Impact Assessment - PRI Dispensary

05th July 2022

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Overview of Healthcare in India

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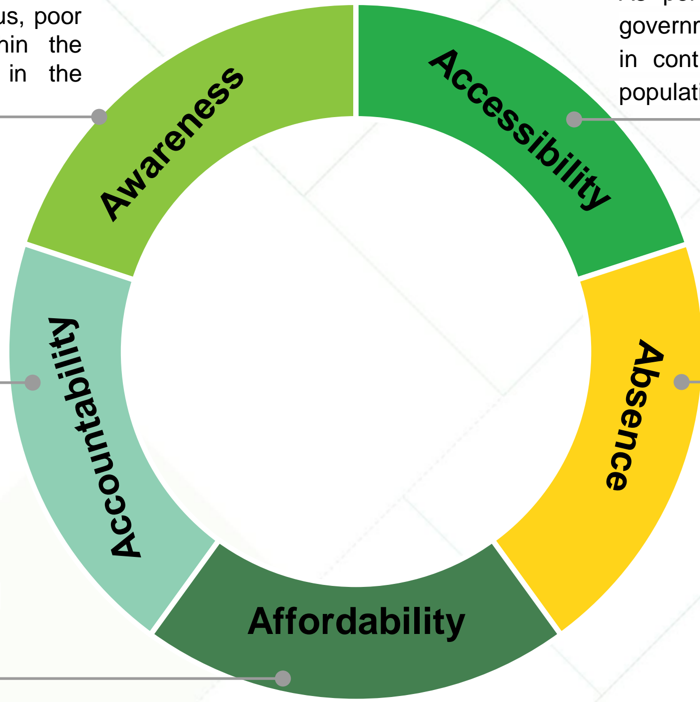
Indian public health system faces a 5-fold challenge in delivering healthcare

Lack of awareness stems from low educational status, poor functional literacy, low accent on education within the healthcare system, and low priority for health in the population, among others.

As per a report dated 2019, in India there is one government allopathic doctor for 10,926 patients. This is in contrast to the WHO guidelines stating a doctor population ratio of 1:1000.

NHRM gives great importance to accountability with increased community ownership of healthcare systems through community-based health workers, village health and sanitation committees etc. However, its **implementation across the country has faced challenges.**



A 2011 study estimated that India has roughly **20 health workers per 10,000 population**, with allopathic doctors comprising 31% of the workforce, nurses and midwives 30%, pharmacists 11%, AYUSH practitioners 9%, and others 9%

Almost **75% of healthcare expenditure comes from the pockets of households**, and catastrophic healthcare cost is an important cause of impoverishment. Public spending on health is low: at a little over 1% of GDP in 2016-17, while the world average is 5.99%

Source: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6166510/
https://health-policy-systems.biomedcentral.com/articles/10.1186/s12961-019-0448-8
https://www.niti.gov.in/sites/default/files/2021-10/District_Hospital_Report_for_digital_publication.pdf
https://www.medicalbuyer.co.in/only-one-government-doctor-for-10926-people-in-india-report/

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Across Gurgaon, Behror, and Nashik; the number of health care facilities supported by the government are dismal and usually understaffed

- In public health care Gurgaon and nearby areas (including **Kadarpur**) has total 3 general hospitals, 12 community/public healthcare centers (CHC/PHC's), 1 special protection group's hospital and 4 ESI dispensaries.
- There are total 378 Nos. beds in government hospitals.
- Public health care presence is only 13.4% of total beds capacity, 9.4% of total ambulances and 11.1% of total blood banks in Gurgaon

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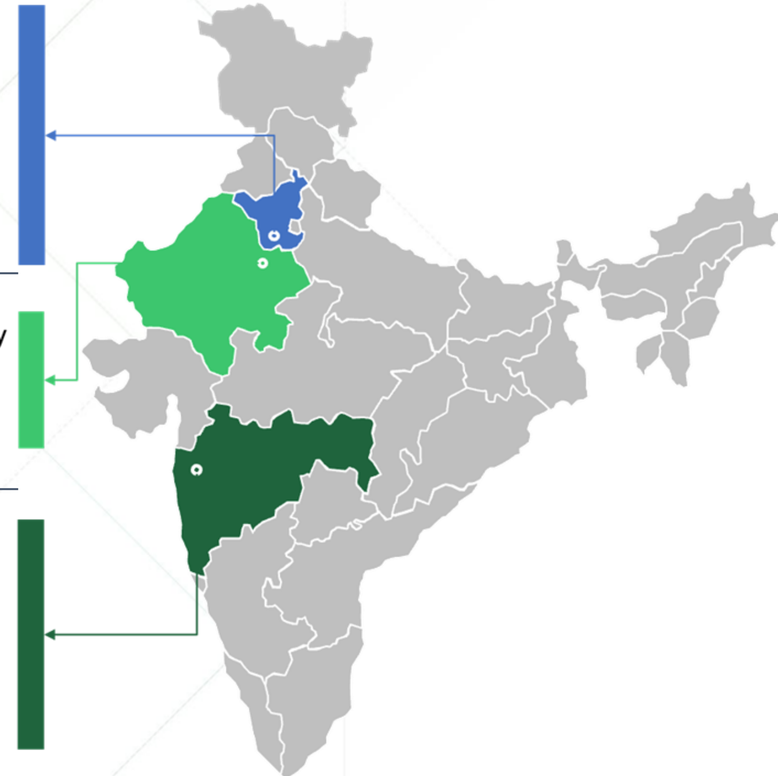
- As of 2017, Alwar (**Behror**) has 760 health sub-centres (HSCs), 120 primary health centres (PHCs), 36 community health centres (CHCs) and 1 district hospital.
- 15% medical officer positions and 61 specialist positions remain vacant.

- In **Nashik**, public hospitals are mostly overcrowded in addition to lacking specialist health workers.
- 10% doctors are in public sector and 70% specialist positions are vacant in rural hospitals.
- Only 22% beds are owned by government hospitals.



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Executive Summary

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Overview as per DAC Framework

Relevance	The Program addresses a critical need of the community. For **70% of the surveyed population** across all 4 locations**,** PRI dispensary or mobile medical van is the **first choice of healthcare for any illness.** However, there are gaps in alignment with the evolving community needs and latest public health interventions.
Coherence	The program aligns with certain objectives of key national programs like Ayushman Bharat to provide continuum of care, however, services provided at the PRI dispensaries are not comprehensive. Of the range of services to be provided under the AB scheme, PRI dispensaries has a convergence of only 33%.
Effectiveness	The program lacked a systematic approach in its design, however over time, certain parameters to streamline implementation were identified and adopted. The program needs to strengthen awareness and diagnosis aspects of the Awareness, Diagnosis, Care and Referral (ADCR) formula which is implemented at the dispensaries.
Efficiency	There is significant difference between budget of government PHC and PRI dispensaries are structured which needs to be rationalised as the starting point towards efficiency**.Further, there is lack of documentation and information regarding fund allocation as well as utilisation, which is concerning.
Impact	The program has created change in help seeking attitude of the community - around 70% across 4 locations are willing to avail institutional healthcare services, healthcare services are now accessible, and led to long term behavioral changes where the community knows the importance of using a medical institution for healthcare needs instead of resorting to home-care or unprofessionals
Sustainability	Sustainability aspect has not been explored in program design and implementation. The program lacks an exit strategy, and have not explored linkages with existing public health infrastructures at a community level. PRI being the sole supporter of the project since inception, financial sustainability of program is not explored.

Satisfactory Needs Improvement Unsatisfactory

** Based on analysis of financial information of 2 quarters

Key Findings

1

Across all the 4 locations, there is a critical gap in existing healthcare facilities - **proximity, over-utilisation, lack of specialised treatments and emergency care.** Other than the PRI dispensary, nearby health facilities are minimum **8-10 kilometres away from settlements / villages**. Patients use public buses or local, shared transport to reach to these facilities,making PRI dispensaries most accessible.

2

For almost **70% of the surveyed population** across all 4 locations**, PRI dispensary or mobile medical van is the first choice of healthcare for any illness.**

Majority of the surveyed population requested for diagnostic/ test facilities to be provided at the dispensary or van

3

With the presence of PRI dispensary and vans, there is an increase in willingness to avail medical help if required. One key reason for this is the low cost and affordable care provided at the PRI facility.

4

During the period Wockhardt Foundation took over the dispensaries, the activities have been streamlined after identifying disease patterns, and based on the needs of the community. One key change is extending the timings of the dispensary based on demand.

5

In Gurgaon and Kadarpur, per person utilisation is higher than the allocated budget, whereas in Dindori and Behror it is lower.

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Key Findings - Kadarpur

1. **Demographics:** Majority of the respondents who were part of the survey belonged to the **age group of 21-40 years**. Of the total respondents, **67% are women**. The male respondents predominantly work in farming and related activities, and also work as daily wage labourers, rickshaw drivers, shopkeepers etc. Of the women respondents, almost 99% are homemakers. **The yearly household income among 76% of the respondents is less than INR 1,00,000. Most patients reported to suffer from Non-communicable diseases such as Blood Pressure and Sugar.** Other common illnesses included seasonal diseases, skin problems, body pain and heart related issues.

2. **Affordability:** Since the only cost for patients to bear is Rs. 10 for each visit, **PRI dispensaries are the most affordable in the region.**

3. **Accessibility:** A large section of community faces difficulty in accessing a healthcare facility due to **less number of healthcare facilities, large distance between home and facility, lack of transportation, overcrowding at existing facilities and inadequacy of specialist doctors.** However, the presence of ophthalmologist and dentist at Kadarpur dispensary has helped in creating awareness around eye and oral care.

4. **Availability of tests, medicines and diagnostic services:** 61% of the respondents are satisfied with the medicines and the diagnostic facilities. However, recently (2-3 years) an increase in difficulty to access tests and medicines due to Covid was also reported. **Currently, the dispensary only conducts clinical assessments and referrals to other government hospitals are made considering the lack of financial resources of the community.** This has brought about a dissatisfaction among the patients as they see a fall in quality of services since the last 2 years.

5. **Areas of Improvement:** The patients in Kadarpur reported that they **require additional diagnostic lab facilities and tests, especially X-Ray and ultrasound facilities.** The community faces **difficulty accessing gynecology and pediatric care and reported complications in pregnancy.**

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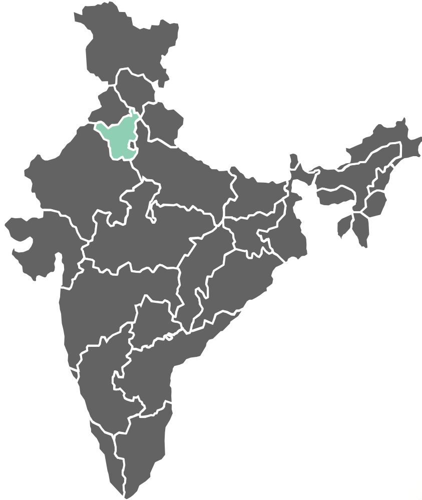
Key Findings - Gurgaon



1. **Demographics:** 64.25% of the respondents are homemakers with 72.54% of them earning upto INR 1 Lakh annually. **Majority of the respondents (59%) were females,** 26.94% of them were aged between 21-40 years, out of which majority (46.11%) of the **females were homemakers and** few were **employed as house-help, construction workers etc.** 41 percent of respondents were **males**, with the **majority** (18.13 percent) being between the ages of 21 and 40. They are **employed in private companies, work as labourers or are unemployed.**

2. **Awareness:** Patients reported **increase in awareness about nutrition intake during pregnancy has reduced the number of miscarriages.** Further, Patients' willingness to undergo diagnosis has reportedly improved.

3. **Accessibility:** A large section of community faces difficulty in accessing a healthcare facility due to **less number of healthcare facilities, large distance between home and facility, lack of transportation, overcrowding at existing facilities and inadequacy of full time doctors.** Despite this, PRI dispensary was the first choice of health facility for any illness for 73% of the respondents.

4. **Availability of infrastructure, diagnostic services and medicines:** The respondents were satisfied with the quality of the infrastructure. **PRI Dispensary had partnerships with Government and other organisations** for scans, lab tests, etc, which was helpful for the patients to avail diagnostic services. The challenge, however is in accessing follow-up services as the dispensaries are not operational anymore. **It was reported that general medicines for cough, cold, fever, aches etc were available at the dispensary.**

5. **Areas of Improvement:** **A significant number of respondents wanted the dispensary to be reopened.** Emergency care, test facilities (XRay, MRA scan), and pregnancy and delivery care are requested. Further, **45% of the respondents expressed their interest in supporting the dispensaries**, by creating more awareness among the community about the facilities.

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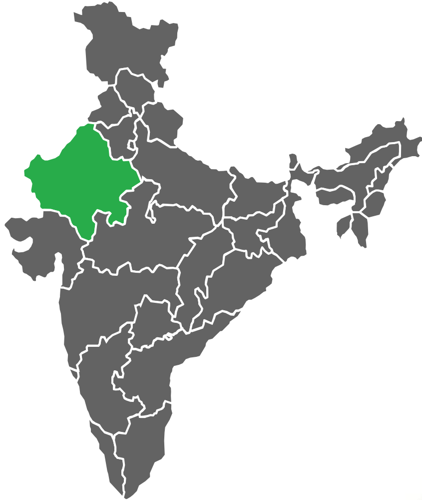
Key Findings - Behror



1. **Demographics:** Only **26% of the respondents** in Behror **were women** with an average age of 51 years. Of these, **majority were homemakers,** and 37.5% worked were involved in farming and related activities. Majority of the **male respondents were engaged in agriculture and related activities**, with 23% working in service sectors and undertaking their own businesses. The **average annual household income of respondents in Behror is INR 1,35,806**

2. **Awareness:** There is an **improvement in perception of approaching and utilising the medical facilities available in the region,** and there is an **uptake of proactive preventive care.** However, **relatively awareness on immunization and nutrition is less.**

3. **Accessibility:** The mobile medical van and **dispensary at Behror caters to around 15-20 villages**, with a **daily footfall of 30-40 patients.** Despite this, it can be noted that the community faces a **challenge in accessing medical services especially tests as they have to travel a long distance and the existing healthcare facilities are not sufficient.** There is also **difficulty in accessing specialist healthcare especially gynecology and pediatric care.**

4. **Availability of infrastructure, follow ups and testing:** A significant number of patients reported that they find the quality of infrastructure facilities such as building, equipment, beds and restrooms available at the dispensary are sufficient and well-maintained. A significant number of patients also reported that at present, they do not face any challenges in following up with the doctors. **However, there is a lack of availability of testing facilities at the dispensaries and vans.**

5. **Areas of Improvement:** 56% of the respondents reported that they are looking forward to the opening of **specialist clinics, more doctors and test facilities.**

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Key Findings - Dindori

1. **<u>Demographics:</u>** Of the surveyed group, majority belonged to the age group of 21-40 years.**50% of the female respondents were working in agriculture and related activities,** 33% of them were homemakers and others undertook informal activities such as tailoring, manual labour etc. **87% of the male respondents were farmers** while the remaining stated tailoring and driving as their main occupation. The **average annual income of respondents in Dindori is INR 327500.**

2. **<u>Awareness:</u>** The reported **increase in accessibility to healthcare services has helped in reducing the apprehensions of patients.** Furthermore, here has been a reported increase in terms of disease prevention, cure and awareness of diseases such as BP, Diabetes, NCD among the elederly.

3. **<u>Accessibility:</u> Difficulty in accessing a healthcare facility and limited availability of specialized treatment are the major challenges faced by the community** .In addition to this, the doctors also feel that patients go through major apprehensions while visiting the doctor. This was aggravated during covid, the patients were scared as there was a lack of awareness. However, **73% of the respondents utilise the medical services offered from the mobile medical vans** which made medical care more accessible to the community.

4. **<u>Availability of medicines and testing:</u>** 83.33% of the respondents reported that the medicines were cheaper at PRI Dispensary than any other health facility which has made medicines affordable for them. **Hence, on an average, the patients rated the access of medicines and tests at the PRI dispensary as 4.9.**

5. **<u>Areas of Improvement:</u>** The community requested that the van come multiple times to the village, as there is no nearby hospital or healthcare center. Further, the community faces an issue with the timings of the van - there needs to be a schedule and it should adhere to the schedule. Additional **test facilities for diabetes and BP, and treatment for pregnant women, TT injections, blood thinners etc. were requested by the community.**

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Efficiency Analysis

Limitations in Efficiency Analysis

The minimum data required to conduct efficiency analysis is as follows:

1. Quarterly continuous budget, utilisation and patient numbers for at least 1 year. For any donor agency, quarterly budget utilisation report is part of minimum reporting requirement. Hence, a lack of the same is concerning.
2. Understanding of the rationale behind budgeting to make comments on the allocation and utilisation. However, documents and information on these finer details were not available. The following analysis section largely includes observations and the questions which PRI itself needs to address with the implementation partners.
3. Additionally, observations made are for select periods, and these periods also has anomalies caused due to COVID-19. Hence it might not give the most accurate picture of efficiency of the program.

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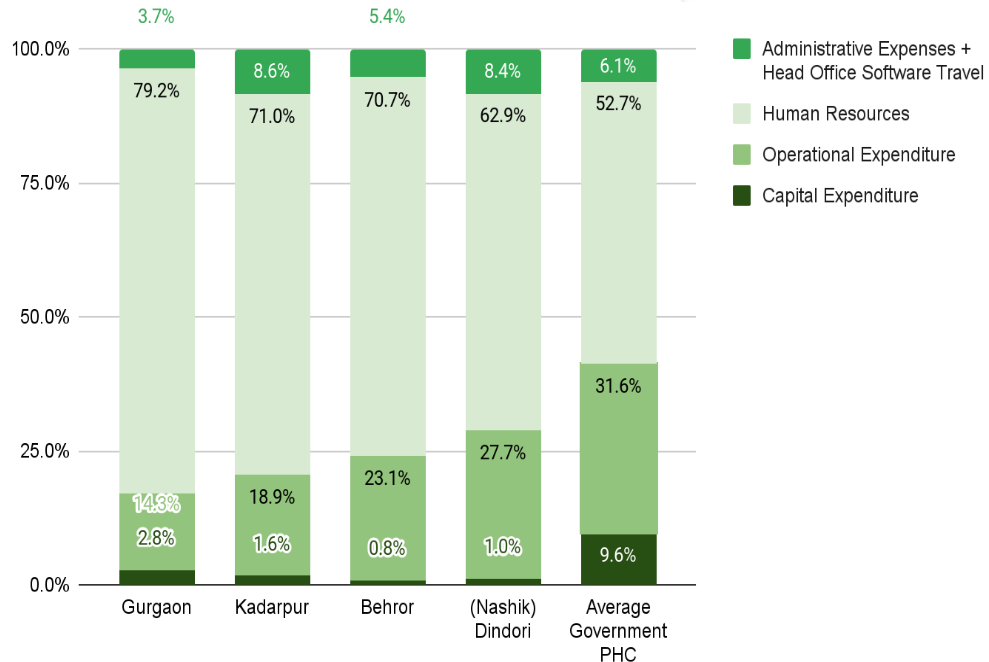
There is significant difference between the budget of a government PHC and the PRI dispensaries which needs to be rationalised as the starting point towards efficiency



- While benchmarking the budget with the average actual spend for a government PHC*, allocation for **HR across 4 locations is higher by 10% to 27%.** The reason for this can be overqualified and highly paid doctors at the PRI dispensaries than required (as stated by Wockhardt team)
- **CAPEX is substantially low** as compared to government PHCs. Our assumption is that as the basic infrastructure is being provided by government or PRI.
- As compared to the **operational expenses** at government PHCs (drugs and consumables, lab investigations), **PRI dispensaries seems under-allocated for the same**.
- Footfall targets at each PRI dispensary are in the range of 55-80 patients per day. Therefore the huge variance in allocation between the locations is not clear.
    - Even the two dispensaries Kadarpur and Dindori, with same number of patient targets, have very varied expense allocations- the Dindori PHC receives half the budget of what Kadarpur does.

*https://www.researchgate.net/figure/Cost-of-delivering-healthcare-services-in-seven-Community-Health-Centers-from-north-India_fig9_306285197

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Efficiency Recommendations

At present, financial data provided to Sattva for the efficiency analysis itself is very limited. Based on discussions with the PRI and Wockhardt team, we understand that there are gaps in financial data management and recording. The following are recommendations to institutionalise budgeting systems and processes:

Program plan needs to have a close alignment with the financial plan. This can be undertaken by having quarterly checks on expenditure to monitor costs and cost control.

Financial plan should have objectives for allocation of budget and have clear rationalisation for the line items. Evaluation of location specific needs and average footfalls per clinic can be used as a starting point to prioritise requirements and budget allocations.

Use standard benchmarks to understand the efficiency in comparison with existing structures so that there is an external ecosystem context (similar programs, existing PHCs). This can help in minimising the over allocation and under allocation of funds while bolstering efficiency.

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Key Recommendations

PRI should continue the program by re-looking at the community needs and shape strategies to mitigate operational inefficiencies

1

Re-evaluate the needs and adopt focused, need-based approach to improve efficiency and resource allocation
Bring in more components of community orientation in understanding the local needs and aligning the offerings at the PHCs in accordance to that. This can be done by rigorous evaluation of operational data and periodic needs assessment (3-5 years, as per the program visibility, nature of community and the shifts in the healthcare ecosystem).

2

Identify and prioritise preventive healthcare approaches
Continuous evaluation of patient data, recommended above will also help in identifying disease patterns which then should be used to identify and prioritize localised preventive health care. This will give PHC level priorities for disease prevention.

3

Build community awareness to adopt preventive practices
Based on PHC wise priorities and the community dynamics, strategies around awareness building and behavioural change at community level should be developed. A mix of digital, community health infrastructures such as ASHA and Anganwadi workers may be deployed for dissemination.

4

Expand community reach through mobile medical units
Improve accessibility through mobile medical units to reach areas that are beyond 5km from the clinic. Using data in terms of availability of community, and specific needs to plan the mobile unit visits will help optimise its route and resource utilisation.

Source: Discussions with PRI team

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To raise its profile in the healthcare space and to strengthen the program by leveraging ecosystem level levers

Ecosystem level Recommendations

Expanding reach through community linkages

There are public health resources available at the community level like ASHA workers, anganwadi workers who have a rapport with the local community. Given that most of these locations have access issues, these infrastructures can be integrated with the programs to ensure better reach of care.

Shift to preventive approach through digitisation

For preventive approach in healthcare, patient data and history is critical as common lifestyle patterns and early symptoms that lead to NCDs often go unnoticed due to the lack of these data points. While Wockhardt has brought in some level of digitisation, for a long term preventive strategy more robust and advanced management of patient's medical history, behaviour, and interaction with local healthcare professionals is needed and should be pursued.

Build and leverage partnerships for continuum of care

Due to the limitations of PHCs, in terms of resources, scale and scope, it has to rely on a network of public and private healthcare resources to fully meet the local healthcare needs. This means both at the institution level and at the geography level, there needs to be partnerships identified and built to provide full breadth of healthcare services needed by the community.

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While relooking at program, serious thoughts can be given on the sustainability of the program from the following lenses

Sustainability Components	Observations	Recommendations
Exit Strategy	There is no exit strategy in the program design at present	As the donor agency, the extent to which PRI will support any PHC needs to be defined (expert support may be sought to define this) and creating community ownership or operational sustainability will be important
Ground level institutional resources	No linkages with ground level institutional resources have been explored.	Strategies to leverage resources such as ASHA workers, Anganwadis etc. should be developed. This can aid the process of spreading awareness and following up with patients.
Convergence with government	At the initiation, PHCs began functioning in collaboration with the government. Over time, the relationship has changed.	One of the options to exit is to hand over the operations to government after a mutually decided success point. To do so, deeper relationships need to be built with governments especially health departments in the relevant geographies.
Behavioural change in community	There is a positive behavioural change among the community	More local, need-based approach may be taken to increase the effectiveness and impact created among the community

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Annexure

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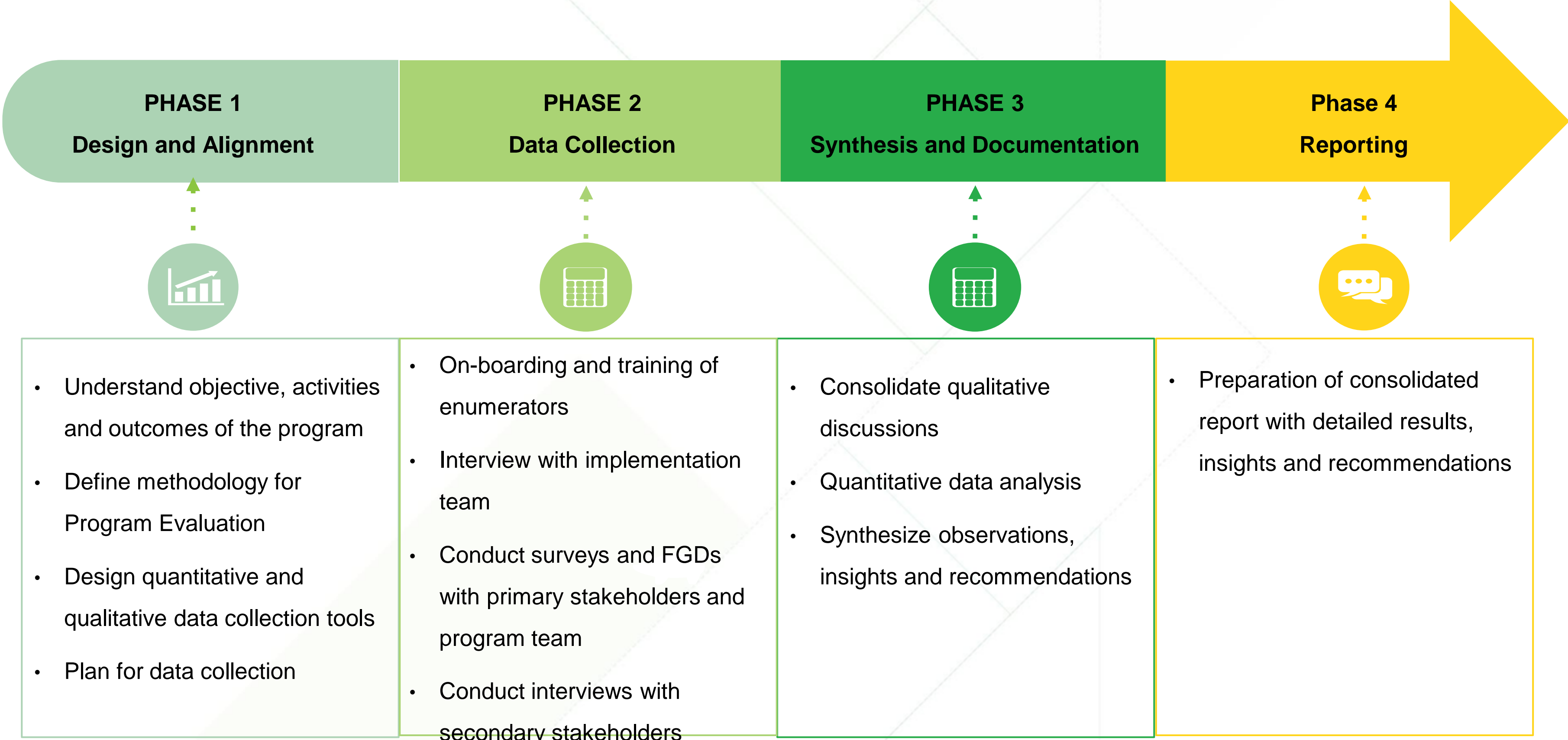
Approach of the assessment



PHASE 1 Design and Alignment	PHASE 2 Data Collection	PHASE 3 Synthesis and Documentation	Phase 4 Reporting
• Understand objective, activities and outcomes of the program • Define methodology for Program Evaluation • Design quantitative and qualitative data collection tools • Plan for data collection	• On-boarding and training of enumerators • Interview with implementation team • Conduct surveys and FGDs with primary stakeholders and program team • Conduct interviews with secondary stakeholders	• Consolidate qualitative discussions • Quantitative data analysis • Synthesize observations, insights and recommendations	• Preparation of consolidated report with detailed results, insights and recommendations

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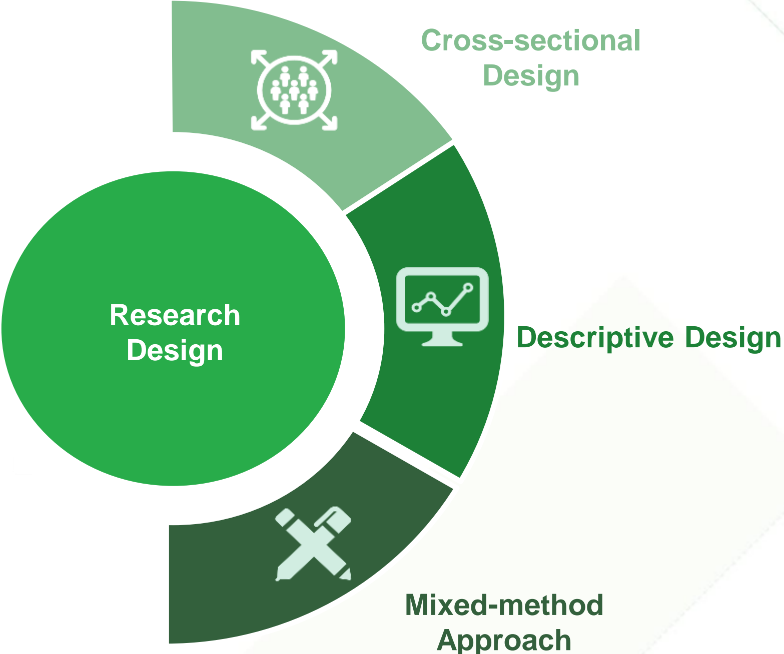
Research design

Sattva adopted a 3-fold design approach for the PRI Dispensary study to gather valuable **impact** related insights from a 360-degree perspective across the stakeholders involved and is fundamental to providing recommendations towards fine-tuning the model and scaling up in the long term.



The study incorporated a **descriptive cross-sectional design** method where data will be collected from a representative population of the beneficiaries to provide a snapshot of the outcome and the characteristics associated with it, at a specific point in time. The following aspects were assessed:

1. Whether the intervention worked as expected to achieve its objectives, and

2. How the objectives were achieved, what the process was, and what the timeline for impact was

The in-depth study will leverage Sattva's extensive experience of more than 10 years in Impact Assessments, an in-built knowledge repository, and tech enabled data collection solutions.

The study will incorporate **mixed-method** approach consisting of **quantitative and qualitative** data collected from primary and secondary sources. This will help gather valuable **impact** related insights from a 360-degree perspective across the stakeholders involved and would be fundamental to providing recommendations towards fine-tuning the model and scaling up in the long term.

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Outreach for data collection

Stakeholder	Sample size	Survey Planned	Actual Survey	Planned FGD	Actual FGDs conducted	Planned IDIs	Actual IDI conducted	Mode of data collection
Community (Gurgaon & Kadarpur)	192 in each location (dispensary+van)	**384**	**389**	-	-	-	-	**Mixed**
Community (Behror)	30	**30**	**31**	-	-	-	-	**Mixed**
Community (Dindori)	30	**30**	**30**	-	-	-	-	**Virtual**
PHC staff (across 4 locations)	1-2 in each location	-	-	**4-5**	**3**	-	-	**Mixed**
Doctors (across 4 locations)	1 in each location	-	-	-	-	**4**	**4**	**Mixed**
Project Partner (Wockhardt)	2	-	-	**1**	**1**	-	-	**Virtual**
CSR team (PRI)	1	-	-	**1**	**1**	-	-	**Virtual**

Note:

1. *Gurgaon dispensary is not operational since 31st December 2021. However, the dentist and ophthalmology doctors from Gurgaon dispensary consults their patients at Khadarpur dispensary currently. Sattva team interviewed these patients.*
2. *Dindori dispensary is not operational since 31st December 2021. However, the community avails the services from the vans. Sattva team reached these beneficiaries.*

**IDI - In depth Interviews, FGD - Focused Group Discussions*

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THANK YOU

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