DVARA
Health Finance

# Vital Signs

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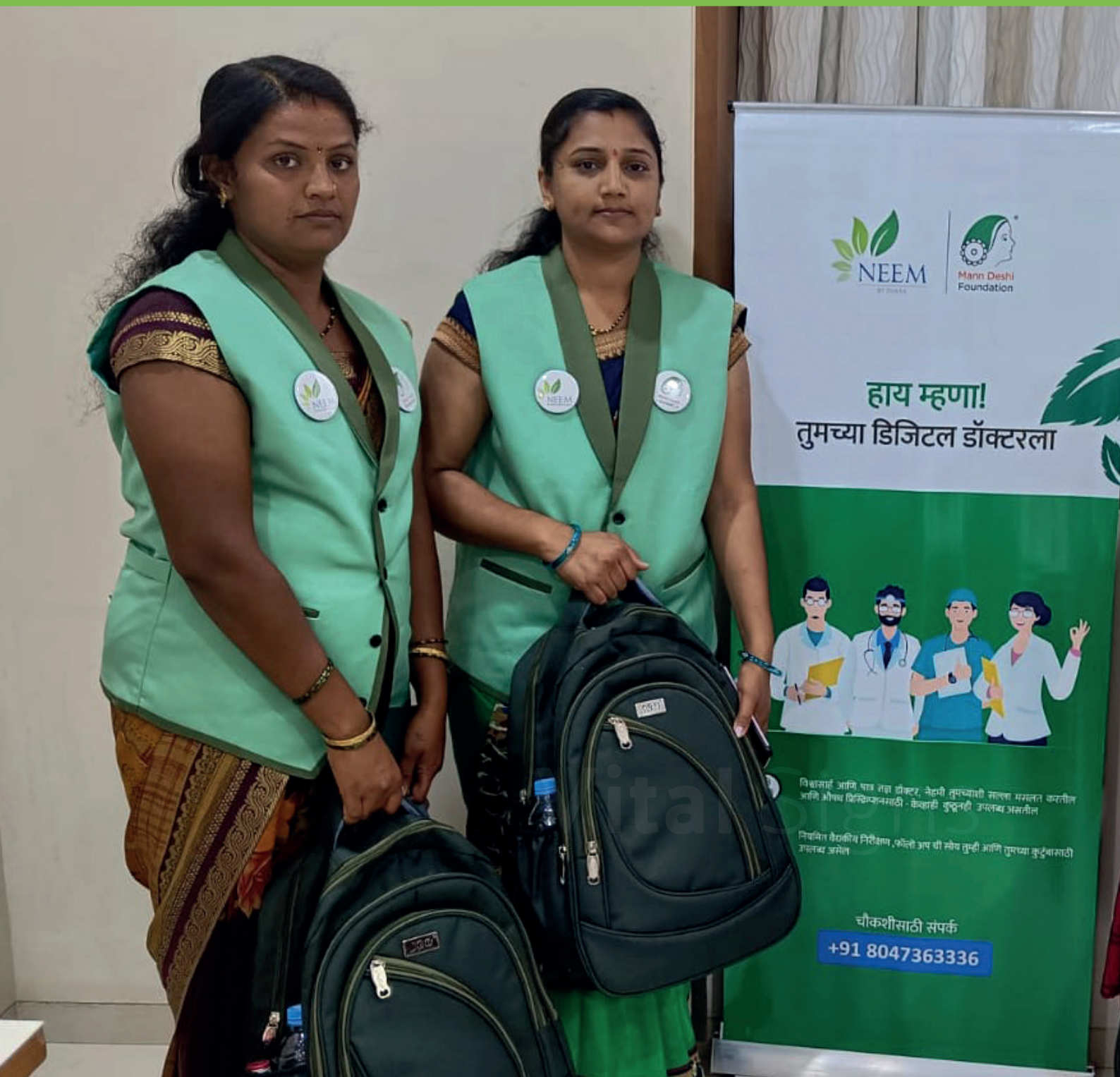

Dvara Health Finance's (DHF) mission is to ensure that spending on health translates into better financial and health outcomes for all Indians. We aim to offer at-scale, tailored financing and information services that will enable lower out-of-pocket expenditure for the individual at the point-of-care. Our first product, the NEEM Account, combines automatic savings, insurance and out-patient care coordination.

Our quarterly newsletter, 'Vital Signs', is an effort to build a community of practice for health sector innovators and practitioners in India. We aim to share learnings from new healthcare models and build a vibrant community that helps improve the value equation for household spending on health.

In this issue, we are delighted to share with you some stories from the front-line and introduce you to a few of our inspiring Health Sakhis (Community Health Workers). In a health system with a systemic shortage of doctors, these health workers have a critical role to play to extend care. We have been inspired by the examples of the Alaskan Community Health Aide and the Iranian Behvarz worker to think about the role of the health worker more ambitiously in our programs. In addition to the initial screening and treatment counselling (supported by point-of-care devices, clinical protocols and a doctor at the back-end), our health sakhis also play a very critical role in monitoring families over time, giving at-risk and high-risk individuals and families they support they need in terms of facilitating transport and appointments and going forward, supporting insurance-related processes. This model of a health worker assigned to a family combined with a tele platform to access doctors/specialists for those who need prescriptions or specialist support appears to be better suited to the needs of customers/patients than one in which the individual is directly pushed to a tele-medicine platform for a transactional interaction without any continuity of care. Acknowledging the need and role for this cadre could pave the way for the creation of a large pool of skilled workers in the private sector desirous of impacting primary care access and stemming the rising tide of non-communicable diseases.

I had an opportunity to moderate a fascinating conversation for the Lancet Commission on Reimagining the Indian Health System on improving the value from out-of-pocket-expenditures. We bring you some insights and take-aways from that discussion here. Finally, we also cover the evidence and issues with respect to the use of polypills to improve cardiovascular health in population settings.

We would love to get your thoughts on this issue. Please write to us at communications.health@dvara.com. You can also subscribe to the newsletter by signing up here.

Wishing you good health!

**Bindu Ananth**
Founder & CEO - Dvara Health Finance

# Section 1: In Spotlight – Meet our Health Sakhis

Reshma Mane

Nisha Kole

[1]

Reshma Mane, 35, hails from a village in Satara, Maharashtra. Reshma completed her formal education until the 10th standard; and has subsequently worked on the small farm that belongs to her family. Reshma remained interested in further learning – so following her marriage at a young age, she completed a diploma course in Economics from a local institute.

With the need to supplement her family's income, Reshma has always juggled jobs along with working on her family's farm. A highlight was her becoming a Vardhini: a government-designated role of a social activist responsible for dissemination of awareness about Bachat (savings) groups, in order to encourage participation, understanding and investment among women.

Reshma found that with time, not only did she become more experienced, but also more driven to give back to her community. When the opportunity arose to be an integral part of the MD NEEM program, as a Health Sakhi, she felt it was a good fit in terms of her individual goals and aspirations.

Undaunted by the multiple examinations and training sessions involved in qualifying as a Health Sakhi – having already experienced such a structure in her prior work as a Vardhini – Reshma's desire to serve her people made her one of the standout Health Sakhis from the very start.

Reshma's day typically starts before sunrise: starting with farm work and tending to cattle, before leaving to see patients under her care 8 a.m. onwards. She sees patients (featuring baseline screening, follow-up visits as relevant and patient counselling) until 11:30 a.m., when she returns home to take care of her food preparation and kitchen work responsibilities. Having completed her tasks at home, she leaves once again to see patients at 3:30 p.m., continuing on until 8 p.m.

Reshma is known for a polite demeanour complemented by unrelenting straightforwardness. She prefers to commute on foot while carrying out her responsibilities as a Health Sakhi – in order to inspire members of the community to walk more as well as be mindful of their activity levels.

[2]

Born in Mumbai before moving to Mann Taluka aged 8, Nisha Kole found integrating with community life an arduous experience. Her lack of experience with both farming as well as the ways of rural Maharashtra garnered constant criticism from members of her new community.

Nisha, 24, has long been driven by a desire to keep learning. She graduated from the 12th Standard before completing a diploma course in Economics – and today, is pursuing a graduate degree in commerce via a distance education program. She credits the steep learning curve of learning the ins-and-outs of farming with reinforcing her mentality when it comes to picking up new skills.

Prior to becoming a NEEM Health Sakhi, Nisha worked on her family's farm alongside her responsibilities as a homemaker. Her family played a significant role when the opportunity to become an HS arose – her husband encouraged her to join the cadre and has subsequently motivated her throughout, while her mother-in-law has taken over a larger proportion of household chores in order to allow Nisha to focus on her distance learning program as well as her work as a NEEM Health Sakhi.

Consistent with her personality, Nisha has forged a reputation in her short time as a Health Sakhi as a curious and enthusiastic individual, who makes it a point to learn from her mistakes.
Nisha highlights the intense expectations shouldered by working women – not just in rural settings - in that their dual responsibilities across their homes and their professional settings leave them unfairly open to criticism in at least one, if not both of these settings at any given point in time. Nisha believes that as long as she knows her goals and what she would like to achieve, what is said by those around her is of little matter.

Nisha's day begins at 5 a.m – with a routine which she dislikes changing even on Sundays. She tends to her cattle, cooks in advance for her extended family, and prays before leaving to see patients. Like Reshma, she returns home at lunchtime to take care of household chores – before leaving to see patients once again, in the second half of the day. After returning home around 7:30 p.m., she cares for her children as well as checks on their progress with their schoolwork. As her day winds up, Nisha plans for the following day's patient interactions; her patients are constantly at the forefront of her thoughts.

# Section 2: A Lancet India Commission Discussion on improving value from out-of-pocket expenditures (OOPE)

The total OOPE of Indians on healthcare is roughly Rs 3 trillion. Despite this high out-flow, the average experience of the patient is characterised by switching across multiple providers – some of whom may not be licensed, unnecessary tests and medication and in general, poor value for money. This theme of increasing value from OOPE has not received sufficient attention despite the fact that this is the largest source of health spending in India.

Bindu moderated this important conversation for the Lancet India Commission with three outstanding panellists – Professor Cristine Legare (University of Texas, Austin), Priya Naik (Samhita), and Sandy Festa (AtlantiCare FQHC). You can view the full discussion here.

We explored four pathways of impact in our conversation:
#1 – Innovate on supply side models that provide better care to patients, including bringing in new actors from the private sector who may be more customer-centric and willing to follow protocols for screening and treatment.
#2 – Aligning customer health care seeking behaviour towards preventive/promotive care through shaping demand.
#3 – Bring a sharp focus on health outcomes at the physician/facility level.
#4 – Financing innovations that enable expenditures to be more prepaid in nature

When thinking about channels to provide primary/preventive care, we have often missed out on the potential of neighbourhood pharmacists. Priya shared Samhita's survey and pilot with pharmacists to enable easy access to routine care, particularly focussed on hypertension. Her view was that this was a viable and customer-focussed channel with a vast potential for increasing value. Simple digital integrations could also increase the range and quality of services provided by this channel.

Professor Legare's research has revealed the critical and beneficial roles that traditional cultures and rituals play in our lives and how working with them instead of against them could have a powerful impact on, say, health outcomes. She started by clarifying that there is no single health system in India. There are multiple ones, of which the formal biomedical system is one. She cautioned against concluding that people are not concerned about primary/preventive care just based on spending in the biomedical health system. Her own research has revealed multiple practices and behaviours, particularly in the context of maternal health, that are geared towards preventive health. She urged us to think about solutions that involve integrating health influencers (community health workers and similar) into formal systems. Combining their cultural competence/understanding with formal training in flexible ways holds enormous potential to improve outcomes.

Sandy spoke about the FQHCs that are aimed at the rural and urban under-served in the United States. These are also known as Community Health Centres and provide a variety of services including preventive care, mental care and support to manage substance abuse. Sandy spoke about the need to hold doctors and other medical practitioners accountable for the quality of health outcomes delivered. She also underscored the cultural competence aspect of primary care to reduce barriers to access, including language. Patient-centred, integrated care delivered by interdisciplinary teams is important to deliver at scale and not just for poor people.

# Section 3: A Review of Literature on Polypill Usage for Population Cardiovascular Health

A polypill refers to a combination of pharmaceutical drugs available in the form of a single pill; the intention of its design being to simplify treatment regimens and associated patient compliance with care plans.

Hypertension - or high blood pressure - is prevalent in north of a billion individuals worldwide. It is a major risk factor for the development of cardiovascular disease and has been long-recognized as a leading cause of premature mortality as well as morbidity. Mills et al (2016) reported that just 7.7% of patients with hypertension in low- and middle-income countries (LMICs) (4 times less than in developed countries) were deemed to have their hypertension under control. The Polypill for the treatment of hypertension is a potential solution to address this challenge. It is available globally in various combinations - which often feature (but are not limited to) a diuretic, a beta-blocker, an ACE inhibitor, and a statin.

The Polypill came to the fore in 2003, when Wald & Law declared that it could reduce the burden of cardiovascular disease by an eye-catching 80%. However, there has been a real resurgence in interest around it in recent years- as a solution to address both flagging medication adherence rates as well as inadequate access to healthcare - following very promising evidence presented by clinical trials. Often discussed as a cost-effective facet to be incorporated within public health programs in LMICs, which can simplify medication prescription, limit the extent of medication side effects and improve long-term cardiovascular outcomes - the Polypill also has the potential to achieve greater health equity in underserved populations within developed nations.

Despite its promise, the Polypill is not without its critics. First, on the clinical side, the fixed doses within a Polypill limit the customizability and flexibility of treatment plans. Further, there is a subset of populations with hypertension in whom the presence of certain comorbidities contraindicate the Polypill. Next, on the side of health systems - it has been pointed out that the introduction of such a solution could leave populations susceptible to overmedication. This could also lead to public health efforts to promote lifestyle interventions being undermined; such as dietary modifications and physical exercise.

In conclusion, the Polypill has the potential to be a cost-effective solution that makes hypertension treatment widely accessible. There is however, a need for further exploration of implementation solutions that address critics' concerns, so as to move a step closer to widespread adoption of such a solution.

References
(1) Yusuf S, Joseph P, Dans A, Gao P, Teo K, Xavier D, et al. Polypill with or without aspirin in persons without cardiovascular disease. N Engl J Med. 2021;384(3):216–28. https://doi.org/10.1056/NEJMoa2028220

(2) Wald NJ, Law MR. A strategy to reduce cardiovascular disease by more than 80% [published correction appears in BMJ. 2003 Sep 13;327(7415):586] [published correction appears in BMJ. 2006 Sep;60(9):823]. BMJ. 2003;326(7404):1419. doi:10.1136/bmj.326.7404.1419

(3) Ostovaneh MR, Poustchi H, Hemming K, et al. Polypill for the prevention of cardiovascular disease (PolyIran): study design and rationale for a pragmatic cluster randomized controlled trial. Eur J Prev Cardiol. 2015;22(12):1609-1617. doi:10.1177/2047487314550803

(4) Roy A, Naik N, Srinath Reddy K. Strengths and Limitations of Using the Polypill in Cardiovascular Prevention. Curr Cardiol Rep. 2017;19(5):45. doi:10.1007/s11886-017-0853-y

(5) Muñoz D, Uzoije P, Reynolds C, et al. Polypill for Cardiovascular Disease Prevention in an Underserved Population. N Engl J Med. 2019;381(12):1114-1123. doi:10.1056/NEJMoa1815359

(6) Roshandel G, Khoshnia M, Poustchi H, et al. Effectiveness of polypill for primary and secondary prevention of cardiovascular diseases (PolyIran): a pragmatic, cluster-randomised trial. Lancet. 2019;394(10199):672-683. doi:10.1016/S0140-6736(19)31791-X

(7) Mills KT, Bundy JD, Kelly TN, et al. Global Disparities of Hypertension Prevalence and Control: A Systematic Analysis of Population-Based Studies From 90 Countries. Circulation. 2016;134(6):441-450. doi:10.1161/CIRCULATIONAHA.115.018912

(8) Muñoz D, Wang TJ. The Polypill Revisited: Why We Still Need Population-Based Approaches in the Precision Medicine Era. Circulation. 2019;140(22):1776-1778. doi:10.1161/CIRCULATIONAHA.119.043491

(9) Sharif M, Patel J, Rifai MA, et al. One Pill for Them All: Polypill Therapy for the Prevention of Cardiovascular Disease. American College of Cardiology; 2021. Retrieved from: https://www.acc.org/latest-in-cardiology/articles/2021/03/19/11/59/one-pill-for-them-all

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