**All Health Care is Local: Service Delivery in an Emerging Market**

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Virika is one of three hospitals in Fort Portal (population 40,000). Last year, about 26,000 patients were treated at Virika, using 135 inpatient beds plus an outpatient department (OPD).

Virika’s mission to serve the poor in its rural location poses a significant challenge, due in part to unreliable external funding. The initial collaboration with Virika Hospital in Uganda builds on three principles developed in work with Aravind Eye Care System in India and other institutions in emerging markets: cross-subsidization, focused care, and a collaborative approach.

**Cross-subsidization**

Financial sustainability through cross-subsidization requires focusing on revenue generation from a subset of customers able to pay a higher price, developing a package of services for which that customer group will be willing to pay, and generating sufficient revenues from this group to supplement the losses incurred from the rest of the customer base.

Since 1976, Aravind Eye Care System has pursued a mission “to eradicating needless blindness” by offering both free and paying services. This cross-subsidization generates a surplus that is used to finance growth. Within Fort Portal some individuals and institutions are able to pay a higher price for services, but this has not been a focus of the Virika Hospital staff or leadership. Instead, when asked about the hospital’s ability to cover costs, Virika staff will point to inefficiencies and productivity losses. While these are important, our research suggests that greater benefits can come from emphasizing revenue generation. Virika’s staff estimates that 7 percent of patients are private-ward (high-price) patients. If true, increasing that percentage to 8.5 percent would have the same impact as reducing the operating costs by $36 per patient. Increasing the percentage of private-ward patients to 30 percent, a number closer to that achieved at Aravind, would require increasing the revenue generated per paying patient by about $32 per year, about one-quarter of what would be required at the current rate.

Once identified, the higher-income customer group must be offered a package of services for which they are willing to pay a higher price. From Aravind, we know that services can be structured such that customers will self-select either a free or paying service (even when the medical/clinical quality is the same for both). Virika is now developing packages that include appointments and more comprehensive services for this subset of customers.

Finally, the revenues generated from the high-priced customers must be sufficient to subsidize the costs of lower-priced clients. Much of the challenge with respect to the high-priced customers is changing the priorities of a mission-driven organization. At Virika, several patients who were asked to be placed in the private ward have been sent to the general ward by mistake because paying patients were not a priority for the staff. In other instances, 10 times who received private-ward services were not charged for them by the cashier.

Even the Uganda Catholic Medical Bureau (UCMB), the umbrella organization that oversees one-third of the private not-for-profit hospitals in Uganda, tracks revenues per services and commends hospitals that lower this number (lower charges mean increased utilization, which is considered a surrogate for meeting the hospital’s mission). The UCMB leadership understands that an increase in revenues per patient can improve long-term access by increasing the hospital’s ability to cover costs—and thus survive. Nonetheless, it is too early to determine whether Virika will be able to move closer to financial sustainability. However, a number of tangible steps have been taken, including increased focus on staff ideas and input, increased attention to the needs of paying customers, and a specific target date for financial sustainability.

**Collaborative Approach**

The last principle may be the single most important: this project is a collaborative effort of the U-M Medical School, the Ross School of Business, and Virika Hospital. The ideas come from all three entities, and each learns from the others but, ultimately the solutions must come from the local institution. The Medical and Business Schools play a supporting role, taking on projects and providing input as requested by the local institution.

This project differs from many others in that it begins at the hospital level instead of a national, or worldwide, health policy level. The experiences with individual hospitals that have attempted to transfer lessons learned to other institutions have been mixed. Even the Uganda Catholic Medical Bureau (UCMB) is generalizing to others, while not losing sight of the unique challenges of each institution. For example, although much of the discussion above focuses on revenue generation, it is understood that revenue generation, where appropriate, is one means of promoting access and quality of care. Whether or not the collaboration succeeds in furthering such goals will be determined by the answers to two questions: Is Virika able to become financially self-sustaining while continuing to serve its mission? and how will the lessons learned be transferred to health care delivery elsewhere in Uganda and in other emerging markets?

**A focused service that allows the hospital to develop expertise others cannot match is essential to financially sustainable model.**