per analysis by Madhurima Nundy, Center of Social Medicine and Community Health, JNU, New Delhi (Financing and Delivery of Health Services in India, Background Papers, NCMH, GOI, 2005, pp 134), the Christian missionary organizations lead in providing health services (47% of all beds in private facilities and 17% of all private hospitals/dispensaries).

In the last two decades, many NGOs have come in to focus for their remarkable contribution in health care. For instance Institute of Health Management Pachod and Streehithakarini in Maharashtra;Banwas Sewa Ashram in Uttarpradesh,Parivas Sewa Sanstha in Delhi,Soceity for Education Welfare and Action in Gujarat, Rural Unit for Health and Social

Affairs in Tamil Nadu,Child in Need Institute and Tagore Society for Rural Development Rangabehia project in West Bengal etc are examples of successful NGO experiments .Each of these organizations is considered as model health care NGOs and has multidimensional activities like health awareness, clinical service, health care training, health research etc.The NGOs are an integral part of present health infrastructure and perform tasks which otherwise would be left undone. The fact that without the assistance of voluntary agencies, the states cannot meet every need is gaining ground. Voluntary health agencies reduce the burden of state, at all levels, in health care delivery system. It is being argued that voluntary agencies, being close to the people, can ensure the much needed peoples involvement and successful implementation of programmes and also, with their committed workers, can deliver the goods more effectively than government machinery, if the former are called up on to perform in micro level planning and implementation of various target group oriented programmers.

The following tables give a bird's eye view of the NGO contribution in health sector in India

Table 1 Total Health Expenditure in India, 2001-02

Expenditure	**Exp in Rs 1000s**	**Percapita Exp (in Rs)**	**Distance of the (%)**	**The Expenditure as a % of GDP**
1Public expenditure	214,391,018	207	20.3	0.94
Private expenditure	818,104,032	790	77.4	3.58
External support	24,846,646	24	2.3	0.11
Total health expenditure	1,057,341,696	1021	100.0	4.63
GDP at market prices	22,81,30,50000			

As per new series (base: 1999 - 2000) of National Accounts Statistics, CSO dated 28 Feb. 2006

Table 2: Statement on funds for health care in India, 2001-02

Source of funds	**Exp. In Rs 000s**	**% Distribution**
	a) Public funds	
1. Central Government	67,185,399	6.4
2. State Government	132,709,065	12.6
3. Urban Local Bodies and Panchayat Raj Institutions	14,496,554 #	1.3
	Total(a) 214,391,018	20.3
	(B)private funds	
1 .Households	760,939,107	72.0
2.Firms	55,365,142$	5.3
3. Non Government Institutions Serving Households (NGOs)	**799,783***	**0.1**
	Total(b)818,104,032	77.4
	(c) External support	
1 Grants to Central Government	16,483,158	1.5
2. Material Aid to Central Government	825,937	0.1
3 .Grants to State Government	2,389,555	0.2
4. To NGOs	**5,147,996**	**0.5**
	Total(c)24,846,646	2.3

Total funds	1,057,341,696	100.0

Estimate based on data from NHA study on health financing by local bodies undertaken on behalf of MOHFW

$ From the report of National Commission on Macroeconomics and Health (2005)

* Estimate based on NHA study on Health Financing by NGOS undertaken on behalf of MOHFW

The statement in table 2 above gives the details of sources that financed health care expenditure incurred in India for the year 2001-02. It can be seen that Central Government contributed Rs 67,185million (6.4 percent) while the contribution of state governments and local governments was Rs, 709 million (12.6 percent) and Rs 14,496 million (1.3 percent) respectively. In private expenditure, the household funds or the out of pocket expenditure incurred by households for availing health care services was rupees 760,939 million which accounts for 72.0 percent of total health expenditure in India. The total expenditure incurred by firms in public and private sector for providing medical care benefits to employees and their dependents was rupees 56,365million. The contribution of NGOs at Rs 800 million was mainly through donations from Indian philanthropic organizations and from their own resources in the form of interest from deposits and rent from buildings etc. The total external aid received for providing health activities was rupees24,846 million, most of which has been routed through the central government and can be tracedfrom the budget documents of MOHFW.

Table 3 Comparison with available estimates of health expenditure in India for the year 2001-02(Figures in millions)

Source of funds	**NHA**	**NCMH 2005**	**CSO [2005]**
(a) Public Funds			
Central Government	67,185	78600 ,	170740 *
State Government	132,709	156,520	
Local Government	14,497	23,990	
Total (a)	214,391	259,110	170,740
(b) All other funds			
Firms (Public enterprises, Public sector Banks, Private Firms)	56,365	55,460	NA
Households	760,939	747,600	765,260

Foreign Agencies	24,847	2210	NA
NGOs	**800**	**3,660**	**NA**
Total (b)	842,951	808,930	765,260
Total Health Expenditure	1,057,342	1,068,040	9,36,000

* Does not include expenditure on family welfare services, medical education, medical reimbursements to govt employees but includes public expenditure on veterinary care services

Table 4 Source of funds for health care provided by NGOs in India 2001-02

Source of funds	**Amount in Rs 000s**	**%Dist**
Grants from Government1	5,400,845	26.7
Donations from individuals/households 2	905,142	4.5
Donations from private firms2	101,020	0.5
Grants from Indian funding agencies	224,265	1.1
Own revenue of NGOs(rents,	575,518	2.8

interest on deposits etc2		
User charges in hospitals and dispensaries owned by NGOs2	7,8459280	38.9
External assistance(FCRA Contribution)3	5,147,996	25.5
Total	20,204,066	100

1 Based on data from Central & State Budget documents and NHA study on Local Governments

2 Estimate based on NHA Study on Health Financing by NGOs

3 Receipt of Foreign Contribution by Voluntary Associations Annual Report 2001-02, Ministry of Home Affairs

The table 4 indicates that total health expenditure by NGOs during 2001-02 was estimated at Rs 20,204 million. About 39 percent of it had been raised through provision of curative care services (User charges/ reimbursements from health insurance companies). The grants from Central/ State/Local governments accounted for 27 percent of their expenditure, while external aid accounted for 26 percent of their expenditure. Remaining funds were generated from NGOs own revenue, grants from Indian funding agencies and through donations from private firms and individuals. Further details on use of these funds by NGOs is presented in table 5

Table 5 Health expenditure by NGOs by Function, 2001-02

Health care function	**Amount in Rs 000s**	**%Dist**
Medical goods/Pharmacy services	1,818,548	.41.9
Ancillary care services	9921194	4.9
Rehabilitative services	1,091,129	5.4

Communicable Disease Control Activities	3,000,640	14.18
Non Communicable Disease Control Activities	478,884	2.4
Reproductive and Child health related Activities	1,369,973,	6.8
Testing of food/Water	10,103	0.1
Medical Education and Research	1,582,137	7.8
Capital expenditure	480,905	2.4
Health Administration and health insurance	4,0410.0	
Functions not specified	1,072,943	5.3
Total	20,204,066	100

Source: Based on NHA Study on Health Financing by NGOs undertaken on behalf of MOHFW

According to the data from the 42nd and 52nd round of NSSO on utilization of health services in charitable hospitals, there is low utilization of out-patient services; however the 52nd round of NSS shows that there is an increase in the utilization of charitable institutions in urban and rural areas.

Not-for-profit organizations draw from a variety of sources for finance; these include government funding as grants-in-aid, funding from foreign sources, corporate funding and user fees. Although, some not-for-profit organizations charge user fees for their finances; the average total expenditure per hospitalization in a charitable hospital is less than in for-profit hospitals but higher than public hospitals (NSS 52nd Round 1998).

Review of literature

Duggal Gupta and Jessant(1986) conducted a study on" NGOs in Rural Health Care "at the behest of the Indian Council of Medical Research(ICMR) to gain a deeper insight in to the role and functioning of the many different types of NGOs in the field of health located in Maharastra,a state having the largest number of such agencies. That study brought out the largest variation between the aims and motivation of the various of NGOs as well as their different approaches, which vary from the running of rural hospitals to community participation and conscientisation.That also brought out the change of approach of the NGOs during the past two decades from being more medical functionaries to involvement in community activities. An interesting finding of that study was that the NGOs had hitherto neglected socially and economically backward districts as compared to their better concentration in the average and highly developed districts in the state of Maharastra.It highlighted the need to pay more attention to the deprived masses in the backward districts where infrastructure was highly underdeveloped.

Indian Institute of Management Ahmadabad (1987 conducted a comparative study among the NGO hospitals, Government hospitals and private hospitals. It reported that, in general, the cost per hospital bed per day in the NGO sector was very less than the government and private sectors. The study suggested that NGOs might be relatively efficient providers of hospital-based care compared to others. In fact NGOs often achieve substantial 'cost savings' due to lower pay scales compared to government employees and in some cases honorary physician services, both of which lead to a lower wage bill and lower overall cost.

Baru (1987) made a study on' Factors influencing variations in health services' in Andhra Pradesh. The study was limited in two well developed districts (Krishna and Guntur) as well as two backward districts (Mehbubnagar and Medak).It considered public, private and voluntary sectors providing health services. With regard to voluntary sector, study explored that growth and distribution of voluntary agencies were skewed in favor of well developed districts. The reasons for concentration of VOs in a particular area were many:(a) Well developed districts were under British rule and more number of hospitals as well as dispensaries were set up by Christian missionaries; but backward districts were under Nizam's rule and very few hospitals

were set by missionaries;(b)In 1977,a severe cyclonic storm took place in Krishna as well as Guntur districts and hence there was a rapid growth of voluntary organizations for relief and rehabilitation work;(C)In well developed districts, infrastructural facilities were better for setting up VOs.

Duggal and Amin (1989) have made a study on 'Cost of Health Care'. Results indicate that the level of precipitate health expenditures of NGOs is with in the range of current government spending on primary health care. It is worth noting that in most cases N GO projects function in addition to the normal government system. The similarity in average costs of NGO- provided services to those provided by government funded primary health care suggests that these added resources are being used at least as efficiently as those in the public sector. This may reflect the unmet needs that are being met with additional NGO inputs.

Bhattacharjee(1996) has completed a study on "NGO Approaches to Health and Development in India: Strategies and Sustainability" .He observes, in order to achieve appreciable and sustainable results, an NGO will have to make long-term commitments to the community.

The Population Foundation of India commissioned around 30 projects. It selected fourteen action research projects carried out by voluntary organizations during 1995-96 .For the case study and qualitative evaluation Dr Sunil Mishra (2000) brought together all fourteen case studies of action research projects in a volume and analyzed the dynamics of social change, the factors that led to success and the problems. He found that NGOs could work as catalysts of change. A concern for community participation as well as a need for mass education, under an NGO, was very crucial to bringing about an attitudinal change in health behavior. Unfortunately, this refreshing trend ignored the important role of traditional healers and dais in health care, and very little attention was paid to the Indian systems of medicine

Types of NGOs

The voluntary health effort as it exists today can be broadly classified as follows.

Specialized community health programmes –Many of them go a little beyond health, by running income-generation schemes for the poorer communities, so that they can meet their basic nutritional needs

Integrated development programmes –In these programs, health is a part of integrated development activities. Consequently, their emphasis on health care may not be as systematic or as effective as that of the previous group. However, the long term impact of their work on health and the development of the community are significant.

Health care for special groups of people-This includes education; rehabilitation and care of the handicapped .These specialized agencies are playing an important role, keeping in view the fact that hardly any government infrastructure exists in this sector of health care

Government Voluntary Organizations These are voluntary organizations which play the role of implementing government programmes like Family Planning and Integrated Child Development Services

Health works sponsored by Rotary clubs, Lions clubs and Chambers *of* ***Commerce***-They usually concentrate on eye camps-conducting cataract operations in the rural areas on a large scale with the help of various specialists etc.

Health researchers and activists –The efforts of these groups are usually directed towards writing occasional papers, organizing meetings on conceptual aspects of health care and critiquing government policies through their journals (*which usually have limited circulation*)

Campaign Groups-These groups are working on specific health issues, such as a rational drug policy and amniocentesis, among others.

Problems

However, these'models'are far from perfect; they do not posses the conditions of replicability, as does the government sector. On the other hand, the vastness and regional diversities that characterize India also make it extremely problematic to think of replication or standardization of 'models'. An appropriate system should evolve from the people themselves. Just as health conditions emerge from the community's interaction with its surroundings, it's the peoples struggle through time that determines the nature of services that they receive.

NGOs have increasingly been promoted as alternative health care providers to the state, furthering the same goals but less hampered by government in efficiencies and resource constraints. However the reality of NGO health care provision is more complex. Not only is the distinction between government and NGO providers sometimes difficult to determine because of their operational integration, but NGOs may also suffer from resource constraints and management inefficiencies similar to those of government providers. Some registered NGOs operate as for-profit providers in practice. Policy development must reflect the strengths and weaknesses of NGOs in particular settings and should be built on NGO advantages over government in terms of resource mobilization, efficiency and/or quality. Policy development will always require a strong government presence in coordinating and regulating health care provision, and an NGO sector responsive to the policy goals of government.

Problems

Superficial forms of local participation, lack of community ownership, non-remuneration of health workers and midwives, inadequate training, and ultimately limited programme gains are some of the problems. The successful NGO participation will depend on drawing on diverse local perspectives, promoting broad based participation and providing culturally appropriate ways to include all community members, particularly women. Government's continued delay in announcing the National Policy on the Voluntary Sector is another problem. In the post liberalization period after1991, a new found respect for private enterprise is clearly visible in the country; unfortunately the same level of respect for the government sector is missing. Government alone cannot deliver social justice for women and poor.NGO sector with out any interface from the government sector will not survive.NGOs have become one of the best vehicles to supplement government sector in meeting its development targets. The government is committed to provide an enabling environment to the NGOs.NGOs should not be given total autonomy. There is a strong need for capacity building and training for NGOs in India. A strong, vibrant and efficient NGO sector would address lot of problems which the government could not. Partnership between government and non government sector is imperative.

The NPISH sector has its own constraints and limitations. For most of the charitable institutions, the question of sustainability is central to their existence. In order to achieve appreciable and sustainable results, NGOs have to make long-term commitments to the community. They

frequently face difficulties such as shortage of trained staff, high turnover of middle-level workers, and dependency on donor agencies. For example, funding from foreign churches of the Christian network has reduced. User fees have therefore been introduced to take care of recurrent costs. It is evident that in the wake of increased privatization and corporatization of health services, not-for-profit institutions have also faced demands and competition to improve their services by introducing technology and specialized services.

Numerous trust hospitals have become more commercial in their operations, hence altering their character from a charitable institution to a private for-profit/corporate image. There needs to be greater transparency to see if they are adhering to the conditions of cross-subsidizing prescribed by the law, such as 20% free admissions and free outpatient services for the poor. A 1990 World Bank study showed that limited numbers of NGOs are involved in health and family welfare in rural areas and they mostly had weak financial management and technical capacity (Misra et al. 2003). The Rainbow Christian Academy, Nagpur, has evaluated around 40 Mission Hospitals in India and Nepal. Their findings suggest that majority of these hospitals are struggling with problems; most with financial problems, that threaten to endanger their very existence (Health Action January 2007).

Policy options

This bring us to the fact that various strategies need to be utilized by charitable institutions to ensure their survival and growth; apart from existing financing sources such as user fees, foreign funding, individual donations etc and at the same time ensuring lower costs to the community.

The resources could be garnered from the community (through community health insurance, healthcare-microfinance linkages and boutique healthcare), individual and corporate philanthropists (through donor marketing), product sales (such as opticals etc), government (through public-private partnerships), government, universities and private research institutions; international and national NGOs(through collaborations, training); and consultancy activities.

(a Community Health Insurance (CHI)

In India social health insurance covers about 35 million people through the Employee State Insurance Scheme and the Central Government Health Scheme. These two schemes cover the

formal sector employees and civil servants. Private health insurance is limited to the corporate sector and the upper middle class and covers less than 15 million people. Even counting those covered by employer provided services, the total number of Indians covered by any form of health security is less than 10%.However a new phenomenon called Community Health Insurance has been emerging in the rural areas and has been steadily covering larger and larger sections of the informal sector. Today there are more than 30 Community Health Insurance Schemes in India. According to a recent ILO study CHIs protect about 7 million people in India.

CHI (Atim C, 1998) can be defined as "any not-for-profit insurance scheme that is aimed Primarily at the informal sector and formed on the basis of a collective pooling of health risks, and in which the members participate in its management." Most often, the schemes are initiated by a hospital, and targeted at surrounding populations in the area. As opposed to social health insurance, membership is almost always voluntary rather than mandatory. The distribution of CHIs is mainly limited to Southern, Eastern and Western India. There are three basic models of CHIs in India. The provider model is when the NGO plays the role of the insurer and the provider of health care. The insurer model is the classical insurance scheme, with the NGO managing the risk but purchasing care from independent health care providers. And finally in the linked model the NGO passes on the risk to an insurance company, herby enlarging the risk pool.

Case: Ashwini is a non-profit hospital based in Gudalur Hills, Nilgiris, Tamilnadu. Since 1992 they have initiated a CHI scheme for the tribal population. Currently, this scheme covers 13000 members and the insurance reimbursements are able to contribute around 50% of total hospital income (Financial year 2006-07).

b) Boutique Healthcare

Boutique healthcare, the term as we know it, is providing healthcare to a selected few, with minimal waiting time, more doctor-patient interaction time and email or telephone access; at a premium. By providing high-margin, high-demand services, a not-for-profit hospital can keep the affluent people who consume them from shifting to private clinics and ensure that the extra amount it receives helps finance its historical mission. Boutique healthcare helps in cross-subsidizing user fees so that the people who look for such exclusive services receive them and at the same time the revenues earned may be utilized to provide medical and health services to people who cannot afford them.

Case: L V Prasad Eye Institute (LVPEI), Hyderabad, is a not-for-profit healthcare Institution that is committed to excellence and equity in eye care. At LVPEI, approximately 50% of the patients pay and the other 50% are treated free of cost. Of the 50% who pay, two categories pay a rate that is higher than the base fee. "Supporter "patients pay roughly double the general charges and "Sight Savers" patients who pay almost three times the general charges. In return, these patients receive services such as priority appointments, minimal waiting times, air-cooled waiting lounges and concierge service for the time they are within the Institute. The revenues collected from these patients go towards supporting the free patients and meeting all the recurrent expenditure and some of the capital expenditure of the Institute. The presence of such "Boutique services" has helped make revenues from patient care a major source of funds available to the Institute, thus decreasing the dependence on donations for its expansion and also the creation of an endowment fund.

C) Healthcare-Microfinance Linkages

As per National Bank for Agricultural and Rural Development (NABARD), microfinance is provision of thrift, credit & other financial services & small products to the poor in rural, semi-urban & urban areas for enabling them to raise their income levels & improving living standards. In few microfinance schemes we see linkages to healthcare provider services (such as Grameen Bank, Bangladesh and SEWA, Gujarat), but lately few non-profit healthcare organizations have also initiated microfinance activities to improve the financial status of the communities thus improving their ability to pay for the health services.

Case: National Dawakhana, a charitable primary care provider in Nanded city, has linked microfinance activities to its services. These activities are used to empower women economically, and at the same time provide these groups with health education on maternal and child care, HIV/AIDS etc.

d) Donor Marketing

A large number of healthcare; especially not-for-profit organizations, and social service organizations rely on external funds to support their activities. These external funds include individual donations, corporate donations, foundation grants and government funds — grants or tax allocations. For these organizations, revenues generated through their services may not be sufficient to sustain them in the long term. Therefore, donor marketing strategies are an essential component of these organizations.

Case: L V Prasad Eye Institute, Hyderabad uses various donor marketing strategies such as use of tax exemption leaflets for donations, institute website and establishment of donor office.

e) Product Sales

Few not-for-profit healthcare organizations in the field of ophthalmology use optical sales to bring in additional revenues to the organization.

Case: The vision centers of LVPEI, Hyderabad, which are established in the rural areas of various parts of Andhra Pradesh, provide free basic eye care services. These centers earn their revenues by sale of optical which are made by the vision technicians manning these centers and these revenues are able to cover the entire recurring costs of these centers.

f) Private-Public Partnerships

The National Health Policy, 2002 advocates the partnership of government with NGOs to provide healthcare services, especially in the rural areas. These partnerships are in the form of sharing of services, finances for NGO-run health centers etc.

Case: West Bengal Government in year 2004, came out with a scheme for not-for-profit healthcare organizations to share their services such as specialist doctors etc, and in return could refer patients to government facilities such as X-ray, laboratory etc. The benefits to the not-for-profit healthcare organizations are that they save the investment costs of these equipments while their patients can avail these services at government hospitals.

g) Collaborations

Most of the mission hospitals have been working in the rural areas since many years. They have considerable understanding of the local economic situation, burden of disease etc. This provides them opportunities to collaborate with medical institutions for research on geographical disease patterns, internships of medical doctors for rural healthcare etc.

These collaborations provide opportunities for these institutions to network with professional organizations, thus helping them to project their work to a wider group of people.

Case: Project ORCHID, funded by Bill and Melinda Gates Foundation, is a collaborative project between Australian International Health Association (AIHI) and Emmanuel Hospital Association; aimed to increase the HIV prevention capacity of a network of NGOs in Manipur and Nagaland.

h) Training

Various non-for-profit hospitals in the country could offer training programmes in nursing, hospital administration, community programmes management etc for availability of human resources in these areas and also providing revenue-earning streams for these institutions.

Case: Evangelical Mission Hospital, Tilda, Raipur, has a nursing school which is recognized by Indian Nursing Council (INC) for general nurses and midwives course.

i) Consultancy activities

Many not-for-profit healthcare organizations that have created areas of "Centers of Excellence" in their organization are looked up by other healthcare organizations to provide guidance. These consultancy assignments could provide excellent linkages with a wider network of organizations, apart from additional revenues.

Case: Lions Aravind International Center for Ophthalmology (LAICO), a consultancy arm of Aravind Eye Hospitals, Madurai. With support from INGOs like Lions International, Sight Savers International, CBM International, IEF, ORBIS International, WHO and Seva Foundation, it aims to develop eye hospitals supported by them into centers of excellence with sustainable eye care programmes. LAICO currently partners with 175 eye hospitals located across India, South East Asia, Latin American and Africa.

Conclusion

It would depend a lot on the existing service patterns of any not-for-profit healthcare organization to decide which strategies need to be chosen. But, in the wake of rising medical costs, decreased paying capacity of poor, and absence of social health insurance mechanism for informal poor, there is a need to ensure the financial viability of various not-for-profit healthcare organizations. The above examples exemplify that these strategies are being utilized by various not-for-profit healthcare organizations in the country for their sustainable operations. It will depend on the leaders and managers of various mission hospitals to see how they could incorporate any of these strategies within their own organizations.

Case Studies

Aravind Eye Hospital, Madurai

Given the magnitude of blindness and the challenges faced in a developing country like India, the Government alone can not meet the health needs of all. Realizing this predicament,Dr Venkatswamy established an alternative health care model. Aravind Eye Hospital (AEH), Madurai, has won as many accolades from management gurus for its effective business model. From an 11-bed hospital in Madurai to the largest provider of eye care services in the world, Aravind has come a long way indeed.

Working with the mission of 'Eliminating Needless Blindness', the main hospital (paying section) has eight specialty clinics, seven operating theatres (OTs) and 268 patient beds. Every day, an average of 100 surgeries is performed and 1,200 outpatients are treated. The free hospital, situated adjacent to the main hospital, has four OTs with a capacity for 320 inpatients. The camp Hospital, situated close to the main Hospital, with two OTs with a capacity for 600 inpatients handles an average of about 100 camp surgeries.

It has full-fledged super-specialty clinics including retina and vitreous, cornea, glaucoma, IOL, pediatric ophthalmology, neuro-ophthalmology, uvea and orbit and oculoplasty, manned by highly-qualified specialists. The Hospital is the headquarter for the Madurai Eye Bank Association, which receives corneas from various institutions in India and the US.

"The Hospital was self-supporting for all the recurring expenditures from the beginning, and after five years it had accumulated surplus for its own development and the establishment of the new hospitals at Theni, Tirunelveli, Coimbatore, and Pondicherry Care System. Around 70 per cent of its patients are provided free treatment.

The model of healthcare used at AEH is not only innovative, but absolutely the most effective model of healthcare. It operates under the notion of compassionate capitalism. With good management and a highly efficient fee system, the non-profit hospital is able to operate with a 40 per cent margin. This is despite the fact that 7 out of 10 patients pay nothing, or close to nothing, and the hospital does not depend on donations. This economically self-sustaining model is based on generating enough revenue from 30 per cent of the patients to cover the costs of providing free or low-cost eye care to the majority. Instead of relying on donations and funding, AEH developed the ability to manufacture all the materials it needed.

The Hospital reduces costs by using ophthalmic paramedical staff to do all the preparatory and post-operative work on each patient, allowing ophthalmologists to perform an increased number of surgeries. Each ophthalmic surgeon has two tables, which allows a surgeon to perform one 10 to 20 minute operation, and then swivel around to do the next. Post-op patients are wheeled out and new patients wheeled in. With its efficient strategies, AEH is known to reach the bottom of the pyramid.

The hospital was also one of the early starters to integrate ICT in its healthcare services as early as in 1983. "Using Wi-Fi, it created 'vision-centers' to generate awareness about eye camps, and VSAT-mobile vans to go into the interiors of the villages about 8-10 times a month.

Its self-sustaining model is being copied in at least 30 countries around the world. "The staff is almost 10 times as efficient as the national average. And the engine of growth was not a hard-headed businessman, but a 86-year-old philanthropist called Dr Govindappa Venkataswamy.

One of the main hurdles was getting patients to the hospital. The often elderly patients required escorts, or could not afford transportation and the rural-urban divide was more evident than ever. AEH started an outreach programme using community organizations to identify and assist potential patients with the help of tele-opthalomology. Today, the patient acceptance rate is between 95 to 98 per cent.

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In addition to hospitals, it has an ocular products manufacturing facility—Aurolab. Its tele-ophthalmology network has become a global online resource for AEH and for the entire field of ophthalmology. AEH partners with over a thousand community organizations and international NGOs such as the Lions Club International, Sight Savers International, Seva Foundation and Orbis International. The World Health Organization has designated it as a 'Collaborating Centre for Prevention of Blindness'

. Since it opened, AEH has given sight to more than 2 million people. The operating model is open for other hospitals to learn from and help realize its vision of eliminating unnecessary blindness by 2020.

Sewa Rural

Jhagadia block of Baruch district is a poor, tribal area which did not have even basic government health services in its rural areas. 95% of deliveries were home-based and done by Traditional Birth Attendants (TBAs) and there were high mortality (IMR 172 & MMR >1500) and morbidity rates. NGO SEWA-Rural collaborated with the state government under the USAID scheme to demonstrate a model where the state government and an NGO worked as partners in implementing community health interventions. Consequently, the government decided to entrust the management of the Primary Health Centre (PHC) at Jhagadia to SEWA-Rural for 10 years from 1989-99. Official resolutions were passed by the state government and the NGO took over total healthcare responsibility including implementation of all national programmes. During this period (1984 to 1999-2000), there was a reduction in mortality (IMR down from 172 to 46.4) and morbidity rates and immunization rates increased to 98%. There was an increase in area covered (11 villages and 11,000 population in 1981-82 increased to 30 villages and 40,213 population in 1998-99) and an overall increase in health awareness. In a standard government PHC budget, more than 80 per cent is spent on salaries while only the remaining part is available for delivery

of services and related programmatic activities, which is found to be inadequate. SEWA Rural saved money on salaries of approved field staff by managing with a smaller number of full-time field staff with relatively low salary and utilizing services of more village level workers without compromising the quality of the services. SEWA Rural required additional funds for other important aspects including field operational research studies and documentation, which it believed to be crucial for the success of the programmes and it was able to mobilize extra funding from other sources. Hence, the SEWA Rural experiment demonstrates that if reallocation of budgetary heads is allowed at the local level with organized and decentralized planning and management, efficient service delivery by a PHC can be ensured within the existing financial allocations.

Ankur Project -SEARCH.

The case study of Replication of Home Based New-born Care-SEARCH, Save the children USA, Bill and Melinda Gates Foundation.
Implemented with a population of around 87,000 people across 91 villages and six slums across Maharashtra, this project replicated community based new born care strategies, which involved training and supporting a community based worker to provide skilled newborn care services, birth asphyxia and pneumonia (2001-2005)

2. MNGO/ FNGO / SNGO Programme:

NRHM, Orissa has successfully established partnership with civil societies including NGOs in delivering Reproductive and Child Health (RCH) services through mother NGO (**MNGO**) to the marginalized population of the un-served and under-served area. As of December, 2007, 17 MNGOs, 97 FNGOs were working in 207 sub-center area of 21 districts of the state providing RCH services to about 13,00,000 population. In addition to this there are 2 SNGOs initially started and functioning targeting of about 2 lakh population. Basically the **MNGO** &

FNGOs are working concertedly in eco- inhospitable blocks and sub-centers for demand generation at the grass-root to have access to RCH services and information and for addressing

the unmet needs of the identified targeted population. Orissa is perhaps the only state where the **MNGO** scheme is fully operational. This achievement is only for effective decentralization, flexibility in decision-making, timely release of funds and adequate accountability systems. Apart from the regular ongoing activities, the MNGOs are supplementing and complementing in implementation of both state and central Govt. sponsored schemes and programmes. i.e.-

• 11 nos. of MNGOs actively participated in organizing & conducting ASHA training Programme in partnering with Local health administration and NRHM, Govt. of Orissa

• MNGOs of six districts already capacitated to mobilize SHGs on gender, health and nutrition (a collaborative programme of W&CD,H & F.W and UNICEF, Orissa)

• All MNGOs are the members of District NGO Committee which has been formed under the Chairmanship of District Collector.

• All MNGOs and FNGOs are members in the Rogi Kalyan Samiti and facilitate the process of formation of village health and sanitation committee

• Doing advocacy for better implementation of JSY

• Continuously persuading the elected PRI representatives for involvement in ongoing health programme through sensitization, orientation training and dialogue.

Through MNGO scheme population residing in remote inaccessible areas of 276 sub centers is able to receive RCH services, especially immunization, ANC/PNC and Family Planning Services. IEC Materials in colloquial language developed by the MNGOs, FNGOs, and involvement of local folk media are immensely beneficial to generate awareness on breast feeding, immunization, and care during pregnancy and on institutional delivery. NRHM /Government of Orissa have strategically planned to utilize MNGO/FNGO force to improve the RCH indicators of those identified areas at par with the State average.

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