Notes from Call with Aravind Eye Foundation, 2/10/12

GiveWell: Alexander Berger
Aravind Eye Foundation: Donna Campbell

GiveWell: Could you tell me about any changes at Aravind since our last review?

Aravind: I think the main change has been understanding how best to enable people to participate in the work without compromising Aravind's self-sustaining model of healthcare – which is what they're famous for and what we want to promote world-wide.

As GiveWell pointed out in your first review, we don't raise money for cataract surgery, because we have a sustainable business model – one paying customer covers two free or subsidized surgeries. Keeping true to this model, Aravind has grown from an 11-bed hospital in Madurai, India to a network of seven hospitals and treated roughly 30 million patients in 30 years. Last year, Aravind performed 325,000 sight-saving surgeries.

But there are some areas that are not immediately self-sustaining, yet are critical to our mission of eliminating needless blindness.

GiveWell: Could you tell me a little more about those areas?

Aravind: There are four main ones I want to mention:

Capacity-building. We've trained 270 hospitals in India and the rest of the developing world to help them increase surgical output and deliver more efficient, high quality, patient-centric care. Most hospitals are set up to treat certain ailments in the community, but they don't use scientific methods to estimate the need for their services, as well as their own capacity. Over time, this results in underutilization of existing resources. The World Health Organization estimates that only 25% of the world's eye care resources are utilized.

Through LAICO, Aravind's healthcare management arm, we have developed processes and tools to address this problem. First, we help hospitals quantify three points. One, the need for eye care services in their community. Two, the capacity of their hospital in ideal conditions – meaning that they have an adequate flow of patients, the staff required, and the equipment and other resources. Finally, the actual number of surgeries and direct patient services currently provided. Now, they can see the disparity between the service currently being provided, the market potential, and their own capacity. Often the differences are startling. In some cases, the service they provide is about 5 to 10% of the market need, and using under 20% of their potential capacity.

Next we help these hospitals figure out concrete strategies to address these gaps: strategies for getting patients, strategies for providing services efficiently, strategies for ensuring high quality -- because quality is what sustains demand and creates a willingness to pay. And finally, what is the business model financing the whole operation, given that patients will come from the entire mix of economic strata? In short, capacity building is about helping hospitals achieve their full

market potential, as well as the full capacity of their own organization.

To date we estimate that we've added about 750K cataract surgeries worldwide. They have been funded historically by the International Association for the Prevention of Blindness, the World Health Organization (WHO), the Seva Foundation, and the Lavelle Fund for the Blind. Each of those training segments cost roughly $50,000.

Giving access to people in rural areas. As part of WHO's Vision 2020 initiative, Aravind committed to build 100 rural vision centers, which cover 50,000-70,000 people each. 70% of India's population lives in rural areas -- usually there is no resident eye doctor, and a cataract patient might travel 250 miles for surgery. The result is that the incidence of preventable and treatable blindness or low vision is highest among the rural poor.

Each Rural Vision Center is staffed by a highly trained ophthalmic technician who provides eye examinations, dispenses eye glasses, and treats minor ailments and injuries. Via a web cam and broadband Internet connection, patients are examined by doctors and specialists at Aravind Eye Hospitals. Typically, a center costs $25,000 to establish and operate for the first two years. But after that, most are self-sustaining from examination fees and sales of spectacles. To date, we have built 40 centers with contributions from Standard Chartered Bank, the Seva Foundation, the Lavelle Fund for the Blind and private donors.

Medical research. India is a particularly rich environment for ophthalmological research because of a unique combination of environmental and genetic factors -- plus it's a very large population. While a US researcher might see a few dozen cases of a particular disease, in India you could see hundreds of examples. Aravind works with some of the leading universities and NGOs in the world -- Johns Hopkins, University of California, Cole Eye Institute, National Eye Institute, University of Paris, London School of Hygiene and Tropical Medicine to name just a few -- on basic and clinical research.

Patient Support. Some types of eye disease require extensive, long-term treatment that our patients could not afford without support. One complete cycle of treatment -- including surgery, radiation, and chemotherapy -- for a child with retinoblastoma (eye cancer) is about $1,000. We also pay for travel and food for patients traveling to the hospital, and provide free spectacles to school children.

GiveWell: For the capacity-building projects, why not get loans to finance the investment since you said that the hospitals become profitable within two years?

Aravind: That's a model that some organizations are using, and a few people have suggested it to Aravind. Deutsche Bank launched an investment fund to help eye care hospitals expand. Acumen Fund invests in social enterprises; the Rockefeller Foundation has an impact investing program. But I think that Aravind wants to focus on where the need is greatest, rather than which hospitals will be the most financially successful. In the end, our mission is eliminating needless blindness.