Leading Change
Making Choices

Raising the Standard for Quality Eye Care In Developing Countries

EXPERIENCE OF THE
INTERNATIONAL EYE FOUNDATION
1999 – 2004

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Introduction

The burgeoning rates of blindness, 90% of which is in developing countries, can only be addressed when the quality of eye care is that which patients will seek, accept, and for those who can afford, be willing to pay for. While training more eye care professionals is a piece of a larger puzzle, the root causes of current inefficiencies, poor quality, and under-utilization of services lie in the poor management and lack of financial sustainability of existing services. There are choices that we can make in the way we think about the delivery of eye care, the definition of "the poor", and the needs of eye care providers, and what we do to implement those choices. Specifically:

Delivery of Eye Care Services: what choices can we make so our services will be more efficient, productive, and of sufficient quality that patients will be satisfied with the service, the treatment outcome, and be willing to pay a fee toward the cost of their care?

"The Poor" is a relevant term. While patients may not be rich, they may be willing and able to pay a fee for services they choose to access. What choices can we make so that the large majority of our patients can afford to access various services?

Needs of Eye Care Providers have been avoided when a program is seen as "charitable". Eye care professionals want to be appreciated, to have the resources to provide the quality of care for which they were trained, and expect a certain level of remuneration. What choices can we make to retain qualified our staff and ensure accountability to our patients?

The International Eye Foundation (IEF) is assisting eye hospitals in Africa, Asia, Central America, and the Middle East to achieve significant results by helping them make and implement their choices.

History

Since IEF's founding in 1961, our sight-saving programs have benefited over 60 countries. Programs have evolved from short and long-term volunteers providing direct service, to establishing training programs for ophthalmic professionals "within" developing countries, to attacking the leading disease-specific causes of preventable blindness once affordable "magic bullet" drugs became available, and expanding national eye care services to provincial and district levels. In December 2004, the World Health Organization updated its global blindness estimates to 37 million blind and 124 million with low vision. Existing resources cannot now meet this challenge. Simply training more eye doctors to work within an inefficient and resource poor system will fail.

Barriers Faced by Patients Needing Eye Care

Much has been written about the reasons why patients don't come for eye care. For example, they state that they are afraid, cannot afford transportation, have no one to take them and cannot see well enough to go alone, long waiting times and the need to return at a later date for treatment, poor results from neighbors and friends who had surgery, or simply don't want to go to the public hospital and cannot afford the higher prices in private clinics.

These barriers revolve around access to and efficiency of service, cost, and customer satisfaction. As noted earlier, paradigm shifts have to be made in the "delivery of eye care" related to efficiency and quality, the definition of "the poor" and what prices people may be willing to pay in order to support financial sustainability, and attention to the "needs of eye care providers" in improving quality of care, patient satisfaction, and job satisfaction.

SightReach® Management & SightReach Surgical®

In 1999 with support from the US Agency for International Development, IEF launched its *SightReach®* Program to address the enormous burden of blind and visually impaired worldwide by strengthening the capacity of eye hospitals in developing countries to increase their number of surgeries and improve the quality of services for all populations regardless of economic status. The dependence on external resources to finance recurrent costs severely limits the ability to reach the poor and most vulnerable populations in greatest need.

Existing eye hospitals have tremendous potential to use their resources more effectively and to reach full surgical productivity. Highly effective and productive eye hospitals in Asia, specifically the Aravind Eye Hospital System in India, provide models for increasing productivity and achieving financial sustainability while serving all populations including the poor. IEF's *SightReach® Management* approach is an adaptation of the Aravind model and is demonstrating that it is not only feasible, but can achieve success outside the Indian sub-continent. Two important components of IEF's *SightReach®* Program are *SightReach® Management* and *SightReach Surgical®.*

1. *SightReach® Management*: IEF has developed this effective model combining the best of modern clinical eye care practices with business planning and management systems to create a hybrid social-entrepreneurial approach to eye care delivery. IEF assists partner eye hospitals in developing countries, both public and private, to undertake organizational and infrastructure changes through a sub-grant and technical assistance from headquarters. The goal is to have both public (government) and private hospitals seeing both paying and subsidized/free patients, providing quality care to all, and achieving financial sustainability.

2. *SightReach Surgical*® is IEF's in-house social enterprise created to address the barrier of cost faced by developing country hospitals in procuring critical ophthalmic equipment, instruments and medical supplies to treat their patients.

Economics of Changing Service Delivery Models

Historically, health services in the developing world have been offered by the public (government) sector free of charge to everyone, but are usually accessed only by the poor and the working poor who cannot afford private care. Those who can afford, seek care offered in the private sector. Two questions arose.

Why must public institutions provide all services free and not earn income?

The answers have always related to the lack of political will and governmental legislation allowing for earned revenue. The risk of corruption is always a concern. And no system or personnel positions were in place to either receive income or account for revenue and expenses.

You mean I'm going to charge poor people?

SightReach® Management:

"investing in ophthalmologists and eye hospitals to improve quality, productivity, management, and financial sustainability, breaking the cycle of dependence on government and donors"

Why don't private hospitals treat poor patients?

Answers include the perceived lack of funds to afford treating patients free of charge, and the lack of business training to pursue models where earned income would be sufficient, and indeed profitable, to treat patients known as "the poor."

You mean I'm going to treat patients for free?

Models exist, especially missionary hospitals, that charge a minimal fee, but that fee does not relate to true costs. Funds are often put in a special account to be used for unique purchases and not to cover operating costs which are dependent on external grants and donations. Innovative models on the Indian sub-continent classified as social enterprises utilize multi-tiered pricing and other income generating services to subsidize the poor. Revenue is tied to true costs leading to financial self-sufficiency. The Aravind Eye Care System is such a model, but it was felt this model cannot work outside India for reasons relating to population density, the private nature and resource wealth of the hospital, and lack of political will.

Partner Selection Criteria

Initially, three criteria guided our willingness to work with a partner hospital, a) political will, b) leadership, and c) a cohort of patients willing to contribute financially toward their care. If the political environment and legislation demand that all health care is free of charge, success will not be achieved. If the hospital's leadership is not strong enough to meet the resistance to change from internal and external stakeholders, success will not be achieved. And if those patients who can afford to pay are not willing to contribute to a number of pricing choices, success will not be achieved.

Over the last five years, we found that political will and paying patients are almost non-issues. The critical factor is leadership because resistance to change is inevitable, and intended and unintended obstacles arise that can derail the best plans and hopes for success. Leadership must be nurtured, supported, and given the tools to ensure that changes stay on track.

Program Components and Achievements of *SightReach® Management*

A comprehensive redesign to achieve improved quality, efficient service, customer satisfaction, and financial sustainability are similar whether IEF is transitioning public sector hospitals to introduce innovative income generation while still treating the poor, or private hospitals to subsidize poor patients while remaining financially viable.

From 2000 to 2004, an initial group of seven eye hospitals and clinics in six countries in sub-Saharan Africa, Central America, the Middle East, and Asia partnered with IEF to demonstrate the sustainability approach. IEF also supports the Lions Aravind Institute for Community Ophthalmology (LAICO) at the Aravind Eye Hospital in Madurai, India to provide management training for teams from IEF's partner hospitals. The data noted in the components below was collected between 2000 to 2004.

Quality of Care is defined as appropriate care that treats eye disease resulting in restoration of eye health and/or sight. An example is ensuring that all cataract patients receive an intra-ocular lens (IOL) to restore clarity of vision after cataract surgery. Implications to achieving this include an adequately trained surgeon, equipment and instruments to perform this procedure, standardization of protocols, and financial resources to cover the cost of the intra-ocular lenses and surgery.

Improved quality of care:

- All 7 hospitals practice modern extra-capsular cataract surgery with an intra-ocular lens implant (ECCE/IOL).
- At least one surgeon in all 7 hospitals is using the Small Incision Cataract Surgery (SICS) technique promoted by IEF.
- Five of the 7 hospitals report on quality of cataract surgery outcomes using tools developed for this purpose.

Quality of Service is critical to customer satisfaction ensuring that patients are seen in a timely fashion, treated with respect, and will recommend the service to their friends and family. Patient counselors advise patients, alleviate anxiety, and address needs contributing to overall patient satisfaction.

Improved quality of service:

- All 7 hospitals have improved clinical and service delivery practices, increased staffing, introduced new counseling services, made physical modifications to buildings, improved procurement practices, and improved information and reporting systems, among other changes. One hospital has introduced and is testing a new computerized Patient Management Information System.
- All 7 hospitals have established or reorganized outreach campaigns to screen large numbers of persons efficiently, and counsel potential surgical patients to accept surgery at the base hospital.
- Four of the 7 hospitals have established or reorganized optical services for patients and the general public providing refraction and new, high quality prescription eye glasses at multi-tiered pricing levels.

Efficiency refers to all areas of the eye care service, but especially to patient flow-through in the outpatient department, turn-around time between surgical patients in the operating room, and adequate personnel to perform required duties.

Increased efficiency and productivity (aggregate of 7 hospitals):

- 405,421 persons were examined, increasing from 19,814 in 2001 to 182,763 in 2004.
- 35,230 persons received surgery, increasing from 5,140 in 2001 to 15,585 in 2004.
- Of the total surgeries performed over the last 3 years,
  - 24,742 persons received cataract surgery (tripling from 4,064 in 2001 to 11,155 in 2004)
  - 1,835 children under 15 years of age received surgery (increasing from 311 in 2001 to 586 in 2004).

Outreach is critical to increasing patient volume and marketing services in communities both for private or public hospitals alike. Patient counselors have proven to be of great value in ensuring acceptance of services. Well planned screening campaigns enable the highest visibility and immediate return of patients to the base hospital **with** their friends and neighbors for further treatment and/or surgery. By alleviating fears of travel, surgery, and cost issues, women are more easily able to access care than if they had to seek it on their own.

Improved equity (aggregate of 7 hospitals):

- The percent of persons served free or at a subsidized cost increased from 45% in 2001 to 70% in 2004.

Income generation is a term often shied away from, especially when discussing public, government, or charity hospitals. Where earned income is used to provide services to the poor, there is an assumption that income will be earned on the backs of those poor who should receive their services free. In fact, IEF's public sector partners still treat the majority (over 90%) of their patients free. Major revenue sources come from other services accessed by eye patients and non-eye patients alike. It is important to remember there is a cost to care for each patient. Limited donor and/ or government funds will only allow for care of a certain number of patients. When income is earned and put toward patient care costs, a larger proportion of poor patients will receive subsidized or free care. In effect, stretching the budget to treat more people! Donor funds can then be used for increasing capacity and expanding services.

Improved financial sustainability (aggregate of 7 hospitals:

- The total revenue increased from $7,010 to $1,762,346 and the percent of total costs recovered increased from 6% to 130.3% from 2001 to 2004.
- Two of the 7 hospitals have reached or exceeded the break-even point and 2 other hospitals are nearing this milestone of cost recovery.

Management is critical to success. Many hospitals in developing countries, especially in the public sector, do not have manager or accountant positions. IEF's initial investment supports the creation of these positions until earned income can sustain their costs. To achieve efficiency as well as quality of care and service, standards and policies must be instituted and monitored to ensure accountability. Accounting tools are critical to proper use of funds and adequate tracking of revenue and expenditures. In general, it is no longer adequate to expect the senior doctor to be responsible for all administration and management of an eye hospital. While s/he may remain as head of the institution, their focus be on clinical care and quality controls.

In order to share the successes and tools of the *SightReach®* program, IEF supported LAICO's development and launch of a new internet website called *V2020 e-resource*:

http://www.laico.org/v2020resource/homepage.htm

to provide easy access to a large number of documents, articles, manuals, patient education materials, and new planning tools worldwide.

IEF's first *SightReach® Management* partner, the Lions SightFirst Eye Hospital in Lilongwe, Malawi, Africa chose to make major changes in all services in order to achieve sustainability. Improvements in all areas are outlined in the graphic below.

Procurement

While increasing the number of patients being treated and introducing income generating services, costs have to be reduced. Ophthalmic equipment, instruments and supplies critical to patient care are a major cost. Dependence on used ophthalmic equipment and instruments that may or may not meet patient requirements, while generously donated, inhibits planning to increase the number of patients treated. The high cost of products manufactured mainly in developed countries, or poor access to affordable products made in other countries increases costs and limits the resources available to treat patients. *SightReach Surgical®,* IEF's social enterprise, was established to address the barrier of cost in developing countries by procuring new ophthalmic products from manufacturers worldwide and selling them on demand to ophthalmologists in developing countries at below market prices.

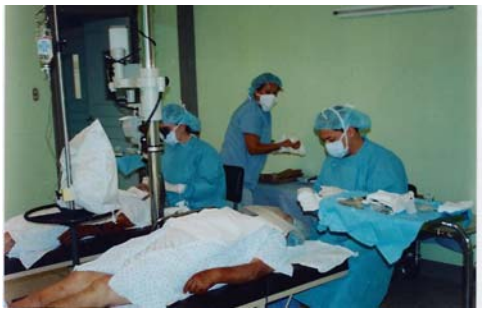
Cost Per Hospital Partner

Sub-grants to IEF's *SightReach® Management* partners ranged from $60,000 to $160,000 over four years not including IEF technical assistance from headquarters. Investments of this magnitude are often made annually by donors simply to support the status quo of operating costs. We believe that the investments made by *SightReach® Management* have a much greater impact because they increase capacity to raise the standard of quality, the number of patients treated, and the potential for financial self-sufficiency that have innumerable benefits for internal growth.

Scaling Up To Spread The Vision

It has been said that existing resources cannot meet the needs of the current 37 million blind and 124 million with low vision. Training more eye care providers and even finding additional financial resources will not meet the demand now or in the future as long as those resources are directed toward inefficient, unproductive, poorly managed, financially dependent eye care services. It may be more interesting and glamorous to focus on training and modern equipment, or visiting villages to provide treatment for "the poor" free of charge. However, the more mundane and challenging aspects of improving the quality of care relate to management and financial sustainability.

IEF, in partnership with Seattle-based Global Partnerships (GP) envision a larger network of high quality, financially sustainable eye clinics in Central America that reach wider proportions if not all of the populations in that region. The challenges include bringing more clinics on board whether they be satellites of existing *SightReach® Management* partners or new affiliates, and finding creative ways for patients to cover the costs of the services they wish to access. IEF and GP are linking community micro-finance institutions to IEF's eye clinic partners where patients can borrow the funds they need to access quality eye care bringing more patients with resources to the eye care providers, increasing financial sustainability. A win-win-win situation!



Drs. Mariano and Nicolas Yee of *Visualiza* in Guatemala, IEF's first *SightReach® Management* partner in Central America, demonstrate efficiency in the operating room. Visualiza is now a "demonstration site" for Central America.

SightReach® Management
Guiding Principles

1. Leadership is critical to guiding change and successfully negotiating intended and unintended obstacles.
   - Must be nurtured, supported, and given the tools to ensure that changes stay on track.
   - Must be willing to accept business principles.
   - Must work with stakeholders by establishing a dialogue and have an agreement with government, donors, NGOs and the ophthalmology society in order to negotiate the organization's mission and expectations.
   - Must manage competition by making sure patients know the service is open to all and targeted, but not limited to, lower and middle income patients.

2. A reputation for quality care that people will seek, accept, and pay for must be built.
   - SICS surgery with IOL should be offered to all. Those who want phaco-emulsification, foldable lenses, or US-made IOLs, and to choose the ophthalmologist they see will choose to pay for those options.

3. The goal of managing physical and human resources is to increase quality of service, efficiency, and productivity.
   - Space should be adequate to direct patient flow and offer multiple accommodations. Capital changes may be required to offer different accommodations and amenities. The physical location of the private vs. subsidized patients can be separated.
   - Adequate full-time staff must be in place in proportion to the number of patients seen. The service must attract and retain at least one full-time ophthalmologist. Time allocation for the ophthalmologist can be divided between patients with appointments, open clinics, and surgery.
   - Protocols must be in place and standardized.

- Patient visits must be streamlined to improve quality of service (have patient records ready when the patient arrives, introduce appointment times, provide comfortable furniture, and have toys for the children.
- A team approach leads to efficiency and better patient care. Delegating certain patient services to technical support staff and counselors results in the patient getting more attention, not less.
- Sufficient paramedical and technical resources should be in place to keep turn-around time between patients to a minimum in the clinic and operating room .

4. Financial sustainability can be achieved while serving the poor and low-income patients.
   - Understand fixed vs. variable costs.
   - Ophthalmologists must be convinced that it is profitable to charge lower fees to a larger number of patients. Variable costs will increase, but so will income.
   - Ensure that pricing is based on cost. Simplified packaging of services reduces administrative burden and eases communication of pricing to patients.
   - Concentrate on cataract services. The price of one cataract operation should be equal to one month's income of the lowest 60% of the population. Some patients will pay more and some less depending on the accommodations and amenities they choose.
   - Procurement affects costs of service. Costs can be reduced through bulk buying and purchasing through NGO distributors such as IEF's *SightReach Surgical®.*
   - Diversify income sources such as fees, optical services, and non-business-related income such as a gift shop or cafeteria.

5. Organizational growth must be managed. Once capacity has been increased, the same or increased number of patients are needed in order to keep fixed costs down. Active outreach, contracts to provide services to corporations offering employee health benefits, and other social service contracts are ways to guarantee a constant flow of patients.

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David Green, MPH, author of "compassionate capitalism", mentor and consultant, for encouraging IEF to reorient all of our programming around sustainability.

***SightReach® Management* implementing partners:**

Africa
- Lions SightFirst Eye Hospital, Lilongwe, Malawi
- Lions Eye Unit, Queen Elizabeth Central Hospital, Blantyre, Malawi
- Kilimanjaro Centre for Community Ophthalmology and the Kilimanjaro Christian Medical Centre, Moshi, Tanzania

Central America
- *Visualiza*, Guatemala City, Guatemala
- ASAPROSAR, San Salvador, El Salvador

Middle East
- Magrabi Eye Hospital, Cairo, Egypt

Asia
- Gomabai Nethralaya and Research Center, Neemuch, Madhya Pradesh, India

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