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THE EXCELLENCE EDGE

MYTHS ABOUT RURAL HEALTHCARE BUYING BEHAVIOUR

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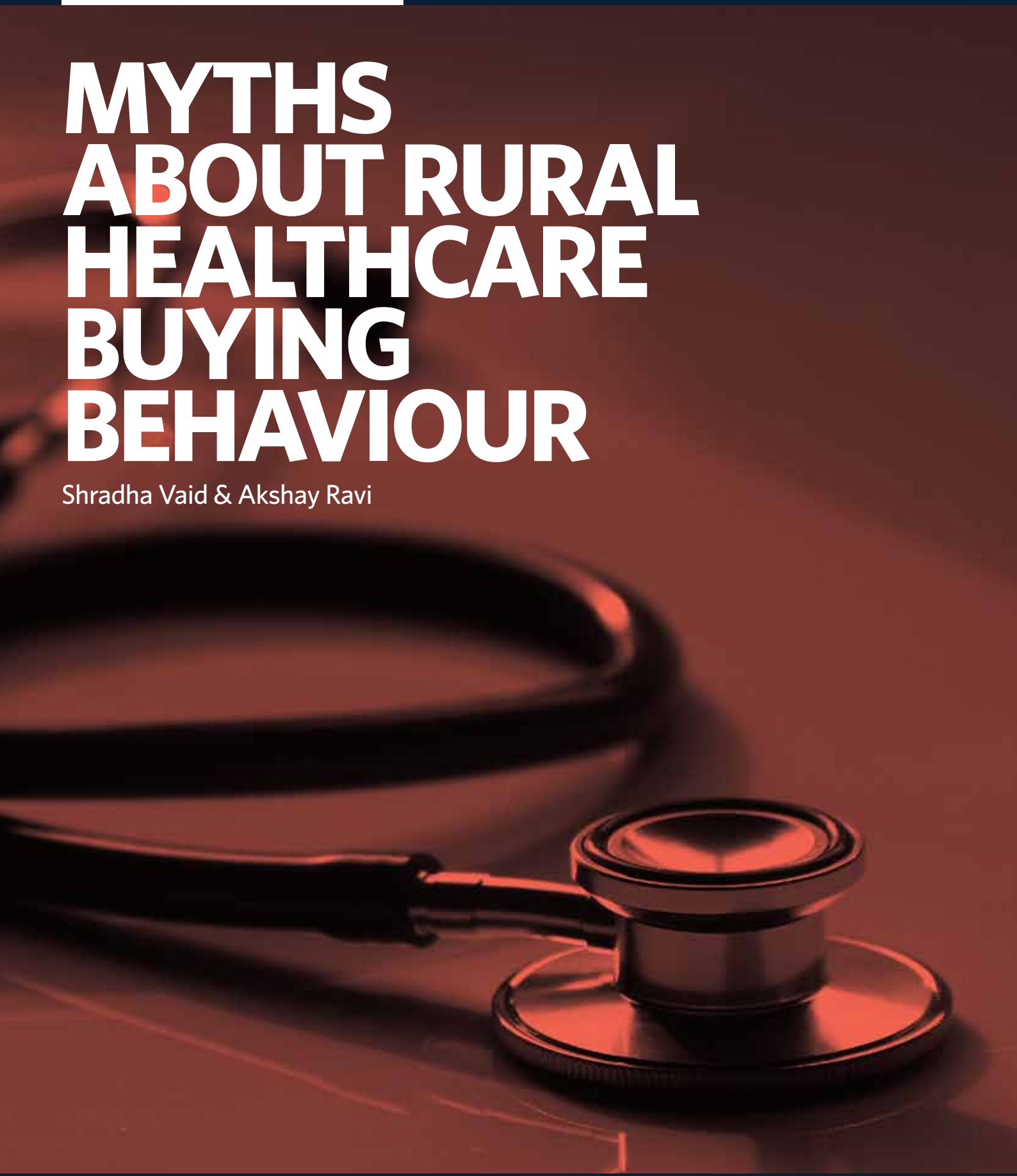

While the rural primary healthcare spend in India is estimated at over INR 80,000 crore[1], the sector has seen limited interest from private sector organizations till date. The high growth witnessed by the healthcare delivery space has been predominantly driven by private investment in secondary and tertiary assets in metro/tier I cities.

The limited interest in rural primary healthcare from the private sector is due in part to Government spending crowding out private sector and also the perceived lack of financial attractiveness of the space. The Central and State Governments allocate over INR 20,000 crore or nearly 0.2% of GDP for the National Rural Health Mission (NRHM) programme; in addition, a proportion of state health budgets (over INR 60,000 crore[2]) is also spent on programmes aimed at improving rural healthcare. While the objective of these programmes is to strengthen rural primary healthcare infrastructure, quality of care remains a concern given the massive infrastructure and manpower deficit. Additionally, the belief about rural consumers availing limited consultations and having limited paying capacity has also limited private interest and investment in the space.

However, most of these beliefs are just myths and the rural consumer has changed significantly in the last few years. This article addresses the 3 largest myths about the rural healthcare consumer and is based on an in-depth survey across 400+ rural households in c. 8 districts spread across Maharashtra[3]. We believe the rural healthcare sector is on the cusp of change with a large demand supply gap for quality services and significant opportunities for private players going forward.

- 1 Based on normative estimates of average per household spend on primary care per month derived from NSSO surveys and proprietary research carried out in rural Maharashtra, adjusted for India rural pricing (based on February, 2014 rural CPI indices)
- 2 Volume III of the XIIth Five Year plan on Social Sectors
- 3 We believe the results are generalizable to rural India in principle

MYTH 1:LIMITED WILLINGNESS TO PAY FOR HEALTHCARE IN RURAL AREAS

TRUTH:

EVEN POOR HOUSEHOLDS SPEND C. INR 400 PER MONTH ON HEALTHCARE WITH VALUE FOR MONEY SERVICES BEING HIGHLY VALUED

Across districts and income classes, we found high willingness to spend for healthcare. On an average, a rural household spent over INR 400 per month on healthcare[4]

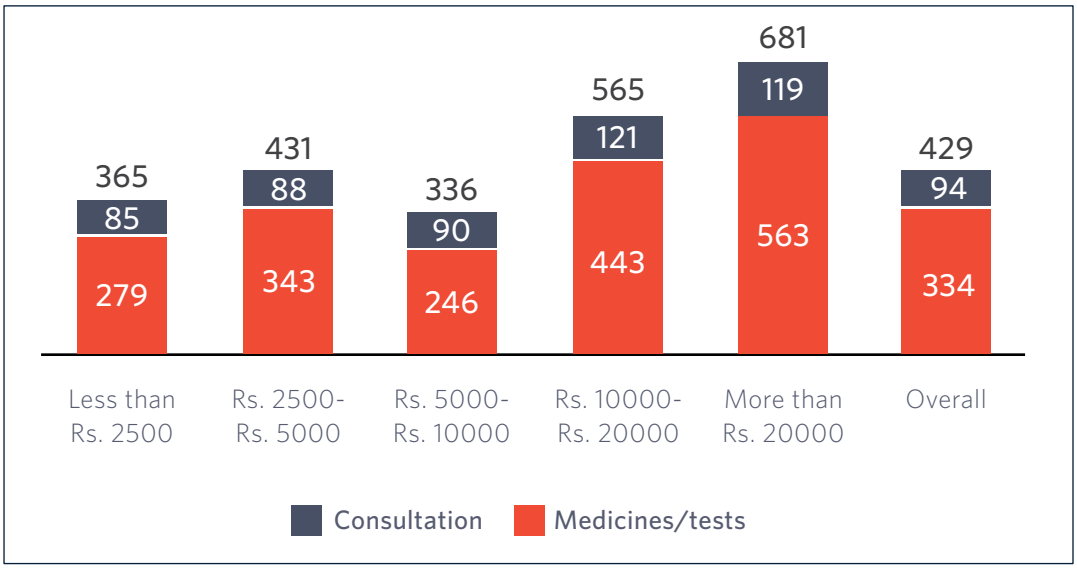

Figure 1: Average monthly spend on primary care in INR across reported household monthly income categories

Consumption patterns for the rural poor are in line with those in urban areas.Even with conservative estimates, healthcare accounts for over 7% of the share of expenditure for the lowest income percentile categories[5], similar to that for the urban poor.

There is increasing awareness and prioritization of quality of treatment over cost – the general sense of entitlement of free services and doles is increasingly not applicable for healthcare. A large number of respondents surveyed across villages had the following comment - *"Even poor people will readily pay for medicines if the treatment is of good quality, we do not compromise on health."*

- 4 According to the latest NSSO spending estimates for rural Maharashtra – INR 114 per month per capita i.e. nearly INR 540 per month per household is spent on medical care
- 5 In the absence of reasonable estimates for rural income distribution, NSSO 68th round estimates of expenditure considered; MPCE for the lowest 20th percentile of rural Maharashtra reported at INR 1,050

MYTH 2: LOW AWARENESS ABOUT HEALTHCARE LEADING TO LIMITED CONSULTATION

TRUTH:

AT LEAST 1 CONSULTATION PER HOUSEHOLD PER MONTH; INCREASING AWARENESS AND DEMAND FOR SPECIALIZED SERVICES

Even in remote and smaller villages (< 2,000 population), consumers appreciated the importance of qualified doctors – while reporting dissatisfaction with current BAMS/ BHMS doctors several consumers indicated a preference for MBBS doctors. When asked about specific health services desired in their villages, a majority of the respondents expressed the need for specific diagnostic tests – pathology tests, X-ray, sonography, birthing facilities, etc., once again underlining the large demand-supply gap in these areas.

"We need facilities to check bones - lot of old people in our village"

"All diagnostic facilities should be provided - like X-ray, sonography, blood tested etc."

"Minimum facilities like BP testing, sugar testing and pregnancy checkups should be provided"

"Sonography and pregnancy tests need to be provided in the village health centre"

"If possible we would want even advanced diagnostics like CT scan in our village"

Figure 2: Responses given by rural consumers when asked about specific health services needed in their villages

With increasing awareness, rural consumers are becoming increasingly open to consult doctors for health issues. On an average, our survey indicated at least 1 consultation visit per month per household[6]; while this is less than urban areas (estimated at 1.5[7] - 2[8] visits per household per month) we believe the trend is positive and upwards with sufficient base demand and awareness for a private player to cater to.

- 6 According to the Planning Commission's study "Out of Pocket Expenditure in Healthcare", 2012, conducted in villages in 5 states of India – Assam, Jharkhand, Rajasthan, Tamil Nadu and Uttarakhand, on an average 70 persons per 1000 population were ill during the last 15 days prior to the survey
- 7 Based on age adjusting US ambulatory OPD visit rate per 100 population – affluent segment of urban India likely to behave in a similar manner with respect to access to and ability to pay for quality care
- 8 Das J, Hammer J, Sanchez C. The impact of recall periods on reported morbidity and health seeking behaviour. J Dev Econ.2012

MYTH 3: SEGMENT MOSTLY SERVICED BY PHCS AND GOVERNMENT CENTRES

TRUTH:

MAJORITY PREFER TO VISIT PRIVATE PRACTITIONERS EVEN IF IT MEANS TRAVELLING LARGE DISTANCES

While government centres (SCs, PHCs and CHCs[9]) are the most accessible and affordable, limited capacity addition and lack of focus on quality[10] has led to increased dissatisfaction amongst rural consumers.

With increasing access to and awareness about private health services in urban areas, there has been a large scale shift in preference towards the private sector with emphasis on quality care - over 90% of respondents reported going to a private doctor or clinic for primary care[11].

"We poor people have no choice but to go to Govt. setups because we don't have money"

"Govt. doctors are not good. Their treatment is ineffective"

"Govt. centres have limited facilities; the doctors there refer us to private clinics anyway"

Figure 3: Reasons given for choosing a private doctor/clinic for primary care

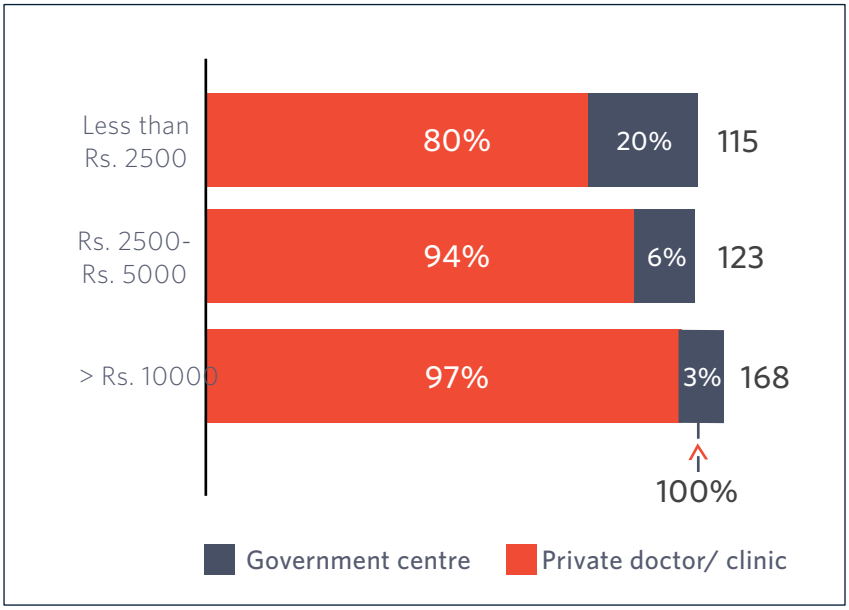

Figure 4: Place of visit for primary care consultation

- 9 SC: Sub centre, PHC: Primary Health centre, CHC: Community Health centre
- 10 Based on review of NRHM Statistics – 2012 report; limited addition of SCs and PHCs from 2007-2012, shortage of trained medical and paramedical staff at the centres, poor quality of infrastructure (access roads, electricity, water supply)
- 11 Similar results have been obtained by researchers in rural Andhra Pradesh, Bihar and Uttar Pradesh. Gautham, Binnendijk et al. (2011) and Working Paper No. 575 of the International Institute of Social studies

Given limited penetration of private facilities, this shift in preferences has led to consumers having to travel large distances even for primary care with additional conveyance costs – at least 10-15% of existing spend on healthcare. Extrapolated for the entire state of Maharashtra, this translates into an annual social burden of nearly INR 10,000 crore.

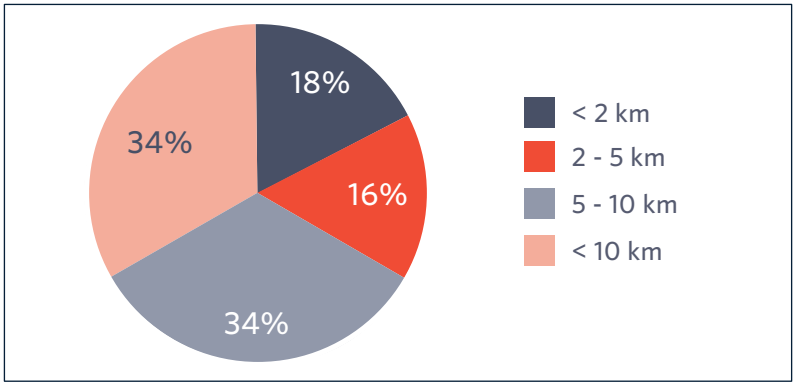

Figure 5: Average distance travelled for primary care

In addition to a consumer push, the rural healthcare sector is also seeing a greater regulatory push with state governments across the country initiating insurance and subsidy schemes; although these schemes have limited outpatient consultations included currently, there has been an increasing willingness of governments to explore new models of partnership with the private sector.

STATE/UT	SERVICE TYPE	DESCRIPTION
Delhi	Diagnostics	• Partnership between Hindlabs and CGHS to provide advanced laboratory and imaging services to CGHS beneficiaries • Hindlabs provides services at near CGHS rates to beneficiaries
Karnataka	Health insurance	• Joint venture between Karuna Trust, National Insurance Company and Govt. of Karnataka • Community health insurance scheme - including coverage for outpatient care, out of pocket expenses and loss of wages) • Premiums fully subsidized for SC/ST BPL and partially subsidized for non-SC/ST BPL; low premium of INR 22 per person per year • c. 6 lakh beneficiaries across 25 PHCs
Karnataka	Management	• Management of 25+ PHCs outsourced to Karuna Trust • c. 80% of the operational costs borne by the Government • No user fee
Tamil Nadu	Ambulance	• Round the clock emergency transport of pregnant women • Contract given to an NGO • Capex borne by the Government • Scheme supported through user charges; Poorest 10% patients are subsidized by the Government; others pay INR 5 per km.
West Bengal	Primary care	• Mobile boat based health services – carries diagnostic equipment, medicines, doctors and support staff • Villages on different islands grouped together as blocks • Bidders quote an all-inclusive price for conducting camps on a regular basis – services include free consultation, diagnostics, medicines and obstetrics
Uttarakhand	Primary care	• Mobile Health van/hospital including diagnostic services • Covers 6 districts through 15 camps conducted on fixed dates every month • Capex borne by the Research Institute • 50% of operating expenses borne by the Government • Users charged only INR 10 registration fees (valid for 2 visits)

Figure 6: PPP models in primary healthcare[12]

• 12 XIIth plan document, Volume III on Social Sectors; KPMG report on Public Private Partnerships in Health

In light of the changing rural landscape, we believe there is a large opportunity for private players to enter and cater to this segment. Opportunities are available for players across the service chain – improving access, providing primary care, providing diagnostic services, improving quality of trained manpower, etc.

However, several challenges will have to be addressed. Given the low population density in rural areas, multi-tier cluster models are likely to be needed to ensure scale. At the same time, developing effective monitoring systems and managing logistics will be critical for success. Manpower availability – both skilled and semi-skilled, and their retention are also likely to be key challenges and innovative compensation and rotation policies will have to be designed to address the same. While technology can be potentially leveraged to provide tele-services, careful evaluation of the impact of additional costs of breakdowns, repairs and down times will have to be done to ensure profitability. Finally, efficient systems and processes will have to be designed to make the model scalable.

Innovative customized and localized solutions will have to be developed along with appropriate bundling of services to address key challenges and make the business scalable and sustainable. The market is definitely attractive and rural consumers are increasingly willing to accept for-profit private sector models if quality care is assured.

Areté Advisors LLP (Areté) is a boutique, sector-focused management consulting firm with offices in New Delhi and Mumbai, India. Areté works with corporate clients in the Agriculture & Foods, Construction, Healthcare, Logistics, Real Estate and Retail sectors.

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