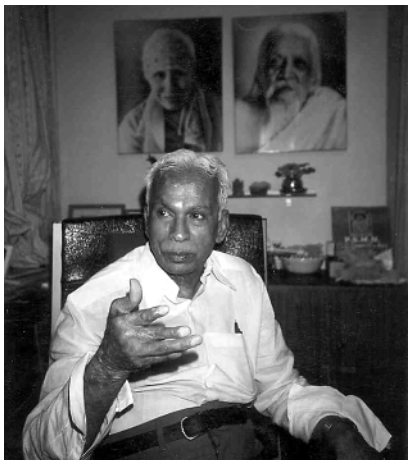
Profile

Restoring sight to the millions — the Aravind way

In India, an eye hospital has become a legend for its surgery and ''compassionate capitalism''. John Maurice reports.



Govindappa Venkataswamy, founder of Aravind, the largest and most productive eye care institution in the world. Despite a lifelong struggle with arthritis, ''Dr V'', as he is called, has himself performed more than 100 000 successful eye operations.

Madurai, population 1.1 million, the oldest and second-largest city in the southern Indian state of Tamil Nadu, is known for its temples, particularly the Meenakshi temple at the centre of the city, to which pilgrims flock every year.

Madurai is also famed for what to many people is another kind of temple, a place where nearly one and a half million blind have been flocking over the past quarter of a century and have left, after a few days, with their sight restored. This is the Aravind Eye Hospital, a five-storey building within walking distance of the Meenakshi temple. Go in and sit on a bench in the reception area. The throngs of people milling around may not surprise you — this is India, after all — but you'll be struck by the calm, the hush over the bustle, and the frugal furnishings that you'd expect in a temple or an ashram. Wait a bit longer and if you're lucky you may bump into an elderly man with an impish twinkle in his eye. This is Govindappa Venkataswamy, or "Dr V", as everybody here calls him. He founded the hospital 25 years ago, when at 58 he had reached official retirement age and had to quit his government hospital work. Dr V will set you straight with a chuckle: "Temple? Ashram? No, no, not at all. This is just an ordinary hospital."

For an "ordinary hospital" Aravind has some pretty extraordinary facets. Its growth, for example. It started out, in 1976, with Dr V, his sister and his brother-in-law doing eye surgery in a rented house with only ten beds. Since then, year by year, annex by annex, it has grown into a 1900-bed institution, with four hospitals in different parts of the state (and a fifth under construction), plus a children's hospital, an international institute for community ophthalmology which trains eye care workers from other developing countries, an outreach programme that organizes mobile "eye camps" and eye care education in villages, a manufacturing facility that makes lenses, pharmaceuticals and surgical supplies, an eye bank that handles about 900 corneas a year, and a medical research foundation.

For many staff members at Aravind, the institution's growth owes much to what Dr V calls "the higher consciousness", taught by the Indian philosopher and mystic, Sri Aurobindo, as a way people can become better instruments of divine forces. If you ask Dr V, who over the past half-century has been a disciple of Sri Aurobindo, how much of the sage's philosophy permeates the work at Aravind, he says quite simply: "You do your best in your job and higher ideas come to you and you try to realize those ideas too, but you need to be at work, not sitting meditating."

Aravind's Executive Director R.D. Thulasiraj puts it this way: "On the everyday level, a job is a job. But when you look back you can see how the forces that Sri Aurobindo talks about have been at work. People talk about Dr V's vision. But when he started there were no plans, no business strategy. Opportunities and resources kept coming our way as if they were part of a bigger picture and the hospital just grew and grew. Somehow money has never been important to us, either individually or for Aravind. Somehow there's always been enough. The main thing has been the patient care and the work itself. We have a strong focus on work and we have developed a certain value system which guides our work very strongly." Mr Thularisaj worries about what will happen to that value system — and to Aravind — when Dr V and his family are no longer around.

Perhaps one of the most extraordinary aspects of Aravind, though, is the volume of patients it handles — 1.3 million last year, which in the international blindness prevention community is held to be a world record (few hospitals in India or elsewhere see more than 10–15% of that number). And Aravind doesn't just wait for patients to turn up. Its community outreach activities, including mobile eye camps, help keep the demand flowing. "We don't have to push people, just inform them," Dr V says. "Today, even in small villages, people have access to information through television or the internet, which is creating demand for good water and good health. And people are more and more prepared to pay for their health, even the very poor."

Aravind's productivity is, in the words of an American ophthalmologist, "simply mind-boggling". Aravind ophthalmologists examine about a million out-patients at the institution's four hospitals plus half a million villagers who turn up for an eye examination in the 1500 or so mobile eye camps Aravind organizes every year. And then there's Aurolab, Aravind's manufacturing facility, which makes over 700 000 world-standard intraocular lenses (that are used to replace the natural cataract-clouded lenses once they are removed) — and sells them in over 80 countries at prices up to 10 times cheaper than are current in the West.

But the most mind-boggling Aravind statistic and one that would put to shame many an eye hospital in any part of the world, is its surgical productivity. Where an Indian eye surgeon performs on average 350 operations a year and most European or American

ophthalmologists even fewer, Aravind's 70 surgeons collectively average 2000. Last year, they performed nearly 200 000 operations, mostly for cataract removal, more than the annual total number of cataract operations recorded for any entire European country.

"The important thing," says Mr Thulasiraj "is to achieve productivity without sacrificing quality." So Aravind must hire only top-drawer, world-quality ophthalmologists? "No, we hire local practitioners, train them to become high-calibre surgeons, and pay them a monthly salary a little above the average paid in government hospitals." One problem is keeping these surgeons. About 7 to 10 drop out of Aravind every year. "They know that, with the quality of work they have been trained to do and with Aravind's reputation, they can double or triple their incomes by going into private practice," says Mr Thulasiraj. "We try to keep this attrition in check by regularly updating our pay rates to keep up with the market but of course we're a non-profit institution and can't compete with private practice rates."

Among those struck by Aravind's efficiency is US-based international eye care consultant David Green: "Aravind exemplifies to near-perfection an industry market paradigm: high-volume input, which allows economies of scale, which, together with the use of low-cost consumables and high productivity, keeps running costs low and allows high-quality output, which creates a strong demand and high-volume input ... and so on." The industry analogy has even prompted some commentators to liken Aravind to the McDonald's fast-food chain, an analogy that Dr V happily accepts.

Aravind hospitals have two sections, one for paying patients, the other for "free" patients. Paying patients pay a 3000-rupee (US$ 65) fee, which includes cataract surgery and a private room with bathroom and toilet. In the US, the bill for much the same service is likely to top US$ 1500 and can be as high as US$ 2500. A patient who opts for the free wing of the hospital will share a room with 30 others and sleep on a cane mat (as most people in southern India do in their own homes). Patients in the free section, Dr V insists, receive the same quality of surgery, performed by the same surgeons (who rotate monthly between the free and the paying wings), using the same standard of equipment as the paying patients. Most of the non-paying patients will be asked to contribute 500 rupees, or US$ 10, to the cost of medicines and the intraocular lens (an Aurolab-made lens costs about US$ 8, vs up to US$ 150 for the same top-quality lens in the West). Dr V explains: "When people lose their sight, they lose their jobs and income. A few days after the operation here, they're back on the job and if they're earning, say 50 rupees a day, in ten days they've paid for their treatment. So having to pay doesn't diminish the demand for treatment."

It is Aravind's efficiency that enables it to offer free or almost free eye care to 70% of its patients and to earn enough from the 30% that choose to pay. Enough, in fact, to pay for all its expenses, which totalled US$ 3.1 million in the last financial year, from a total income of US$ 6 million (of which nearly 80% comes from the paying patients' fees). The excess is all ploughed back into the business to pay for the continuing expansion of Aravind's facilities. Its major expenses are the intraocular lenses (18%, paid to Aurolab, which is run as a separate business) and staff salaries (16%).

For many, the Aravind system is such a singular mix of ingredients — efficiency, quality, compassion, philosophy, family — that it cannot be transposed elsewhere. Dr V doesn't agree. "With our system, you can produce the same quality of service anywhere. It's quite applicable anywhere." Aravind, in fact, is helping about 100 eye hospitals throughout India apply many of the ingredients of its system, and a good number of these hospitals have seen their productivity double or even triple in the space of a year or two. Aravind consultants are also working with seven hospitals in other countries, notably in Bangladesh, Cambodia and Nepal in Asia, and Kenya and Malawi in Africa, helping them adapt the principles of Aravind to their local needs and cultures. The most successful operation to date has been in Nepal, which shares much of India's cultural background. Elsewhere, Aravind's attempts to export its system meet with scepticism among some observers. A major stumbling block, they say, is the absence in other countries of a dense enough population to provide the huge patient load that fuels the Aravind system.

As for applying the Aravind model to other sectors of health, "the problem there," says Mr Green, "is finding a procedure that is as standardizeable and uniformly reproducible as cataract surgery and therefore that can be performed as cost-effectively.

Meanwhile, every day, from 7 a.m. to 6 p.m., Dr V, now 83, still puts in a full day's work (although the day-to-day running of the business has been taken over by Dr P. Namperumalsamy, a brother-in-law of Dr V's). These days, Dr V is busy planning a new hospital in Pondicherry. He is also studying, with the help of his state-of-the-art computer and the internet, how best to help a struggling hospital in northern India increase its productivity from 400 to 4000 eye operations a year.

"Are you happy?" a business management consultant asked him recently. "I enjoy the beauty of the flowers. I enjoy the sky's beauty. I enjoy the rains coming down. It all becomes a world of consciousness and I feel happy all the time. I don't feel as if this is a job I have to do. No, I get excited that this can be done. I tell people all the time: if you can do something then you must go ahead and do it." ■

Aravind surgical patients listening to a hospital counsellor advising them on postoperative care.