Serving the Healthcare Needs of the Poor with Specialized Clinics

HIGHLIGHTS

- Specialization and streamlined procedures of healthcare clinics allow for good quality and low-cost results.
- Innovative approaches reduce operating costs.
- Cross-subsidization allows poor patients to access care and helps make the clinics financially sustainable.

Development Challenge

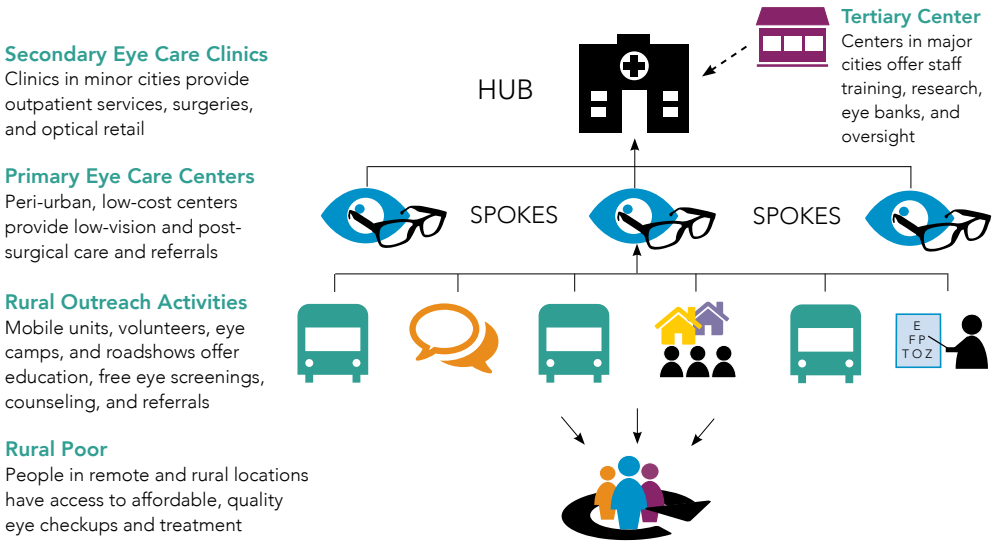
Most health systems in developing countries struggle to meet patients' most basic medical needs. Public services are often overburdened, and private services are usually too expensive for low-income segments of the population to afford. For poor people living in rural and peri-urban areas, medical care requiring specialized physicians or equipment is even farther out of reach, in terms of both geography and cost. Millions of people do not receive specialized treatment or even basic corrective surgeries because care is not available or the costs of travel and surgery are too high.

Business Model

Single-specialty clinic chains provide the poor with access to specialized medical services. The model builds standard of care protocols that result in economies of scale, which help drive down costs. These clinics identify, triage, and channel patients; standardize procedures in ways that maximize efficiency gains and quality assurance; develop innovative ways to ensure high patient volumes and facilitate uptake; recruit and train staff and adopt measures to retain them; and cross-subsidize services to be able to provide free or low-cost services to the poor.

Eye care was one of the first areas to adopt the single-specialty clinic model. Many innovative eye care business models originated in India. The model is being applied to many subspecialties, such as reproductive health, dentistry, diabetes treatment, and kidney care. It lends itself to areas where treatment can be provided as an outpatient service, patients pay out-of-pocket, and demand is high and unmet by public or other facilities. Replications of the model reveal the importance of factors in the enabling environment, such as low regulatory barriers, low costs of labor and materials, the existence of a paying patient segment, and the owner's interest to serve a social mandate.

Example of Hub-and-Spoke Eye Care Clinic Business Model



Awareness

All chains use extensive community outreach activities to raise awareness, such as health talks, road shows, and health educators. To maximize service use, clinics often use these activities just before screening camps or mobile clinic visits. Some chains target specific population segments, such as agricultural workers and students. Traditional outreach activities in rural areas are complemented by Internet-based outreach. Increasingly, chains are advertising directly to patients. Many chains cite word of mouth as responsible for the majority of their new patients.

Acceptance

Fear of surgery, loss of eyesight through poor care, and bad surgical outcomes are the main reasons cited for low uptake of free cataract surgery. These fears—not all of them unfounded—are most prevalent among rural, less-educated people. Addressing these concerns and creating community ownership are the main objectives of community outreach and education.

Accessibility

Clinic chains focus on attracting patients from rural areas for whom specialized services were previously inaccessible. They locate hubs outside the major cities, where services are often already available through multispecialty hospitals. The chains use a hub-and-spoke design and conduct extensive community outreach. These features extend their service delivery into peri-urban and rural areas and reduce time and travel costs for patients. When services are not available near a community, many chains provide reimbursement or even transportation to primary or secondary health care centers.

Affordability

Many clinic chains provide a proportion of their services free to the poorest people. The proportion is determined by the chains' ability to reduce operational expenses, by the values and vision of the social enterprise, and by the mix of financing tools used.

Single-specialty clinic chains have made highly specialized health interventions available to the poor through free service provision, extensive outreach activities, and peri-urban clinics. This model has reached millions of patients, many of them saved from further disability, blindness, and poverty.

Some specialized clinics, such as eye care clinic chains, have reached scale, with a handful demonstrating international replicability. The number of patients reached ranges from tens of thousands to millions.

Results and Effectiveness

Eye care clinic chains reduce the prevalence of avoidable blindness in the areas where they operate. In doing so, they not only improve health but also increase income. For example, in rural Assam, where weaving and small handicrafts are a primary livelihood, poor vision contributes to loss of income. Since February 2015, ERC Eye Care has treated approximately 9,000 patients in Assam, performing 350 cataract correction surgeries at its hub hospital.

Successful treatment raises patients' productivity. In addition, by allowing patients to maintain or reclaim their economic independence, it makes them less likely to be an economic burden on their family and community and to incur catastrophic health expenditures. An impact evaluation assessment on the provision of eyeglasses to low-income, visually impaired individuals found that the glasses increased their productivity by 35 percent.

Specialized clinic chains often provide higher-quality care than general clinics at an affordable price. At the Aravind Eye Care System, streamlined procedures have reduced the time spent per patient, resulting in an average surgery time of six minutes compared with 21 minutes in the United States. Tasking surgeons with only one operation allows them to perform more surgeries, reducing the cost per operation to USD 40–125. Cost reductions do not come at the expense of quality: AECS has a postoperative infection rate of 0.05 percent compared with a national average of 0.09 percent in the United States.

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This series on Inclusive Innovations explores business models that improve the lives of those living in poverty. Editors are Elaine Tinsley and Natalia Agapitova. Written and researched by Niharika Hanglem.

June 2017