

## **DRAFT REPORT ON RECOMMENDATION OF TASK FORCE ON PUBLIC PRIVATE PARTNERSHIP FOR THE 11<sup>TH</sup> PLAN**

The Planning Commission constituted a Working Group on Public Private Partnership to improve health care delivery for the Eleventh Five-Year Plan (2007-2012) under the Chairmanship of Secretary, Department of Health & Family Welfare, Government of India with the following members:

1.	Secretary, Department of Health & Family Welfare, New Delhi	Chairman
2.	Secretary (Health), Government of West Bengal	Member
3.	Secretary (Health), Government of Bihar	Member
4.	Secretary (Health), Government of Jharkhand	Member
5.	Secretary (Health), Government of Karnataka	Member
6.	Secretary (Health), Government of Gujarat	Member
7.	Director General Health Services, Directorate General of Health Services, New Delhi	Member
8.	President, Indian Medical Association, New Delhi	Member
9.	Medical Commissioner, employees State Insurance Corporation, New Delhi	Member
10.	Dr. H. Sudarshan, President /Chairman, Task Force on Health & Family Welfare, Government of Karnataka, Bangalore	Member
11.	Dr. Sharad Iyengar, Action Research & Training in Health, Udaipur, Rajasthan	Member
12.	Executive Director, Population Foundation of India, New Delhi	Member
13.	Dr. S.D. Gupta, Director, Indian Institute of Health Management Research, Jaipur	Member
14.	Ms. Vidya Das, Agramee, Kashipur, District Rayagada, Orissa	Member

15.	Dr. C.S. Pandav, Centre for Community Medicine, All India Institute of Medical Sciences, New Delhi	Member
16.	Dr. V.K. Tiwari, Acting Head, Department of Planning & Evaluation, National Institute of Health & Family Welfare, New Delhi.	Member
17.	Dr. A Venkat Raman, Faculty of Management Sciences, University of Delhi	Member
18.	Dr. K.B. Singh, Technical Adviser, European Commission, New Delhi	Member
19.	Shri K.M. Gupta, Director, Ministry of Finance, New Delhi	Member
20.	Shri Rajeev Lochan, Director (Health), Planning Commission, New Delhi	Member
21.	Joint Secretary, Ministry of Health & Family Welfare, New Delhi	Member Secretary

The Terms of reference of the Working Group were as under:

(i) To review existing scenario of Public Private Partnership in health care (Public, Private, NGO) in urban and rural areas with a view to provide universal access to equitable, affordable and quality health care which is accountable at the same time responsive to the needs of the people, reduction of child and maternal deaths as well as population stabilization and also achieve goals set under the National Health Policy and the Millennium Development Goals.

(ii) To identify the potential areas in the health care delivery system where an effective, viable, outcome oriented public private partnership is possible.

(iii) To suggest a practical and cost effective system of public private partnership to improve health care delivery system so as to achieve the goals set in National Rural Health Mission, National Health Policy and the Millennium Development Goals and makes quantitative and qualitative difference in implementation of major health & family welfare programmes, functioning of health & family welfare infrastructure and manpower in rural and urban areas.

(iv) To deliberate and give recommendations on any other matter relevant to the topic.

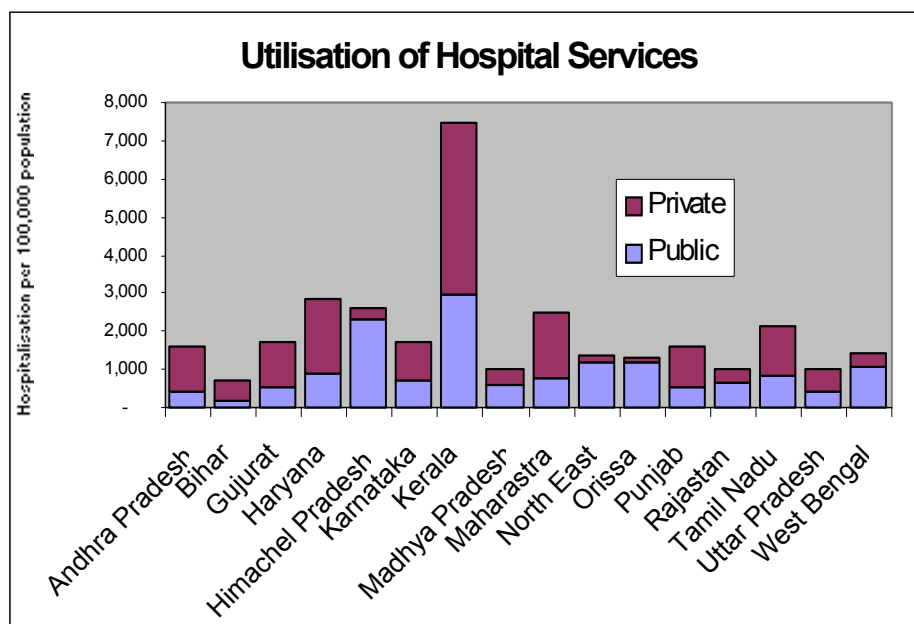
## **DEFINING PUBLIC PRIVATE PARTNERSHIP IN HEALTH**

Public-Private Partnership or PPP in the context of the health sector is an instrument for improving the health of the population. PPP is to be seen in the context of viewing the whole medical sector as a national asset with health promotion as goal of all health providers, private or public. The Private and Non-profit sectors are also very much accountable to overall health systems and services of the country. Therefore, synergies where all the stakeholders feel they are part of the system and do everything possible to strengthen national policies and programmes needs to be emphasized with a proactive role from the Government.

However for definitional purpose, “Public” would define Government or organizations functioning under State budgets, “Private” would be the Profit/Non-profit/Voluntary sector and “Partnership” would mean a collaborative effort and reciprocal relationship between two parties with clear terms and conditions to achieve mutually understood and agreed upon objectives following certain mechanisms.

PPP however would not mean privatization of the health sector. Partnership is not meant to be a substitution for lesser provisioning of government resources nor an abdication of Government responsibility but as a tool for augmenting the public health system.

## **THE ROLE OF THE PRIVATE SECTOR IN HEALTH CARE**



**Source Pearson M, Impact and Expenditure Review, Part II Policy issues. DFID, 2002**

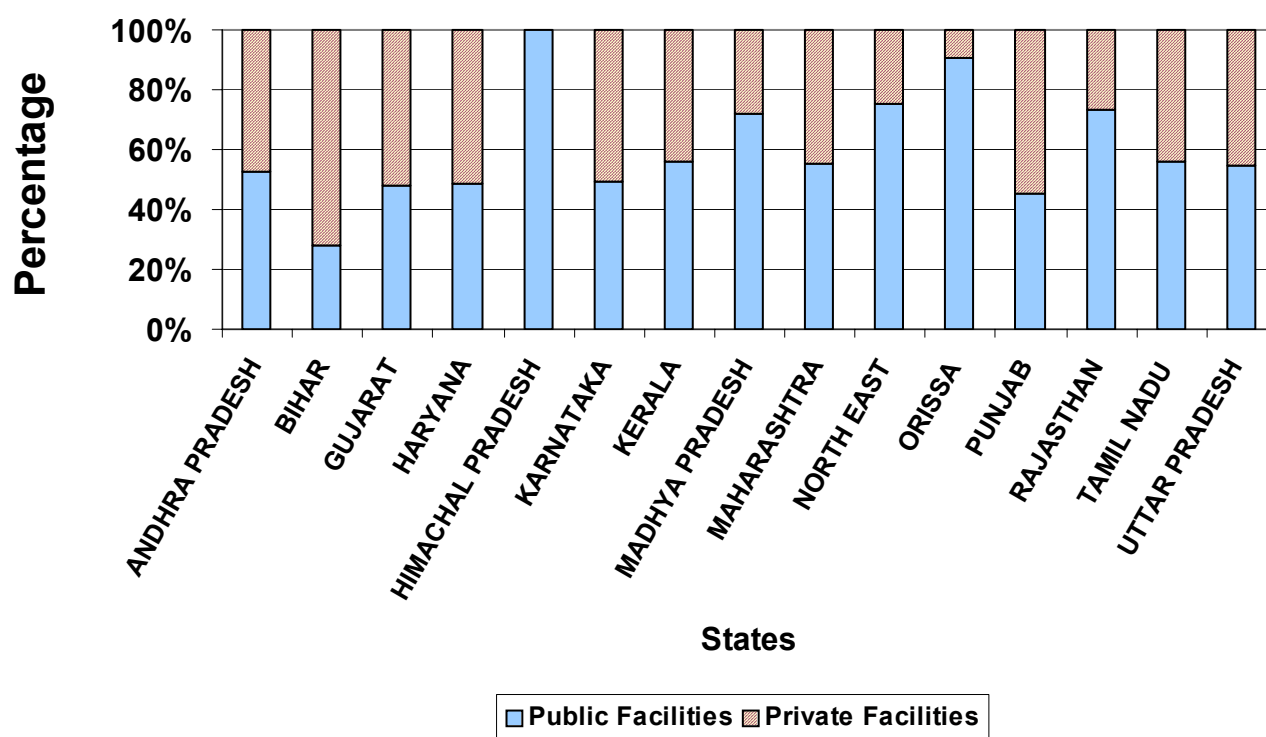
Over the years the private health sector in India has grown markedly. Today the private sector provides 58% of the hospitals, 29% of the beds in the hospitals and 81% of the doctors. (*The Report of the Task Force on Medical Education, MoHFW*)

The private providers in treatment of illness are 78% in the rural areas and 81% in the urban areas. The use of public health care is lowest in the states of Bihar and Uttar Pradesh. The reliance on the private sector is highest in Bihar. 77% of OPD cases in rural areas and 80% in urban areas are being serviced by the private sector in the country. (*60th round of the National Sample Survey Organisation (NSSO) Report*).

The success of health care in Tamil Nadu and Kerala is not only on account of the Public Health System. The private sector has also provided useful contribution in improving health care provision.

Studies of the operations of successful field NGOs have shown that they have produced dramatic results through primary sector health care services at costs ranging from Rs. 21 to Rs. 91 per capita per year. Though such pilot projects are not directly upscalable, they demonstrate promising possibilities of meeting the health needs of the citizens by focused thrust on primary healthcare services. (NSSO 60<sup>th</sup> Round)

### India: Percentage of Hospitalizations In The Public and Private Sector Among Those Below The Poverty Line, According To State



Source Pearson M, Impact and Expenditure Review, Part II Policy issues. DFID,2002

While data and information is still being collated, the private health sector seems to be the most unregulated sector in India. The quantum of health services the private sector provides is large but is of poor and uneven quality. Services, particularly in the private sector have shown a trend towards high cost, high tech procedures and regimens. Another relevant aspect borne out by several field studies is that private health services are significantly more expensive than public health services – in a series of studies, outpatient services have been found to be 20-54% higher and inpatient services 107-740% higher. (*Report of the Task Force on Medical Education, MoHFW.*)

Widely perceived to be inequitable, expensive, over indulgent in clinical procedures, and without standards of quality, the private sector is also seen to be easily accessible, better managed and more efficient than its public counterpart.

Given the overwhelming presence of private sector in health, there is a need to regulate and involve the private sector in an appropriate public-private mix for providing comprehensive and universal primary health care to all. However there is an overwhelming need for action on privatization of health services, so that the health care does not become a commodity for buying and selling in the market but remains a public good, which is so very important for India where 1/3 of the population can hardly access amenities of life, leave alone health care.

In view of the non-availability of quality care at a reasonable cost from the private sector, the upscaling of non-profit sector in health care both Primary, Secondary and Tertiary care, particularly with the growing problems of chronic diseases and diseases like HIV/AIDS, needs long term care and support.

### **OBJECTIVES OF PUBLIC PRIVATE PARTNERSHIPS**

Universal coverage and equity for primary health care should be the main objective of any PPP mechanism besides:

- Improving quality, accessibility, availability, acceptability and efficiency
- Exchange of skills and expertise between the public and private sector
- Mobilization of additional resources.
- Improve the efficiency in allocation of resources and additional resource generation
- Strengthening the existing health system by improving the management of health within the government infrastructure
- Widening the range of services and number of services providers.
- Clearly defined sharing of risks
- Community ownership

### **REVIEW OF EXISTING SCENARIO OF PPP**

#### **POLICY PRESCRIPTION**

Public-Private Partnership has emerged as one of the options to influence the growth of private sector with public goals in mind. Under the Tenth Five Year Plan (2002-2007), initiatives have been taken to define the role of the government, private and voluntary organizations in meeting the growing needs for health care services including RCH and other national health programmes. The Mid Term Appraisal of the Tenth Five Year Plan also advocates for partnerships subject to suitability at the primary, secondary and tertiary levels. National Health Policy-2002 also envisaged the participation of the private sector in primary, secondary and tertiary care and recommended suitable legislation for regulating minimum infrastructure and quality standards in clinical establishments/medical institutions. The policy also wanted the participation of the non-governmental sector in the national disease control programmes so as to ensure that standard treatment protocols are followed. The Ministry of Health and Family Welfare, Government of India, has also evolved guidelines for public-private partnership in different National Health Programmes like RNTCP, NBCP, NLEP, RCH, etc. However, States have varied experiences of implementation and success of these initiatives. Under the Reproductive and Child Health Programme Phase II (2005-2009), several initiatives have been proposed to strengthen social-franchising initiatives. National Rural Health Mission (NRHM 2005-2012) recently launched by the Hon'ble Prime Minister of India also proposes to support the development and effective implementation of regulating mechanism for the private health sector to ensure equity, transparency and accountability in achieving the public health goals. In order to tap the resources available in the private sector and to conceptualize the strategies, Government of India has constituted a Technical Advisory Group for this purpose, consisting of officials of GOI, development partners and other stakeholders. The Task Group is in the process of finalizing its recommendation.

## **REVIEW OF PPP IN THE HEALTH SECTOR**

During the last few years, the Centre as well as the State Governments have initiated a wide variety of public-private partnership arrangements to meet the growing health care needs of the population under five basic mechanisms in the health sector:

- **Contracting in**-government hires individual on a temporary basis to provide services
- **Contracting out**- government pays outside individual to manage a specific function
- **Subsidies**-government gives funds to private groups to provide specific services
- **Leasing or rentals**-government offers the use of its facilities to a private organization
- **Privatization**-government gives or sells a public health facility to a private group

An attempt has been made here to encapsulate some of the on-going initiatives in public private partnerships in selected states.

### **A. Partnership between the Government and the for profit sector**

#### **1. Contracting in Sawai Man Singh Hospital, Jaipur**

- The SMS hospital has established a Life Line Fluid Drug Store to contract out low cost high quality medicine and surgical items on a 24-hour basis inside the hospital. The agency to operate the drug store is selected through bidding. The successful bidder is a proprietary agency, and the medical superintendent is the overall supervisor in charge of monitoring the store and its functioning. The contractor appoints and manages the remuneration of the staff from the sales receipts. The SMS hospital shares resources with the drug store such as electricity; water; computers for daily operations; physical space; stationery and medicines. The contractor provides all staff salaries; daily operations and distribution of medicine; maintenance of records and monthly reports to SMS Hospital. The SMS Hospital provides all medicines to the drug store, and the contractor has no power to purchase or sell medicines himself. The contractor gains substantial profits, could expand his contacts and gain popularity through LLFS. However, the contractor has to abide by all the rules and regulations as given in the contract document.
- The SMS Hospital has also contracted out the installation, operation and maintenance of CT-scan and MRI services to a private agency. The agency is paid a monthly rent by the hospital and the agency has to render free services to 20% of the patients belonging to the poor socio-economic categories

2. The Uttaranchal Mobile Hospital and Research Center (UMHRC) is three-way partnership among the Technology Information, Forecasting and Assessment Council (TIFAC), the Government of Uttaranchal and the Birla Institute of Scientific Research (BISR). The motive behind the partnership was to provide health care and diagnostic facilities to poor and rural people at their doorstep in the difficult hilly terrains. TIFAC and the State Govt. shares the funds sanctioned to BISR on an equal basis.

3. Contracting out of IEC services to the private sector by the State Malaria Control Society in Gujarat is underway in order to control malaria in the state. The IEC budget from various pharmaceutical companies is pooled together on a common basis and the agencies hired by the private sector are allocated the money for development of IEC material through a special sanction.

4. Contracting in of services like cleaning and maintenance of buildings, security, waste management, scavenging, laundry, diet, etc. to the private sector has been tried in states like Himachal Pradesh; Karnataka; Orissa (cleaning work of Capital Hospital by Sulabh International); Punjab; Tripura (contracting Sulabh International for upkeep, cleaning and maintenance of the G.B. Hospital and the surrounding area); Uttaranchal, etc.

5. The Government of Andhra Pradesh has initiated the Arogya Raksha Scheme in collaboration with the New India Assurance Company and with private clinics. It is an insurance scheme fully

funded by the government. It provides hospitalization benefits and personal accident benefits to citizens below the poverty line who undergo sterilization for family planning from government health institutions. The government paid an insurance premium of Rs. 75 per family to the insurance company, with the expected enrollment of 200,000 acceptors in the first year.

The medical officer in the clinics issues a Arogya Raksha Certificate to the person who undergoes sterilization. The person and two of her/his children below the age of five years are covered under the hospitalization benefit and personal accident benefit schemes. The person and/or her/his children could get in-patient treatment in the hospital upto a maximum of Rs. 2000 per hospitalization, and subject to a limit of Rs. 4000 for all treatments taken under one Arogya Raksha Certificate in any one year. She/he gets free treatment from the hospital, which in turn claims the charges from the New India Insurance Company. In case of death due to any accident, the maximum benefit payable under one certificate is Rs. 10,000.

## **B. Partnership between the Government and the non-profit sector**

### **1. Involvement of NGOs in the Family Welfare Programme**

- The MNGO (Mother NGO) and SNGO (Service NGO) Schemes are being implemented by NGOs for population stabilization and RCH. 102 MNGOs in 439 districts, 800 FNGOs, 4 regional Resource Centers (RRC) and 1 Apex Resource Cell (ARC) are already in place. The MNGOs involve smaller NGOs called FNGOs (Field NGOs) in the allocated districts.

The functions of the MNGO include identification and selection of FNGOs; their capacity building; development of baseline data for CAN; provision of technical support; liaison, networking and coordination with State and District health services, PRIs and other NGOs; monitoring the performance and progress of FNGOs and documentation of best practices. The FNGOs are involved in conducting Community Needs Assessment; RCH service delivery and orientation of RCH to PRI members; advocacy and awareness generation.

The SNGOs provide an integrated package of clinical and non-clinical services directly to the community

- The Govt. of Gujarat has provided grants to SEWA-Rural in Gujarat for managing one PHC and three CHCs. The NGO provides rural health, medical services and manages the public health institutions in the same pattern as the Government. SEWA can accept employees from the District Panchayat on deputation. It can also employ its own personnel by following the recruitment resolution of either the Government or the District Panchayat. However, the District Health Officer or the District Development Officer is a member of the selection committee and the appointment is given in her/his presence. In case SEWA does not wish to continue its services, the District Panchayat, Bharuch would take over the management of the same.

2. The Municipal Corporation of Delhi and the Arpana Trust (a charitable organization registered in India and in the United Kingdom have developed a partnership to provide comprehensive health services to the urban poor in Delhi's Molarbund resettlement colony. Arpana Trust runs a health center primarily for women and children, in Molarbund through its health center 'Arpana Swasthya Kendra'. As contractual partners, Arpana Trust and MCD each has fixed responsibilities and provides a share of resources as agreed in the partnership contract. The Arpana Trust is responsible for organizing and implementing services in the project area, while the MCD is responsible for monitoring the project. The MCD provides building, furniture, medicines and equipment, while the Arpana Trust provides maintenance of the building, water and electricity charges, management of staff and medicine.

3. Management of Primary Health Centers in Gumballi and Sugganahalli was contracted out by the Government of Karnataka to Karuna Trust in 1996 to serve the tribal community in the hill y areas. 90% of the cost is borne by the Govt. and 10% by the trust. Karuna Trust has full responsibility for providing all personnel at the PHC and the Health Sub-centers within its jurisdiction; maintenance of all the assets at the PHC and addition of any assets if required at the PHC. There has been redeployment of the Govt. staff in the PHCs, however some do remain in deputation on mutual consent. The agency ensures adequate stocks of essential drugs at all times and supplies them free of cost to the patients. No patient is charged for diagnosis, drugs, treatment or anything else except in accordance with the Government policy. The staff salaries are shared between the Govt. and the Trust.

Gumballi district is considered a model PHC covering the entire gamut of primary health care – preventive, promotive, curative and rehabilitative

Similarly in Orissa, PPPs are being implemented for safe abortion services and social marketing of disposable delivery kits. Parivar Sewa Sanstha and Population Services International are implementing the Sector Investment Plan in the state.

4. The Government of Tamil Nadu has initiated an Emergency Ambulance Services scheme in Theni district of Tamil Nadu in order to reduce the maternal mortality rate in its rural area. The major cause for the high MMR is anon-medical cause - the lack of adequate transport facilities to carry pregnant women to health institutions for childbirth, especially in the tribal areas. This scheme is part of the World Bank aided health system development project in Tamil Nadu. Seva Nilayam has been selected as the potential non-governmental partner in the scheme. This scheme is self-supporting through the collection of user charges. The Government supports the scheme only by supplying the vehicles. Seva Nilayam recruits the drivers, train the staff, maintain the vehicles, operate the program and report to the government. It bears the entire operating cost of the project including communications, equipment and medicine, and publicizing the service in the villages, particularly the telephone number of the ambulance service. However, the project is not self-sustaining as the revenue collection is lesser than anticipated.

Seva Nilayam also operates another program in the Theni district called the Emergency Accident Relief Center for which the government has also provided a vehicle.

5. The Urban Slum Health Care Project the Andhra Pradesh Ministry of Health and Family Welfare contracts NGOs to manage health centers in the slums of Adilabad. The basic objectives of the project are to increase the availability and utilization of health and family welfare services, to build an effective referral system, to implement national health programs, and to increase health awareness and better health-seeking behaviour among slum dwellers, thus reducing morbidity and mortality among women and children. To serve 3 million people, the project has established 192 Urban Health Centers. Five 'Mahila Aarogya Sanghams' (Women's Wee-Being Associations) were formed under each UHC, and along with the self-help groups and ICDS workers mobilize the community and adopt Behaviour Change Communication strategies.

The NGOs are contracted to manage and maintain the UHCs, and based on their performance, they are awarded with a UHC, or eliminated from the program. Additional District Magistrates and Health Officers supervise the UHCs at district level and the Medical Officer is the nodal officer at the municipality level. The District Committee approves all appointments made by the NGOs for the UHC staff. The Govt. of Andhra Pradesh constructs buildings for the UHCs; provide honoraria to the Project Coordinators of the UHCs, medical officers and other staff; train staff members; and supply drugs, equipment and medical registers.

6. In recent examples, collaboration that has developed between Government of Arunachal Pradesh, VHA and Karuna Trust in managing significant number of PHCs may be seen at Annexure IV.



### **C. Partnership between the Government and a private service provider**

Several examples for the above partnership could be quoted from the Indian experience:

#### **1. Partnership between the Department of Family Welfare and Private Service Providers:**

- The DoFW has appointed one additional ANM on contractual basis in the remote sub-centers (which constitute 30% of all sub centers in C category districts in 8 states) to ensure better emergency obstetric care under the RCH programme. Similarly 140 ANMs could be appointed in Delhi for extending their services in the slum areas. The scheme has been extended to the North Eastern states with effect from 1999-2000
  - Public Health/Staff nurses have been appointed on a contractual basis at PHCs/ CHCs having adequate infrastructure for conducting deliveries.
  - In order to plug deficiencies in providing emergency obstetric care at FRU due to non-availability of anesthetist for surgical interventions, states have been permitted to engage the anesthetist from the private sector on a payment of Rs.1000 per case at the sub-district and CHC level.
  - With a view to supplement the regular arrangement, provision has been made for engaging doctors trained in MTP as Safe Motherhood Consultant who will visit the PHC (including CHCs in NE states) once a week or at least once in a fortnight on a fixed day for performing MTP and other Maternal Health care services. These doctors will be paid @Rs.500 per day visit.
  - A scheme for reservation of sterilization beds in hospitals run by government, local bodies and voluntary organizations was introduced in 1964 with view to provide immediate facilities for tubectomy operations in hospitals. At present too, beds are sanctioned to hospitals run by local bodies and voluntary organizations and grant-in-aid is provided as per approved pattern of assistance.
  - The Haryana Urban RCH Model is being implemented in 19 urban slums and benefits 15 lakh beneficiaries. In this model, a private health practitioner (PHP) has been identified to provide comprehensive primary health care service to a group of 1000-1500 targeted beneficiaries. S/he provides services related to National Disease Control Programme, contraception, immunization, ambulatory care. The PHP gets an incentive of Rs. 100 p.a. per beneficiary by the Government. The model is envisioned to be self-sustaining by the 5<sup>th</sup> year.
  - A proposal has been submitted by PSS, Rajasthan to the GOI for establishing a comprehensive RCH clinic in 3 districts, wherein PSS would provide services like sterilization, MTP, spacing, ante/post natal care, immunization, RTI/STI. The cost to be borne by the Govt. is Rs. 18 to 20 lakhs p.a. per clinic. With a view to ensure project sustainability, the user fees is sought to be deposited in a bank account.
  - The Samaydan Scheme in Gujarat aims to ease the problem of vacancies of specialists in health and medical services. About 125 honorary and part-time specialists have been appointed in rural hospitals under the scheme and the removal of age-eligibility criteria for appointment of doctors in government services is also being considered.
  - Under the Urban Health Care Project, the community base health volunteers in the urban areas would roped in to provide primary health care in the urban slums of Gujarat. Their activities would be monitored by CHC/PHC/PPU/Urban Family Welfare Center/Trust Hospital and they would be paid a fixed monthly honorarium.
2. The Department of AYUSH envisages accreditation of organizations with the MoHFW for research and development in order to be eligible for financial assistance under the scheme of Extra Mural Research on ISM&H. The eligible organizations include R&D organizations recognized by the Ministry of Science and Technology, Govt. of India; one Government or semi-Government or autonomous R & D Institution under the GoI/State Government/Union Territory; and one private R&D institutions registered under any State/Central Act as Research Organization.

**D. Partnership between the Government and a private sector and/or the non-profit sector and/or a private service provider and/or multilateral agencies**

1. The National Malaria Control Programme has involved the NGOs and private practitioners at the district level for the distribution of medicated mosquito nets. (LOGISTICS)
2. Under the National Blindness Control Programme, District Blindness Control Societies have been formulated, which are represented by the Government, non-government and private sectors. The NGOs have been involved for providing a package of services
3. The National AIDS Control Programme has involved both the voluntary and private sector for outreaching the target population through Targeted Interventions (WIDER COVERAGE)
4. The Revised National Tuberculosis Control Programme has involved the private practitioners and the NGOs for the rapid expansion of the DOTS strategy. The non-inclusion of the private providers had been one of the main reasons for the failure of the earlier programme. The private medical practitioners serve as the first point of contact for more than two-thirds of TB symptomatics.

The GOI has initiated a Public Private Mix (PPM) pilot project with technical assistance from WHO in 14 sites across the country viz. Ahmedabad, Bangalore, Bhopal, Chandigarh, Chennai, Delhi, Jaipur, Kolkata, Lucknow, Patna, Pune, Bhubaneswar, Ranchi and Thiruvananthapuram. The areas of collaboration with the NGOs include: community outreach; health education and promotion; provision of DOTS and in-hospital care for TB disease; TB Unit Model; programme planning, implementation, training and evaluation.

Presently, there are 550 NGOs and 200 Private Practitioners involved in RNTCP. Attempts are also underway to involve the medical colleges in the programme.

5. The Rajiv Gandhi Super-specialty Hospital in Raichur Karnataka is a joint venture of the Government of Karnataka and the Apollo hospitals Group, with financial support from OPEC (Organization of Petroleum Exporting Countries). The basic reason for establishing the partnership was to give super-specialty health care at low cost to the people Below Poverty Line. The Govt. of Karnataka has provided the land, hospital building and staff quarters as well as roads, power, water and infrastructure. Apollo provided fully qualified, experienced and competent medical facilities for operating the hospital. The losses anticipated during the first three years of operation were reimbursed by the Govt. to the Apollo hospital. From the fourth year, the hospital could get a 30% of the net profit generated. When no net profit occurred, the Govt paid a service charge (of no more than 3% of gross billing) to the Apollo Hospital.

Apollo is responsible for all medical, legal and statutory requirements. It pays all charges (water, telephone, electricity, power, sewage, sanitation) to the concerned authorities and is liable for penal recovery charges in case of default in payment within the prescribed periods. Apollo is also responsible for maintenance of the hospital premises and buildings, and maintains a separate account for funds generated by the hospital from fees for registration, tests and medical charges. This account is audited by a Chartered Accountant engaged by Apollo with approval of the Governing Council. Likewise, Apollo maintains separate monthly accounts for all materials used by patients below the poverty line (including diagnostic services), which are submitted to the Deputy Commissioner of Raichur for reimbursement. Accountability and responsibility for outsourcing the support services remain with the Apollo.

The controlling authority of the Govt. of Karnataka is vested in its District Commissioner. A Governing Council is established to review the performance of the hospital periodically (twice a year), make recommendations to improve the administration and management and also resolve any disputes that might arise. The ten-member council is chaired by the Karnataka Health

Minister and includes the Raichur District Collector, the Apollo CEO, the Principal Secretary, the Health Secretary, the Finance Manager, the Hospital Operations Manager, Medical Directors and local Members of the Legislative Assembly (as special invitees).

6. The Karuna Trust in collaboration with the National Health Insurance Company and the Government of Karnataka has launched a community health insurance scheme in 2001. It covers the Yelundur and Narasipuram Taluks. Underwritten by the UNDP, the Karuna Trust undertook the project to improve access to and utilization of health services, to prevent impoverishment of the rural poor due to hospitalization and health related issues, and to establish insurance coverage for out-patient care by the people themselves. The scheme is fully subsidized for Scheduled Castes and Scheduled Tribes who are below the poverty line and partially subsidized for non-SC/ST BPL. Poor patients are identified by field workers and health workers who visit door-to-door to make people aware of the scheme. ANMs and health workers visiting a village collect its insurance premiums and deposit them in the bank.

The annual premium is Rs. 22, less than Rs.2 a month. If admitted to any government hospital for treatment, an insured member gets Rs. 100 per day during hospitalization – Rs. 50 for bed-charges and medicine and Rs. 50 as compensation for loss of wages – up to a maximum of Rs.2500 within a 25-day limit. Extra payment is possible for surgery. The insurance is valid for one year. If members want to continue the coverage, they must renew their membership and pay the full premium.

7. The Government of Karnataka, the Narayana Hrudalaya hospital in Bangalore and the Indian Space Research Organization initiated an experimental tele-medicine project called 'Karnataka Integrated Tele-medicine and Tele-health Project' (KITTH), which is an on-line health-care initiatives in Karnataka. With connections by satellite, this project functions in the Coronary Care Units of selected district hospitals that are linked with Narayana Hrudalaya hospital. Each CCU is connected to the main hospital to facilitate investigation by specialists after ordinary doctors have examined patients. If a patient requires an operation, s/he is referred to the main hospital in Bangalore; otherwise s/e is admitted to a CCU for consultation and treatment.

Tele-medicine provides access to areas that are underserved or un-served. It improves access to specialty care and reduces both time and cost for rural and semi-urban patients. Tele-medicine improves the quality of health care through timely diagnosis and treatment of patients. The most important aspect of tele-medicine is the digital convergence of medical records, charts, x-rays, histopathology slides and medical procedures (including laboratory tests) conducted on patients.

8. The Yeshasvini Co-operative Farmer's Healthcare Scheme is a health insurance scheme targeted to benefit the poor. It was initiated by Narayana Hrudalaya, super-specialty heart hospital in Bangalore, and by the Department of Co-operatives of the Government of Karnataka. The Government provides a quarter (Rs. 2.50) of the monthly premium paid by the members of the Cooperative Societies, which is Rs.10 per month. The incentive of getting treatment in a private hospital with the Government paying half of the premium attracts more members to the scheme. The cardholders could access free treatment in 160 hospitals located in all districts of the state for any medical procedure costing upto Rs. 2 lakhs.

The premium is deposited in the account of a charitable trust, the regulatory body for implementing the scheme. A Third Party Administrator – Family Health Plan Limited that is licensed by Karnataka's Insurance Regulatory and Development Authority. The FHPL has the responsibility for administering and managing the scheme on a day-to-day basis. Recognized hospitals have been admitted to the network throughout Karnataka, which are called as network hospitals (NWH). These hospitals offer comprehensive packages for operations that are paid by Yeshasvini. A Yeshasvini Farmers Health Care Trust is formed to ensure sustainability to the scheme, which comprises of members of the State Government and the network hospitals. The Trust monitors and controls the whole scheme, formulates policies, appointed the TPA and addresses the grievances of the insured members or doctors.

Only the members of an agricultural cooperative society could join this scheme, and also all members of a given cooperative society must become members of Yeashsvini. This ensures increase in the enrollment rates. The Government, apart from the premium subsidy has provided key access to the cooperatives. The Department of Cooperatives has provided an administrative vehicle to popularize the scheme.

The major drawback of this scheme is that the poor farmers are not covered for all health related issues but only for out-patient care and all expenses connected with surgery.

9. A Rogi Kalyan Samiti (RKS) was formed in Bhopal's Jai Prakash Government Hospital to manage and maintain it with public cooperation. The RKS or Patient Welfare Committee or Hospital Management Society is a registered society and the committee acts as trustees for the hospitals responsible for proper functioning and management of the hospital. Its members are from local PRIs, NGOs, local elected representatives and government officials. Participation of the local staff with representatives of the local population has been made essential to ensure accountability. It functions as an NGO and not a government agency. It may utilize all government assets and services to impose user charges. It may also raise funds additionally through donations, loans from financial institutions, grants from government as well as other donor agencies. The funds received are not deposited in the State exchequer, but are available to be spent by the Executive Committee constituted by the RKS/HMS. Private organizations could be contracted out for provision of the super specialty care at a rate fixed by the RKS/HMS.

At JP Hospital, RKS was formed due to lack of resources and other functional problems, which acted as an impediment to timely, and quality health service delivery. Due to delay or no disbursement of funds, creation of a hospital management society capable of generating revenues became imperative. After the formation of RKS, the quality of services increased in terms of 24-hour availability of doctors and medicine, diagnostic facilities, better infrastructure, cleanliness, maintenance and timeliness of services. Through RKS, the hospital has also been able to provide free services to patients below the poverty line.

10. A public/private DOTS model was established on a pilot basis in Hyderabad at Mahavir Trust Hospital, which is a private non-profit hospital. This partnership also involves private service providers like doctors and nursing homes. This new approach is known as PPM DOTS (Public Private Mix DOTS). As there are virtually no government services in the area, the private sector is a full substitute for the public sector. Individual private practitioners were involved in the DOTS programme as they form the first point of contact for most of the TB patients both for quality health care as well as convenience to refer to the private practitioners rather than the hospitals at frequent intervals.

The Mahavir Trust Hospital acts as a coordinator and intermediary between the government and private medical practitioners (PMPs). It also acts as a supervisor. The PMPs refer patients suspected of having TB to the hospital or to any of the 30 specified neighborhood DOTS centers operated by PMPs. The patients pay the fees to the PMPs. In addition to providing a referral center for an hour every morning at their own expense, the doctor gains professional and commercial benefits to their practice that far outweigh the loss of several patients who could never afford proper treatment in any case. In turn the Mahavir TB clinic informs the private practitioners about the progress of their patients throughout their treatment. The Mahavir Hospital and the PMPs keep the records for the government. The government provides TB control policy, training, drugs and laboratory supplies. Five outreach workers trace late or delinquent patients and provide community mobilization.

All stakeholders gain an advantage through this partnership. The Mahavir Trust Hospital benefits because the money spent on the DOTS service cures patients. The government benefits because the DOTS medicine are properly used instead of being wasted or even contributing to the development of drug resistant TB. The medicines are curing the patients and the spread of the

disease is being arrested. From an economic point of view, the PMPs and nursing homes are able to provide an effective treatment, which enhance their goodwill and affects their business as a whole too.

The pilot project is aimed at attaining uniformity in the diagnosis, treatment and monitoring, wider programme coverage; saving the patient's time and expenditure by a good referral network.

11. Multilateral organizations like the World Bank and the European Commission have supported the Sector Investment Programme in India and the Department of International Development (DFID) in the area of health sector reforms in India.

12. In recent examples, the Chiranjeevi experiment of Govt of Gujarat may be seen at Annexure IV.

### **CHALLENGES FACED IN THE OPERATIONALISATION: KEY CONCERNS**

The existing evidence for PPP do not allow for easy generalizations. However it appears that despite additional efficiencies, the objective of additional resources is not met, as State revenue remains the bedrock of all services. The evidence also reveals great disparity in services and in remuneration. As is evident the objectives of the initiatives have been to overcome some of the deficiencies of the public sector health systems.

Donations, introduction of user fees, insurance schemes are methods to augment resources. Contracting out is resorted to when health facilities are either underutilized or non functional while contracting in is used to improve quality of services or improve accessibility to high technology service or to improve efficiency. Contractual appointment of staff aims to reduce the negative impact of vacant positions. Voucher schemes and community based health insurance etc are invoked to reduce the adverse effects of health care costs on poor patients and improve equity in health system. Mobile health schemes, involvement of CBOs, health cooperatives etc are models in improving accessibility, both physical and to the health system. Some of the partnerships are for a short duration while the other is longer. The thrusts of the partnerships also vary. Some focus on service delivery, some to augment resources and infrastructure, some towards organizational and systemic improvements while others are simply advocacy oriented.

Contracting is the predominant model for public private partnerships in India. Some partnerships are simple contracts (like laundry, diet, cleaning etc) others are more complex involving many stakeholders with their respective responsibilities. For example the Yeshaswani scheme in Karnataka includes the State Department of Cooperatives, the Yeshaswani Trust with its almost 200 private hospitals, a corporate Third Party Administrator and the beneficiaries with the eligibility conditions.

It is seen that in most partnerships, the State Health Department is the principal partner with rare stakeholder consultation. In most cases it signs contracts with very few cases of Hospital Management Societies signing the contracts in a decentralized manner.

In terms of monetary value the contracts at Kolkotta's Bagha Jatin General Hospital provided inexpensive dietary services at the rate of Rs 27 per meal for about 30 patients a day and cleaning service at Rs 24000/- per month. The most expensive partnership was the Rajiv Gandhi Super Speciality Hospital in Raichur where the Government of Karnataka has paid several hundred million rupees to the partner as start up cost plus an assurance to cover future losses.

The above initiatives also show that more than 75% of the projects have been located in backward areas of the states.

However true partnerships in sense of equality amongst partners, mutual commitment to goals, shared decision making and risk taking are rare.

The case studies also bring to fore genuine concerns summarized in terms of absence of representation of the beneficiary in the process, lack of effective governance mechanisms for accountability, non transparent mechanisms, lack of appropriate monitoring and governance systems and institutionalized management structures to handle the task

It is seen that the success or failures of the initiatives are as much dependant upon the above issues as on the political environment, legal framework of the negotiation, the capabilities of the partners, the risks and incentive each party incurs, funding and the payment mechanisms, cost and price analysis prior to negotiation, standardization of norms, performance measurement and monitoring and evaluations systems.

## **POTENTIAL AREAS FOR PARTNERSHIP**

Different models of PPP are useful under different circumstances. The PPP lists have a wide-ranging set of PPP options ranging from options for improved service delivery, augmentation of resources and infrastructure, organizational and systemic improvement, to advocacy.

However any mechanism of PPP must be based on an assessment of local needs and a situation analysis. For example strengthening the public health structure would be a more viable option in many of the remote corners of the North Eastern states where the presence of private sector is negligible.

On a conceptual level, it is quite clear that the private sector is as much responsible for the health of the nation, therefore all health establishments, must provide some critical services, i.e. family welfare, accidents and trauma and emergencies within their geographical areas and manage infectious diseases of epidemic proportions.

However no health system can work through only a network of tertiary care hospitals. The remedies for most of the deficiencies of the health system largely fall within the ambit of Primary Health Care – whether they are promoting, preventive or curative. Therefore at least in the next five years the focus should be on augmentation of the primary health care services in terms of focus on better service delivery options, including ancillary services like ambulance services and radiology services.

However to fulfill the requirement of additional manpower in terms of requirement of 3 lakh nurses and 12,000 Specialist doctors under NRHM, it is essential to explore a range of partnership options in terms of private sector support to nursing institutions and medical schools and colleges to make available the human resources required for NRHM. There would also be massive requirement of managerial capacities under NRHM, which may be obtained through partnerships.

### **The potential areas may be as follows:**

- Services, disease control and surveillance, diagnostics and medicines.
- Infrastructure
- Health manpower
- Behaviour change communication
- Capacity building including training and systems development.
- Managerial service and auxiliary activities of the health sector

In the initial phase caution should be exercised against expanding into too many sectors. Government funding should not exceed an overall cap of 15% of the budget allocation.

Super specialty care is not the goal. The intention is to provide basic health care to all citizens of this country so that they do not face distress and duress in meeting health care needs.

## **RECOMMENDATIONS FOR A PRACTICAL AND COST EFFECTIVE MECHANISM**

### **Framework For Regulation**

As is evident Partnership mechanisms do not work without quality assurance and an enabling environment. Government must ensure that providers are accredited, at least essential standards are set and followed, guidelines and protocols for diagnosis and treatment are developed and used, and providers are kept updated through continuing medical education. System must monitor and correct such important aspects of quality as infection prevention, client satisfaction and access to services. For enablement the government must understand the

advantages, disadvantages and requirements of partnership. They need to understand that partnerships are based on common objectives, shared risks, shared investments and participatory decision-making.

Since there is an element of contradiction in the objective of strengthening of the public health system by the private sector in which the private sector apparently is the ultimate loser, therefore it is essential that the framework for the whole process of partnership is not ad-hoc. **Equity, Quality and Regulation** should underline the entire deliberation and apply not only to the Private Sector but also to the Public Sector.

Primary goal of any health system should be assurance of health care professional competence to the public. For a minimalist regulation system that may be feasible in the current socio-political environment it is suggested that:

1. Any Health Care Professional, practicing in any area / institution, should register with the Primary Health Officer of the Area or the Institution as the case may be. For this purpose an appropriate officer in the Primary Health Centres / Urban Health Centres may be identified as the Primary Health Officer. Every Health Care Institution may be required to designate an officer as the Institution's Primary Health Officer. The Registers maintained by Primary Health Officers should be accessible to public. The Register will also help Primary Health Centres and Public Health Officials to manage public health emergencies and for epidemiological surveillance.

2. Clinical Establishment Act, requiring registration of Health Care Institutions and Hospitals with appropriate Health Authority. Clinics, Nursing Homes and Small Hospitals of less than 100 beds may register with Local Health Authority, to be designated for about 5 lakh population (Revenue Division / Sub Division), larger hospitals may register with District Health Authorities and Tertiary Referral Hospitals may register with concerned State Health Authority. The Act should also provide for registration at the district level with the Zilla Parishad or the DHA wherever capacities of PRIs are wanting and include redressal mechanism for health institutions (Example diagnostic Centres) owned by a non-medical person.

The registers of professionals practicing in an area or within an institution should be in the public domain available for public use and scrutiny. This would eventually lead to setting up of a national database on professionals practicing in different areas and institutions in different parts of the country and will also help in the judicial process. Therefore it is important that Registration should be in the Government domain and not with an autonomous body

The need for regulation should not only be for providers but also for training educators and training facilities. There is also a need for a regulatory framework for the proposed Rural Medical Practitioners as they would be key players in the primary health delivery systems.

Since managerial issues and governance capacities within the public health system are key issues in determining the effectiveness of registration therefore, in the initial phase, self registration should be encouraged followed by an interim accreditation mechanism developed with the help of FOGSI/IMA before a fully e-governed registration system could be institutionalized.

“Accreditation” as a voluntary process with set standards, provision for external review etc. must also be supported and incentives for accreditation must be encouraged. The accreditation initiatives in India at the National level (QCI, NABL) and at the State Level (AP, Karnataka, Tamil Nadu, Kerala and Maharashtra) are progressive steps.

A range of Accreditation Systems ranging from compulsory accreditation, accreditation by independent agencies, and facilitation of establishment of State Accreditation Councils to a blue print developed by the Ministry of Health & Family Welfare may be explored. It is however important to involve the stakeholders, build capacity, have different bodies at different levels, and collect evidence base for the whole process. Accreditation should have synergy with Regulation.

The process of accreditation of Mother and Child Hospital specifying certain minimum standards had already begun in Tamilnadu for the Janani Suraksha Yojana (JSY) Scheme.

However, in the process of accreditation there should be no fallback to the License Raj. There should be a single window for registration/accreditation of health institutions.

### **Framework Of Partnership**

It is a prerequisite to make the partnership a publicly driven process in order to improve its legitimacy in the eyes of the common citizen. It is also important that there is clear articulation of responsibility, an open process and meticulous detailing to avoid suspicions and apprehensions in the minds of all. Therefore the power relations in the partnership also needed to be understood.

There is a need for defining the specific elements of the partnership from both sides as many a time the private provider feels that the Government itself does not undertake any guarantee in the Partnership.

All PPPs should meet at least two basic criteria, namely (a) Value for Money and (b) Clearly defined sharing of risks. There is need to develop skills within the government for assessment of the Value for Money and Risk sharing characteristics of PPPs. One common requirement for assessment of Value for Money proposition is existence of good comparators. For example; NGO Management of PHCs uses current budgetary allocations of PHCs as a comparator to make financial allocation. Similarly average out patient consultations or such other therapeutic procedures, and public health activities in other PHCs can be used to assess the performance of PHC under PPPs. CAG should be requested to develop specialised skills for assessment of Value for Money and risk sharing characteristics of PPP projects. Auditing of government expenditure through PPPs requirement would be different from traditional audit of expenditure directly made by government departments. Unless the CAG develops capacity for auditing of public expenditures through private partnerships, large scale expansion of PPPs would be difficult.

Transparency, Accountability, Trust, measurable efficiency parameters and Pricing remain vexatious issues in the partnership process.

The framework of partnership should also provide for the costing of services to ensure that common citizens can get/buy cost effective services.

The governmental system of fixing rate is fraught with difficulties and it is better to adopt public costing with moderation and states need to work out the cost effectiveness very meticulously. It may be noted that no serious effort at costing of services and standard treatment protocol has been attempted in the government domain. The National Commission on Macroeconomics and health (NCMH) is the first attempt to document the cost of services in the public sector. Attempts at costing under various PPP schemes like the Yeshaswani scheme of Karnataka and the Chiranjeevi scheme in Gujrat have been attempted. However more work is required to be done in this area and the initiative should be taken by the Ministry and the States. (Examples of a few cost effective options are at Annexure 1)

Decentralization should be the key in dealing with partnerships as centralized models suffer from failings enumerated in the aforesaid sections. The challenge under the NRHM is to operationalise partnerships at the District level. Therefore there is also a requirement for district level skills and managerial capacity for making the process accountable, affordable and accessible to common citizens.

The resource support and technical assistance for the PPP mechanism may come from the National Health Systems Resource Centre (NHSRC), State Health Systems Resource Centre



(SHSRC) and the District Health Systems Resource Centre (DHSRC) being set up under NRHM at the National , State and the District level respectively.

The National Institute of Health & Family Welfare (NIHFW) can be the nodal agency for guiding PPP Policy at the National level. A PPP Cell at the NIHFW can also function as the Documentation and dissemination Centre for PPP initiatives in the States. Resource support may be provided under NRHM to fund this Cell. These Cells may be replicated in the States and the Districts within the overall umbrella of the State Health Society and District Health Society under NRHM.

District level Health Resource Centres, can help in developing transparency in PPP and provide the much needed managerial capacity to manage processes like Accreditation and Standards.

Public Private Partnership needs to be mutually beneficial to both the parties so that there is encouragement of enterprises and element of pragmatism. It is important that the health professionals also earn in the process to sustain the partnership. However, the earning should be commensurate to the health services provided specially to the poor. This is possible through the volumes of patients, which the private sector would be getting from the public sector.

There is a need for further documentation of the ongoing experiments in PPP and evaluation of their impact. The evaluation mechanism should highlight the issues of access, utilization, sustainability, cost effectiveness and pricing, equity, transparency, audit etc.

### **Models For Partnership**

It is essential to appreciate the diversity in terms of regional variations in the health status across the country. Therefore, generic models of existing PPP practices like contracting in, contracting out, social marketing, and social franchising may be modified to suit local variations. The assumption here is that a homogeneous prescription would not work and therefore the challenge is to develop the nitty-gritty of a framework allowing for diversity of models esp. at the District Level.

#### **Public-Private-Partnership Models (Details at Annexure 2)**

- Contracting :
  - Contracting out
  - Contracting-in
- Franchising :
  - Partial franchising
  - Full franchising
  - Branded clinics
- Social marketing
- Joint ventures
- Voucher schemes
- Hospital autonomy
- Partnership with corporate sector/ industrial houses
- Involving professional associations
- Build, operate and transfer
- Donation & philanthropic contributions
- Involvement of social groups
- Partnership with co-operative societies
- Partnership for capacity building
- Partnership with non-profit community-based organizations
- Running mobile health units
- Community based health insurance

### **PRINCIPLES OF PPP**

Although the approaches are different for each typology to resolve the health crisis currently in hand, there are certain common underlying principles guiding each of such partnerships, which are enumerated below:

1. Setting up of common goals and objectives, which are committed by all the partners.
2. Outcome based planning
3. Joint decision-making process
4. Creation of a social good by improving the health situation of the poor and underserved as well as standardization and uniformity of quality health service delivery
5. Accountability and responsibility set out vividly for each partner
6. Sharing of costs and resources are done on the basis of equity. The same principle is followed for sharing risk and rewards. Central to any successful public-private partnership initiative is the identification of risk associated with each component of the project and the allocation of that risk factor to the public sector, the private sector or perhaps a sharing by both. Thus, the desired balance to ensure best value (for money) is based on an allocation of risk factors to the participants who are best able to manage those risks and thus minimize costs while improving performance.
7. Regular meetings among the partners to discuss issues at hand and planning and coordinating for the future
8. A clear understanding of the strengths and weaknesses of the partners among themselves is essential to understand their roles and responsibilities clearly
9. The monitoring mechanisms are made sound in order to address the diversity of the partnerships
10. Financial sustainability is an all-pervading factor, which forms the backbone of all partnerships. There has to be a regular flow of funds in order to meet the personnel and operating costs. Some programs have become self-sustainable only by involvement of the people. Such schemes do not require regular funds from the Government
11. Partnerships could be full substitution of the provision of health services, or managing the operations or monitoring or provision of infrastructure (equipments, manpower, etc.)
12. Any vested interest in such structures could destroy the base, and lead to the failure of the whole institution. Thus, a high level of trust and confidence is required in all the PPP initiatives.
13. Effective communications are key to the public's understanding of public-private partnerships. Communications are required to be planned and carried out as an integral part of the management process for any project. It involves timely sharing of information, accurate and consistent messages conveyed to key audiences, realistic messages from trusted sources that set realistic expectations.
14. PPP involves a long term relationship between the public sector and the private sector. While the collaboration between the two may take various forms like buyer seller relationship, donor recipient relationship, the most stable partnership is in the form of "contract" binding on both the parties. The contract mirrors the basic objective of the programme/project, the tenure of agreement, the funding pattern and of sharing of risk and responsibilities. The need to define the contract very precisely, therefore, becomes paramount under PPP.

Project/Programmes under PPP may, however, broadly be classified under three heads namely (i) service contract (ii) operations & maintenance (management) contract and (iii) capital project, with operations & maintenance contract.

#### Selection of Service Provider

Transparency in 'selection' is an essential feature of PPP. Selection of the developer or the service provider may be done in any of the following three ways.

##### (i) Competitive Bidding

This involves a well publicized and a well designed bid process to ascertain financial, technical and managerial capabilities of the service provider or the developer. Either of the two

formats for bidding, namely single round sealed bid auction or multiple round open entry (ascending) bid auction could be adopted. The appropriate bidding process depends on the nature of the valuation that the bidders place on the concession, that is, on the right to do the job.

In some cases the valuation of the project depends on factors that are within the bidder's control, such as construction and maintenance cost of a building or a road. These are also known as 'private value items'. In other cases, the valuation does not depend just on the bidder's own assessment, but also on certain unknown factors that need to be anticipated. These unknown factors are common to all bidders and each bidder may update his/her own assessment based on the assessment of other bidders. These are known as 'common value items' and include factors such as the size of market, willingness to pay of consumers and future behaviour of regulatory etc.

For private value items, a single round auction is appropriate since bidders do not need to learn from the revelation of information of other bidders and a sealed bid auction is preferable since that has the least potential for collusion. Concessions with common value characteristics on the other hand, are best awarded through multiple round bids since this facilitates the process of value discovery by bidders, allowing bidders to observe and respond to quotations/prices as they emerge. Multiple round bid can also be sealed bid but there is opportunity to rebid after the bids are opened. Moreover, wherever the bid process is characterized by a two stage process involving for instance, mega infrastructure projects, the bidders are required to obtain from their prospective lenders the financial terms, expectations regarding state support as well as their comments on the concession agreement etc.

The final selection of the developer/service provider depends upon one or a combination of the following (a) lowest capital cost of the project (b) lowest operation and maintenance cost (c) lowest bid in terms of the present value of user fees (d) lowest present value of payment from government (e) highest equity premium (f) highest upfront fee (g) highest revenue share to the Government and or (h) shortest concession period.

Under situations of only a sole bid being received, the authorities have the choice of either accepting or rejecting the sole bid. In the case of rejecting the sole bid, or when no bid is received, the project/programme proposal itself may be modified and the bid process restarted. Alternatively the selection of the developer/service provider is done through competitive negotiation with the private sector participants.

#### (ii) Swiss Challenge Approach

The Swiss Challenge approach refers to suo-moto proposals being received from the private participant by the government. The private sector thus provides (a) all details regarding its technical financial and managerial capabilities (b) all details regarding technical, financial and commercial viability of the project/programme (c) all details regarding expectation of government support/concessions.

The government may examine the proposal and if the proposal belongs to the declared policy of priorities, then it may invite competing counter proposals from others (in the spirit of 'Swiss Challenge' approach) giving adequate notice. In the event of a better proposal being received, the original proponent is given the opportunity to modify the original proposal. Finally the better of the two is awarded the project/programme for execution.

#### (iii) Competitive Negotiation

Competitive negotiation (direct or indirect) is considered a variant of competitive bidding. The Government thus specifies the service objective and invites proposals through advertisement. The government then negotiates/finalise the contract with the selected bidders.

The government agency (or the local authority) may select the service provider/developer through competitive negotiation in the following cases:

- a) Social sector projects and programmes involving VOs/NGOs/Local Community.
- b) Project involving proprietary technology or a franchise;
- c) Linkage project related to a mega project or a major activity.
- d) Projects and programmes which failed to solicit any response to a bidding process.
- e) Su-moto proposal from private participants.

Negotiation may, however, be 'simple' (direct) or 'complex' (indirect). In the second case, the government negotiates through a master contractor/mother, NGO. In other words, contracts for (public) services are contracted out and the master contractor handles all dealings with sub-contractors/franchises. While the government reviews the works of the master contractor through its monitoring (officials) who may visit the site of programme implementation and meet the beneficiaries, the master contractor may monitor the programme (run by sub-contractors) through collecting information from the beneficiaries selected randomly, based on questionnaires/interviews.

#### Advantage of Master Contractor

Some of the advantages mentioned about master contracting are: (a) government has administrative convenience, and better control in dealing with less number of service providers (b) funds can be raised from other public and private sources, other than the government (c) decision can be taken more quickly despite political pressures and (d) training programmes can be organised for the sub-contractors/service provider/vendors by the master contractor more innovatively.

However, master contract is not always relevant and negotiation vis-à-vis the contract ought to be done directly with the community/beneficiaries as for instance, in the case of wild life protection with the residents living in the vicinity of the forest. Competitive negotiations are, however, less transparent than competitive bidding. With a view to ensure fairness nonetheless, it is recommended that the government auditor may audit such contracts.

16. Payment mechanism: Payment to the private sector could take the form of (a) contractual payments (b) grants-in-aid and (c) right to levy user charges for the asset created/leased in. Contractual payment may be in the form of advance payment, progress payment, final payment annuities and guarantees for receivable etc. Annuities, in turn could be with respect to recovering the fixed cost or for recovering both variable cost and the fixed cost of the project. In the former case, both the government and the private partner share the risk of running the project.

Grant-in-aid in turn can take different forms such as a block grant, capital grant matching grant, institutional support etc. Lease agreement license similarly may allow the concessionaire to recover the cost of construction/operation & maintenance through levying user charges. Moreover, in the case of lease agreement, the asset reverts to the government after the expiry of the contract. The agreement ought to also provide for the condition of asset that would be returned at the end of the contract.

17. Monitoring & Evaluation: It is quite often, thought that the job is over with the signing/finalizing the contract. Payments have to be, however, linked to performance, which in turn requires monitoring. Performance measurement can be done with respect to measuring efficiency or measuring effectiveness. While measurement of efficiency entails comparing the unit cost of providing the service from amongst the various alternatives, measurement of effectiveness involves comparing the desired outcomes from amongst the various alternatives.

Monitoring may be done in either of the following ways (i) by government departments authorized to do so, based on a standardized scale (ii) by independent agencies/regulators based on a standardized scale (iii) by the department or independent agencies, based on the simple criteria of pass and fail by the department or independent agencies, based on the feed back received from the beneficiaries.

Involvement of third party/independent agencies for monitoring appears to be preferable as they leave the government hassle free over the project and minimize government control. A certain percentage of the cost of the project needs to be, therefore, earmarked for contract management. The government and the developer/service provider could mutually decide the third party. The third party involvement could be further supplemented with provisions for adjudication by the highest judiciary.

The following would be useful parameters in monitoring and evaluation of the initiatives:

- Profile of implementing agency: history, organizational structure, management board, business, service provided
- Procedures followed in signing the partnership- decision making process, competitiveness and transparency in selection process, criteria for selection and time taken
- Cope and coverage of services under agreement
- Eligibility conditions for the private agency-minimum investment, proper experience
- Specific clauses in the **MOU**-maximum duration of the contract, pricing and service specification, billing and payment mechanism, managerial flexibility, supervision and monitoring, quality control, employment service conditions of the staff, physical infrastructure support, subsidies and incentives, penalties and fines, exit clause, grievance redressal system
- Performance evaluation, renewal of contract
- Public health objective clause- specific services and subsidies to poor, women and children
- Feedback of stakeholders-state and central bureaucrats, public health facility managers, private agency managers, beneficiaries, staff in both public agency and private agency, community leaders

## **Conclusion**

The Government plays a predominant role in any PPP. Hence it has to follow certain successful strategies in order to become a better partner. The key elements of a successful PPP are as follows:

1. The Government should look at the long-term value in a partnership
2. Selection of the right partner becomes imperative for the government to achieve tangible outputs and create the 'best value'. A partner's experience in the specific area of partnership being considered is an important factor in identifying the right partner.
3. By aligning the stakeholders' interests, the Government could endeavor better value creation
4. The Government could adopt a more strategic approach by stepping back from the day to day management of public enterprises, and instead focusing on the drivers of long term value, setting targets and encouraging alliances and partnerships with the private sector.
5. The Government should introduce greater transparency. Greater openness about the financial performance and service delivery of public enterprises will be a useful discipline on managers within those organizations. Focusing on a few strategic targets will be a start.
6. The Government could introduce greater shareholder expertise by ensuring an appropriate mix of skills and experience among the partners to help carry out the health objectives more efficiently.
7. However, if PPPs are genuinely going to deliver better quality services, it is vital that they are designed with the focus on outputs and performance. The private sector partner or partners need to be clear about what is expected from them and the implications if they fail to deliver.
8. The Government must recognize that it has a continuing role in the public service element of essential services. In some cases, this may mean retaining some elements of service delivery in

the public sector. Therefore it becomes critical to decide on retaining the control over certain services, rather than contracting them.

9. The Government could adopt the following approaches to deliver partnerships:

(a) Undertaking appropriate partnerships by understanding what works best in a given situation, the circumstances in which they are to be implemented and the objectives which they are intended to serve

(b) Creating innovative and imaginative partnerships and creating new ways of working - learning by doing - is key, particularly where there is no existing best practice

(c) Designing a holistic approach PPPs by joined-up thinking, reflecting the needs of customers, potential partners and providers, as well as joined-up Government initiatives rather than the narrowing the objectives to the departmental territory.

The performance of any PPP in the health sector could be evaluated based on the following building blocks:

1. Beneficence or public health gains
2. Non-maleficence or not leading to ill health
3. Autonomy enjoyed by each partner
4. Shared decision-making
5. Equity or distribution of benefits to those most in need

However it may be reiterated that the private partnerships are not sufficient to resolve the dilemma of inadequate health care for the people. The focus of Public policy in the context of the 11th Five Year Plan should be the flagship march for strengthening the public health sector.

**MOST PRACTICAL & COST EFFECTIVE MODE OF PPP FOR IMPROVEMENT IN  
HEALTH SERVICES DELIVERY**

PROBLEM AREAS AT VARIOUS LEVELS IN HEALTH SERVICES DELIVERY	TYPE OF SUGGESTED PARTNERSHIP	WORKING MODELS	COST EFFECTIVITY	REMARKS
<b>HOSPITAL SET-UP</b>				
SHORTAGE/ ABSENCE OF SPECIALISTS	APPOINTING SPECIALISTS ON CONTRACT BASIS ON WEEK ENDS OR SO.	GOVT OF GUJARAT IMPLEMENTED THE PARTNERSHIP IN SEP 2002 IN NARMADA DISTT. AND LATER EXTENDED TO RAJKOT DISTRICT	FUND POOLING FROM UNUSED BUDGET DUE TO VACANT SPECIALISTS POSITION TO USE FOR CONTRACTING PRIVATE PRACTITIONERS	PARTNERSHIP IS ON CONTRACT BASIS AND RS 500(LATER EXTENDED TO RS. 1000 PER VISIT) PER VISIT TWICE A WEEK IS PAID. EVALUATION SHOWED THAT ARRANGEMENTS ENSURED ACCESS TO SPECIALIST SERVICES AT HOSPITALS. HOWEVER, PER DAY HONORARIUM SHOULD BE KEPT EQUIVALENT TO ONE DAY SALARY OF SPECIALIST WITH CONVEYANCE CHARGES OF RS 500/-
ABSENCE/ POOR QUALITY OF RADIO DIAGNOSTIC MACHINERY	INSTALLATION OF RADIO DIAGNOSTIC MACHINERY (CT,USG,X- RAY) BY PRIVATE SECTOR ON CONTRACT IN BASIS IN THE PREMISES OF THE HOSPITAL	CT MACHINES HAVE BEEN INSTALLED AND ARE BEING RUN BY PRIVATE AGENCIES IN 7 GOVT HOSPITALS IN WEST BENGAL .	SERVICES ROUND THE CLOCK AT REDUCED PRICES, FREE SERVICE FOR BPL PATIENTS & SENIOR CITIZENS, A FIXED NO. OF INVESTIGATIONS/MONTH /HOSPITAL AFTER WHICH THEY CAN CARRY AS MUCH AS THEY WISH BUT THEY WILL HAVE TO PAY COMMISSION PER PATIENT	TERMS & CONDITIONS STATE THAT FREE SERVICES SHOULD BE GIVEN TO AT LEAST 35 PATIENTS/ HOSPITAL AND TO NOT MORE THAN 615 CASES/ HOSPITAL/ MONTH AT APPROVED GOVT RATES. 25% COMMISSION AFTER THE SPECIFIED CASES TO BE PAID TO STATE GOVT. MODEL RESULTED IN OVERALL COST REDUCTION ACROSS THE CITY.  PATIENTS FEEDBACK IS MUST FOR COMPLIANCE OF CONDITIONS

				IN CASE OF SMALLER UNITS, GOOD AND BAD LOCATIONS SHOULD BE AWARDED TOGETHER TO COMPENSATE FOR POSSIBLE LOSSES
ABSENCE OF 24x7 LAB SERVICES	ON THE BASIS OF CONTRACTING IN PARTNERSHIP WITH THE PRIVATE SECTOR	<p>PARTNERSHIP BETWEEN M/S THUKRAL DIAGNOSTICS CENTRE LUCKNOW &amp; BMC AND PG ALIGUNJ IMPLEMENTED IN MARCH 2003</p> <p>IN 1994 IN SWEDEN A FOR PROFIT LABORATORY CALLED MEDANALYZE WAS AWARDED A CONTRACT TO HANDLE LAB TESTS FOR PRIMARY CARE PHYSICIAN IN A DISTRICT OF STOCKHOLM COUNTY.</p>	NO EXTRA COST ON STRETCHING THE LAB SERVICES TO ROUND THE CLOCK, FREE SERVICES FOR BPL PATIENTS WHOSE FEES CAN BE REIMBURSED FROM THE HOSPITAL WELFARE COMMITTEE	<p>SELECTED DIAGNOSTIC CENTRE PROVIDES 3 DIFFERENT PACKAGES AT REASONABLE COST FOR EMERGENCY INVESTIGATIONS. THE ARRANGEMENT ENSURES THE PREGNANT WOMEN AND CHILDREN HAVE THE ROUND THE CLOCK ACCESS TO LAB INVESTIGATIONS AT AN AFFORDABLE COST. THE STOCKHOLM MODEL FAILED AS THE COMPANY WAS UNABLE TO HANDLE THE LARGE VOLUME OF SAMPLES AND BEGAN MISHANDLING SPECIMENS AND EVEN FABRICATING RESULTS AS A MEAN OF COPING.</p> <p>EXIT POLICY MAY BE CONSIDERED. ONLY ACCREDITED AND TRUSTED LABS IN HEALTH SECTOR SHOULD BE CONSIDERED. GOVT MAY EXEMPT RENT, WATER CHARGES ETC FOR REMOTE AREAS</p>
DIFFICULTY IN ACCESS TO SUPER-SPECIALIST HEALTH SERVICES IN REMOTE AND HILLY AREAS	SETTING THE TELE-MEDICINE & TELE-HEALTH SYSTEM ON CONTRACTING OUT BASIS WITH THE PRIVATE SECTOR	KARNATAKA INTEGRATED TELE-MEDICINE AND TELE HEALTH PROJECT, IN KARNATAKA DISTT HOSPITAL, NARAYANA HRUDAYALYA BANGALORE IN COLLABORATION WITH	REDUCED TRAVEL AND ELIMINATION OF UNNECESSARY PATIENT TRANSFER, LOW CAPITAL INVESTMENT FOR ESTABLISHING A CARE PRESENCE, TRAINING AND RE- TRAINING AT THE LEAST COST POSSIBLE	<p>THE 27 TELEMEDICINE CENTERS IN INDIA ARE THE LARGEST E-HEALTH CENTERS IN THE WORLD. SO FAR 16000 HEART PATIENTS HAVE BEEN TREATED VIA AN</p>



		INDIAN SPACE RESEARCH ORGANIZATION. OPERATIONAL SINCE 2002.		'E-WAY'.  GOVT MAY OFFER TAX INCENTIVE OR SOME OTHER RELIEF IN LIEU OF WORKING IN REMOTE AREAS. PENALTY CLAUSE FOR NON FUNCTIONING OF FACILITY. FACILITY CREATED MAY ALSO BE OPEN TO OTHER PYT PRACTITIONERS IN SURPLUS TIME.
LOW AVAILABILITY OF DOCTORS AND MEDICAL SERVICES	PARTNERSHIP WITH THE CORPORATE/ BOT FOR MEDICAL/ DENTAL EDUCATION & SERVICES	VARIOUS PRIVATE MEDICAL/ DENTAL COLLEGES ACROSS THE INDIA.	NO EXTRA BURDEN IN CORPORATE AND NO RUNNING COST IN BOT	POLICY FOR PRIVATE SECTOR PARTICIPATION IN MEDICAL/ DENTAL EDUCATION SEEKS TO ATTRACT PRIVATE SECTOR TO SET UP COLLEGES IN THE STATE. CRITERIA IS LAID DOWN BY THE STATE GOVT, MCI & DCI. FINAL DECISION IS BASED ON THE AVAILABILITY OF LAND WITH THE ORGANIZATION, AVAILABILITY OF HOSPITAL HAVING MINIMUM 300 BEDS FOR MEDICAL COLLEGE EXISTING EXPERIENCE FAILED IN DELHI. GOVT MAY PURCHASE SERVICE FOR POOR/NHPS ON PREDETERMINED RATES. HOWEVER, GOVT MAY DECIDE THAT NEW PHCS/CHCS WILL BE OPENED BY PYT PLAYERS AND GOVT WILL BY SERVICES ON YESHASVINI MODEL
NON/LOW AVAILABILITY OF MEDICINES & SURGICAL ITEMS	PARTNERSHIP OF SOCIAL MARKETING TYPE CAN PROVIDE CHEAPER MEDICINES & SURGICALS IN HOSPITAL PREMISES	LIFE LINE FLUID DRUG STORE IN SAWAI MAN SINGH(SMS) HOSPITAL, JAIPUR, RAJASTHAN STARTED IN 1996	WITH NO EXTRA COST STATE GOVERNMENT CAN PROVIDE STANDARD STUFF TO THE PATIENTS AT REASONABLE PRICE ROUND THE CLOCK	THROUGH OPEN TENDER , RMRS INVITE BIDS FROM SUPPLIERS TO PROCURE MEDICINES THAT LLFS SELLS TO

				<p>SMS PATIENTS AT THE PROCUREMENT PRICES. RMRS DECIDES THE PERIOD OF THE CONTRACT, WHICH IS RENEWABLE ON THE BASIS OF GOOD PERFORMANCE. WITH FIXED SALARY AND A ONE – PERCENT COMMISSION ON ALL SALES, THE CONTRACTOR APPOINTS AND MANAGES STAFF FROM THE RECEIPTS. WILL BE SUCCESSFUL WHERE HIGHER VOLUME OF SALE EXIST. SMALLER HEALTH UNITS MAY ALSO BE TAGGED WITH BIGGER ONE IN CONTRACT</p>
LACK OF AMBULANCE/TRANSPORT SERVICES	PARTNERSHIP WITH NGOS/CBO,USER CHARGES/KM SCHEME	EMERGENCY AMBULANCE SERVICES, THENI DISTRICT, TAMIL NADU, PARTNERSHIP IS OPERATIONAL SINCE 2002.	AMBULANCE/TRANSPORT SERVICES CAN BE PROVIDED WITH NO EXTRA EXPENDITURE ON PURCHASING/ MAINTENANCE OF THE VANS	<p>TOTAL COST OF THE PROJECT IS 6,50,000. RS. 5 PER KM AS USER FEE. FREE SERVICES TO 10% CASES,(BPL PATIENTS). MEMBERS OF WOMEN'S SELF HELP GROUP GET 10% CONCESSION. THIS TYPE OF INITIATIVES WILL BE SUCCESSFUL IF LARGE NUMBER OF AMBULANCES ARE CONTRACTED WITH LEAST IDLE TIME AND RATE IS SUBJECT TO REVISION WHEN HIKE BY GOVT</p>
LOW SANITATION AND LAUNDRY STANDARDS	CONTRACTING OUT/NGO PARTNERSHIP	GOVERNMENT OF UTTARANCHAL HAS HANDED OVER LAUNDRY SERVICES IN 9 BIG HOSPITALS TO PRIVATE AGENCIES IN DECEMBER 2001 WHILE THOSE IN DOON HOSPITAL WERE HANDED OVER IN FEB 2003	IMPROVED SANITATION AND LAUNDRY	<p>THESE AGENCIES HAVE BEEN SELECTED ON THE BASIS OF THE COMPETITIVE BIDDING.</p> <p>MANPOWER, CONSUMABLES, EQUIPMENT AND SALARY TO EMPLOYEE</p>

				SHOULD BE CAREFULLY DRAFTED IN AGREEMENT OTHERWISE SITUATION WILL GET WORST
DIETARY SERVICES	CONTACTING IN WITH PRIVATE CATERERS ON COMPETITIVE BIDDING BASIS	ALONG WITH THE LAUNDRY/ SANITATION SERVICES THE GOVT. OF UTTANCHAL HANDED OVER THE DIETARY SERVICES AS WELL IN THE FOR MENTIONED HOSPITALS	HYGIENIC AND NUTRITIOUS FOOD WITHOUT EXTRA BURDEN ON INFRASTRUCTURE	THE SELECTION OF THE PRIVATE PARTNER WAS ON THE BASIS OF THE COMPETITIVE BIDDING BY THE HOSPITAL AUTHORITY. POOLING OF ANCILLARY SERVICES WILL RESULT INTO BETTER PROFIT TO CONTRACTOR. STRICT CONDITIONS ABOUT COMPETENCE OF CONTRACTOR AND JOB TO BE DONE IS NEEDED
HEALTH INSURANCE COVERAGE TO THE STATE POPULATION	COMMUNITY BASED HEALTH INSURANCE ALSO CALLED SELF FUNDED HEALTH INSURANCE SCHEME. HOWEVER THE SCHEME IS NOT FULLY SELF FUNDED BECAUSE IT REQUIRES GOVERNMENT CONTRIBUTION	YESHASVINI-CO-OPERATIVE FARMER'S HEALTH CARE, KARNATAKA. PARTNERSHIP BETWEEN NARAYAN HRUDAYLAYA BANGALORE & APOLLO HOSPITALS HYDERABAD, TRUST WAS LAUNCHED IN 2002	PROVIDE SURGICAL CARE THROUGH LOW PREMIUM HEALTH INSURANCE. COVER NEARLY 1600 TYPES OF SURGERIES. FREE OUT-PATIENT CONSULTATION. MEDICAL AND DIAGNOSTIC INVESTIGATIONS AT NOMINAL RATES. SCHEME COVERS EVEN PREEXISTING ILLNESSES.	1,600 DIFFERENT SURGERIES COSTING UP TO A MAXIMUM OF RS. 200,000.MEDICAL TREATMENT NOT LEADING TO SURGERY IS NOT COVERED. GOVT. OF KARNATAKA ORIGINALLY CONTRIBUTED 50% OF MONTHLY PREMIUM FOR EACH MEMBER NOW ONLY A CONSOLIDATED AMOUNT (OF RS. 3.5 MILLION IN THE SECOND YEAR AND 1.5 MILLION IN THE THIRD YEAR) . FHPL IS PAID 4% OR AROUND RS. 5.9 MILLION AS THEIR FEE.  COMMITTED GOVT CONTRIBUTION ON LONG TERM BASIS AND TIMELY COLLECTION OF CONTRIBUTION IS MUST. RATHER CREATING NEW HOSPITALS, GOVT MAY ENCOURAGE SUCH SCHEMES ON LONG TERM BASIS
AT CHC/ PHC LEVEL				

IMPROPER MANAGEMENT	CONTRACTING OUT WITH THE PRIVATE SECTOR	MANAGEMENT OF PRIMARY HEALTH CENTERS, KARUNA TRUST, KARNATKA A NON PROFIT NGO, FROM 1996 ON TRIAL BASIS , BUT BASED ON FORMAL POLICY DECISION, SINCE 2002	IMPROVED MANAGEMENT WITH THE SAME/LOW BUDGET	GOVT. PROVIDES PHC PREMISES, INITIAL EQUIPMENTS AND SUPPLIES, AND 75% TO 90% SALARIES. STAFFING BY THE NGO. RS. 25000 PER ANNUM AS CONTINGENCY. RS. 75000 PER ANNUM FOR DRUGS/ SUPPLIES. FREE HEALTH CARE TO ALL PATIENTS. SELECTION OF WORKERS SHOULD BE THE PREROGATIVE OF NGO., GOOD WORKING AND POOR WORKING FACILITIES SHOULD BE JOINTLY HANDED OVER. INCREASE IN SALARY OVER TIME MAY BE KEPT IN MIND. APPRAISAL BY THIRD PART IS MUST. GOOD FINANCIAL MGT IS KEY TO SUCCESS
POOR OUTREACH AND REFERRAL SERVICES FOR SLUM POPULATION.	CONTRACTING OUT TO PRIVATE ORGANIZATIONS	ARPANA SWASTHYA KENDRA MOLARBUND, DELHI, IN PARTNERSHIP WITH MCD. PERFORMANCE MEASURES ARE SET FOR THE TRUST, INITIAL CONTRACT IS FOR 5 YEARS.	DISTRIBUTING THE BASIC HEALTH PRODUCTS SUCH AS CONTRACEPTIVES, ORS, CLEAN DELIVERY KITS TO THE SLUM DWELLERS THRU EXISTING COMMERCIAL NETWORK FUNDS POOLED FROM RS. 10 FOR OPD CARDS INCLUDING MEDICINES FOR 3 DAYS, RS. 50 TO 100 FOR EMERGENCY AMBULANCE SERVICES.	PERSONALITY DRIVEN PROJECT. LACK OF CLARITY ON USER-FEE, SHORTAGES OF RESOURCES COMMON. LONG PROCEDURES, OVERCROWDING, LACK OF FOLLOW UP ACCEPTABLE QUALITY OF SERVICES ; COMMITTED STAFF.  EXISTING PVT PRACTITIONERS MAY BE TRAINED AND INVOLVED WITH INCENTIVE OF PER UNIT OF SERVICE. EXISTING PPM APPROACH OF RNTCP CAN BE HELPFUL INITIALLY, SOME SEED MONEY MAY BE GIVEN TO START THE

				PROJECT COOPERATIVE SOCIETIES MAY BE ROPED- IN
UNDER STAFFING OF THE MEDICAL OFFICERS/ ANMS	APPOINTING MEDICAL OFFICERS & ANMS ON CONTRACTING IN BASIS	UTTRANCHAL GOVT. HAS MADE EFFORTS IN APPOINTING MEDICAL OFFICERS & ANMS. THIS HAS BEEN DONE IN VIEW TO IMPROVE HEALTH SERVICES IN REMOTE AREAS AND GIVEN THE DIFFICULTY IN RETAINING SERVICES OF PROVIDERS DUE TO LACK OF ACCOMMODATION AND LOW SALARY.	NO EXTRA BURDEN ON INFRASTRUCTURE AS FUNDS CAN BE POOLED FROM THE FUNDS UNSPENT DUE TO VACANT POSITIONS	TO RETAIN THE SERVICES GOVT. HAS INCREASED THE HONORARIUM OF CONTRACTUAL MEDICAL OFFICERS FROM 11,000 PER MONTH TO RS. 13000 PER MONTH W.E.F. FEB 2004. IN ORDER TO PROMOTE INSTITUTIONAL DELIVERIES, 24 HOURS DELIVERY SERVICES ARE BEING PROVIDED IN 85 HEALTH CENTERS AND CERTAIN INCENTIVES ARE PROPOSED FOR SERVICE PROVIDERS WHO CONDUCT DELIVERIES BETWEEN 8.00 PM TO 7.00 AM. LOCALLY PRACTICING DOCTORS AND STAFF MAY BE GIVEN PRIORITY AS THEY MAY FIND THE AMOUNT ACCEPTABLE. REGULAR REVIEW OF SCHEME IS NEEDED
NATIONAL HEALTH PROGRAMMES				
FAMILY WELFARE PROGRAMME	CONTACTING WITH THE NGOS	1459 PRIVATE HOSPITALS ARE APPROVED FOR PERFORMING VASECTOMY, TUBECTOMY, MTP AND OTHER CONTRACEPTIVES.	GOVT. PROVIDES BASIC SERVICES WHERE NGO CAN PROVIDE BEDS, SURGICAL ITEMS TO PERFORM STERILIZATION SERVICES	DRUGS CHARGES AND OPERATING SURGEONS FEES ARE PAID BY THE GOVT. PAYING COMPENSATION TO STERILIZATION ACCEPTOR. OPERATIONAL COST IN GOVT SET-UP MAY BE CONSIDERED AS SERVICE CHARGE TO PVT PROVIDERS. ADVANCE PAYMENT WILL IMPROVE PERFORMANCE
CATARACT	CONTRACTING	CERTAIN NGOS LIKE	NGOS CAN PERFORM	SOME 100 PRIVATE

BLINDNESS CONTROL PROGRAMME	WITH PRIVATE SECTOR (NGOS)	VHS, CHRISTIAN MISSION HOSPITAL, ANDHRA MAHILA SABHA, F.P.A.I. ETC. ARE GIVEN ANNUAL GRANTS BY GOVERNMENT FOR THEIR RECURRING EXPENDITURE. THIS IS APPLICABLE TO CERTAIN DISPENSARIES RUN BY NGOS IN TRIBAL AREAS ALSO.	CATARACT SURGERIES, ARRANGE EYE CAMPS WHERE GOVT PROVIDES FINANCE.	HOSPITALS ARE APPROVED FOR UNDERTAKING MAJOR SURGERIES UNDER THE ABOVE SCHEME.  ONLY ACCREDITED NGOS HAVING SKILLED MANPOWER SHOULD BE CONSIDERED.
TB CONTROL PROGRAM	PARTNERSHIP WITH PRIVATE PRACTITIONER TO GIVE IEC ON THE DOTS SCHEME AND FOR IDENTIFICATION AND TREATMENT OF THE PATIENTS, GOVT. LABS ARE OPEN FOR THE USE BY THE PRIVATE PRACTITIONER FOR TB DIAGNOSIS	MAHAVIR TRUST HOSPITAL, HYDERABAD , SEWA AT AHMEDABAD AND, MANAV SARTHAK KUSTHASHRAM, JAIPUR ARE SOME OF THE SUCCESS STORIES	SPREADING AWARENESS THROUGH PRIVATE DOCTORS IS COST FREE, OPENING THE LABS FOR USE BY THE PRIVATE DOCTORS CAN DIAGNOSE MORE TB PATIENTS AND TREATMENT OF THE SAME	HOSPITAL CREATES A REFERRAL CARD , INITIAL DIAGNOSIS , COUNSELING , AND TREATMENT PROTOCOL AND REFERS THE PATIENT TO DESIGNATED DOTS CENTER FOR DRUGS. GOVT PROVIDES FREE DRUGS AND MEDICINES TO THE DOTS CENTERS ALSO TRAIN MEDICAL STAFF, PROVIDES LAB SUPPLIES, PRIVATE MEDICAL PRACTITIONERS REFER PATIENTS MODEL OF RNTCP HAS STRONG POTENTIAL FOR ADOPTION IN ALL NHPS
AIDS CONTROL PROGRAMME	PARTNERSHIP WITH NGOS TO SPREAD AWARENESS ABOUT THE HIV/ AIDS , MAKING FREE CONDOMS AVAILABLE TO THE PEOPLE BY NGOS		WITH NO EXTRA COST GOVT CAN SPREAD HIV/ AIDS AWARENESS AND PROVIDE CONDOMS TO THE PEOPLE	MONITORING IS MUST
PULSE POLIO PROGRAMME	PARTNERSHIP WITH PRIVATE DOCTORS / NGOS. NGOS CAN CONDUCTS PULSE POLO CAMPS, PRIVATE DOCTORS CAN GIVE POLIO DROPS TO THE UNDER FIVE CHILDREN THOSE WHO VISITS THEM AS PATIENTS OR WITH PATIENTS		WITH INVOLVEMENT OF PRIVATE PEOPLE PROGRAMME CAN BE IMPLEMENTED MORE EFFECTIVELY WITHOUT ANY BURDEN ON EXISTING INFRASTRUCTURE	VACCINE PREVENTABLE DISEASES ARE ALSO ISSUED FREE OF CHARGE TO PRIVATE NURSING HOMES FOR THEIR USE
RCH PROJECT	CONTRACTING WITH THE PRIVATE HOSPITAL	UNDER RCH PROJECT	EFFECTIVE AND ECONOMIC RCH & FAMILY WELFARE	FUNDS FOR THE SCHEME WILL BE

	<p>UNDERTAKE LSCS SURGERIES WHERE GOVT SERVICES ARE NOT AVAILABLE, FEES ARE MET BY GOVT. HOSPITAL, OBSTETRICIANS , ANESTHETIST CAN BE HIRED FOR LSCS SURGERIES IN GOVT HOSPITAL WHERE THEY ARE NOT AVAILABLE. MTP SERVICES ARE ALSO PROVIDED IN THE PRIVATE HOSPITALS AGAINST THE VOUCHERS WHICH REIMBURSED AFTER EVERY MONTH FROM THE STATE GOVT.</p>	<p>INNOVATIVE MODEL LIKE VIKALP ARE GOING ON.</p> <p>DELIVERY HUTS MAY BE HANDED OVER TO NGOS ALREADY INVOLVED IN RCH</p>	<p>SERVICES CAN BE PROVIDED TO THE PEOPLE</p>	<p>PROVIDED FROM THE DEPARTMENT OF HEALTH, HARYANA TO THE MOTHER NGO FOR FURTHER PAYMENT. THE PAYMENT WILL BE MADE OUT OF THE FUNDS AVAILABLE VOUCHER SCHEMES UNDER THE RCH II PROGRAMME. AN AMOUNT OF RS 1.5 CRORES IS AVAILABLE FOR IMPLEMENTING VOUCHER SCHEMES IN THE YEAR 2005-07. THE NORMS FOR PAYMENTS WILL BE FINALIZED AFTER NEGOTIATION BETWEEN MNGOS AND PRIVATE PROVIDERS.</p> <p>ADVANCE PAYMENT IN FIRST QUARTER MAY BE EXPERIMENTED</p>
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## MODELS OF PUBLIC PRIVATE PARTNERSHIPS

Various models can be utilized for putting these partnerships into action; some of the possible mechanisms for implementation of PPP are given below:

### 1. Franchising

Franchise is a type of business model whereby a manufacturer or marketer of a product or service (the franchiser) grants exclusive rights to local independent entrepreneurs (franchisees) to conduct business in a prescribed manner in a certain place over a specified period. Typically the franchiser has developed specialized skills, knowledge, and strategies and thus able to share its blueprint for a successful product line with franchisees. The franchisees contribute resources of their own to set up a clinic and pay membership to franchiser.

**Partial Franchising:** Most of the social franchising models followed in India are partial franchising models. Franchiser identifies private hospitals and enters into an agreement with franchisee to provide certain services in lieu of payment of fee or commissions from sale of services and goods. These contracts largely confine to a basket of RCH services. However franchisee provides many other services that are not part of the contract. There is no control over quality of services provided by franchisee outside the contract.

Usually one-year subscription fee is given by franchisee to franchiser. In this arrangement, increased performance of franchisee does not lead to increased revenues to franchiser. There is no incentive to franchiser to improve performance through promotional activities. One way to overcome this problem is to have a revenue sharing arrangement between franchiser and franchisee. However many of the hospitals are not transparent about their financial transactions or do they maintain complete record of services provided. One of the innovative aspects of these social franchising efforts is to link rural medical practitioners and/or community based organizations such as SHG to franchisee that has helped to increase the client load for RCH services. The partial franchising efforts in India do not represent public-private partnerships but offer a model and experiences that are highly relevant. Government can have its own model of social franchising with franchiser-franchisee-RMP-CBO linkages. Concentration of private hospitals/ nursing homes in urban areas has to be taken into consideration. In many rural and inaccessible areas where the need for improved access to services is the highest, there are not private hospitals/nursing homes.

**Full Franchising:** Franchisee provides services defined by the franchiser and expansion of range of services depends on mutual agreement. For existing nursing homes and hospitals, this can mean a considerable revenue loss and this has to be filled in by subsidies till the client load improves and the hospitals start making operating profits. Time required for transition of loss making unit to profit making unit depends on a variety of factors such as location of hospitals, demand for services, perceived quality of services and competition. Not many hospitals may opt for this given the uncertainties in financial returns, unless guarantees are given to sustain the model for a long period of time.

### 2. Branded Clinics:

A few organizations have started a chain of branded clinics that offer a wide range of reproductive and child health services. There is scope to expand the range of services provided by these clinics and add social mobilization efforts to their functions. These branded clinics can be opened in areas where there is a need with minimum effort. Branded clinics are more sustainable because of their ability to generate more income than social franchising units.



### **3. Contracting Out**

Contracting out refers to a situation in which private providers receive a budget to provide certain services and manage a government health unit. The two parties usually agree on some or all of the following: the quantity and the quality and the duration of the contract.

Common criteria for identifying those government health clinics that need to be contracted out are the first step in this direction. Large number of vacancies for a long period, high absenteeism, and consistent low performance on all RCH indicators could be the critical criteria.

Some states are more prepared for contracting out services compared to others. Fear of losing jobs and perceived shrinking role of government in health sector are the main reasons for resistance. Advocacy efforts are required in those states where resistance levels are high for contracting out services.

There are several levels at which the contracting out can be done depending on the degrees of freedom given to the contractor. Higher the freedom, higher should be the performance levels of key RCH indicators.

- Option 1: Government hands over the physical infrastructure, equipment, budget and personnel of a health unit to the selected agency.
- Option 2: Government hands over the physical infrastructure, equipment, budget but gives freedom to the selected agency to recruit personnel as per their terms and conditions but following the government norms such as one ANM per 5,000/3,000 population.
- Option 3: Government hands over the physical infrastructure, equipment, and budget but gives freedom the select agency to have their own service delivery models without following the fixed prescribed pattern.
- Option 4: Government hands over the physical infrastructure, equipment, budget and gives freedom to the select agency to have their own personnel, service delivery models, freedom to expand types of services provided and freedom to introduce user fee and recover some proportion of costs.

### **4. Contracting In**

Contracting in is done for a variety of services particularly in major hospitals. These include: maintenance of buildings, utilities, housekeeping, meals, medicine stores, diagnostic facilities, transport, security, communications etc. Hospitals are given freedom to choose the services to be given to contractors. In many cases they lack comprehensive plans and sound financial analysis. Nevertheless, contracting in many hospitals has resulted in conservation of resources, improved efficiency and better quality of services. Contracting in services leads to surplus human resources and they need to be transferred to other health units to fill in vacant positions, if any. Resentment of employees and interference of trade unions are some of the major obstacles to this process.

Contracting in does not work in some places for particular types of services. For instance some state governments could not attract private sector participation for diagnostic services in remote area hospitals with low client load. One option is to subsidize the equipment purchased by private agencies and the other is to make services located in government hospitals open to all. Even a person with prescription from private clinic should be allowed to use privately run diagnostic facilities in government hospitals. This increases the volume of transactions and makes the unit financially viable.

Recruiting doctors, technicians and other staff on contractual basis for a stipulated period of time is widely practiced in several states. In some cases the contracted staff performs all duties of regular staff and in other instances, their services are contracted for a few days in a month and to provide services in a particular clinic. In many states, a large proportion of vacant positions were filled in following this process.

## **5. Social Marketing**

One of the earliest efforts at building public-private partnerships is in the area of social marketing of contraceptives. For more than a decade, HLL, ITC, Indian Oil and other large FMCG companies helped the government with social marketing of contraceptives by piggy backing Nirodh to their products. Later private social marketing companies have emerged as a force to reckon with and gained considerable experience in marketing contraceptive products both social and commercial. The increasing trend now is to enlarge the basket of products by including ORS, IFA tablets, and other health products to make the marketing efforts more self-sustaining. Government provides the subsidized contraceptives, and finances brand and point of purchase promotion schemes of selected marketing agencies.

## **6. Build, Operate and Transfer**

Build, operate and transfer (BOT) models are highly successful in infrastructure development sector in India. BOT requires part financing of projects by the government, financial guarantees when needed, subsidized land at prime locations and assurance of reasonable returns on investment. These models could be useful to establish large hospitals and ensure quality services at reasonable rates to poor people. However these hospitals should be able to withstand market competition to survive and sustain themselves.

## **7. Joint Venture Companies**

Joint venture companies are companies launched with equity participation of government and private sector. Proportion of equity of each partner may vary from one venture to another. Joint venture companies, in most cases in commercial sector, have not succeeded in India due to lack of understanding and trust between partners, inordinate delays in decision-making and dominance of government even with low equity. There is even less chance of their succeeding in health sector.

## **8. Voucher System**

A voucher is a document that can be exchanged for defined goods or services as a token of payment (tied-cash"). This consists of designing, developing and valuing health packages for various common ailments / conditions (like ANC package / STI package / Teen pregnancy package / family planning package etc) which can be bought by the people at specific intervals of time. These vouchers can then be redeemed for receiving a set of services (like 1-2 consultations, lab tests, procedures, counselling and drugs for the condition) from certified / accredited hospitals or clinics and are to be used within 2-3 months of buying the voucher. This means that the package can be bought, used as and when required and ensures privacy for the client.

Regular monitoring is required for ensuring quality standards, training of providers and networking with the people to ensure that the proper use of vouchers. The vouchers are redeemed to the clinics for the number utilised depending on the price for each package of service provided. Clinics that fail the quality standards of service and do not do well on patient satisfaction can be removed from the certified services.

## **9. Donations from individuals**

Within a large country like India and with a creditable high income and middle income groups there are many examples of private donors willing to partner with the public sector. Rich philanthropists, individual donations may be the crucial requirement in areas to make the PPP initiative effective in delivering health care. Though in some states mechanisms and provisions are present for utilizing these private donations for improving local health situation, many other states lack these systems. Efforts have to be made to create simple and transparent institutional mechanisms to encourage donations to contribute to the growth and improvement in reproductive and child health services in their area.

#### **10. Partnerships with Social Clubs and Groups (e.g. Rotary Club)**

Clubs like Rotary and Lion's played a significant role in immunization campaigns, Pulse Polio campaign and other health care services. Since these clubs have a nation wide network, their involvement ensures better coverage. They also bring in their expertise and resources to the health care services.

#### **11. Involvement of Corporate sector:**

The corporate sector has a rich history of being supportive of the health and family welfare interventions for people that work in and live around its premises. Under Corporate Social Responsibility, the corporate sector through the Confederation of Indian Industries (CII) and the Federation of Indian Chamber of Commerce and Industries (FICCI) and several other sector wise business and industry associations have played a significant role in advocacy efforts, funding non-government organizations for innovative interventions, introducing new schemes to encourage service utilization and expending their own resources for promotion of reproductive and child health services particularly family planning services..

#### **12. Partnership with Professional Associations**

There are several professional associations such as Indian Medical Association, Gynaecologists federation, nurses associations etc. These association from time to time extended help in launching new programmes such as Vande Mataram Scheme, Gaon Chalo project and immunization programme particularly pulse polio. They have technical skills and expertise to provide advice on various other matters such as setting standard protocols, quality assurance systems and accreditation. However the managerial capacities of these professional associations have to be strengthened.

Moreover, with widespread chapters/ branches all over the country and huge membership they can play a very important on ethical issues.

#### **13. Capacity building of private providers, pharmacists and informal providers (RMPs)**

Several initiatives taken by the government in the past to improve the technical and counselling skills of private medical practitioners particularly rural medical practitioners by providing them training improved quality of services offered by them. Since they have a huge presence in rural areas and urban slums and a significant proportion of population depend on them for services, there is a need to involve them in a significant way to create demand for services and in making referral system effective. Similarly government medical officers and administrator benefited by participating in training programmes conducted by private institutions. Consultancy services offered by private institutions in the areas of communications, systems development etc is another example of public-private partnership. Another area of partnership is contracting out management of training institutions such as ANM Training Centres, Regional Training Centres to NGOs and private agencies.

#### **14. Special "Category Campaigns" with the private sector to improve health**

The WHO-ORS campaign and the Goli- ke- Hamjoli campaigns are examples of the use of the commercial sector to advance national health goals. The category campaigns expand use of a health/family-planning product, increases the volume and the users for the product. In India, the Goli ke Hamjoli and WHO-ORS campaigns succeeded in increasing product awareness, availability, sales, and use. At the same time, this entails using a generic promotional strategy, increased private-sector investment and the value of the market, policy change; coordination with partner pharmaceutical firms; affiliation with professional associations; expansion of market channels; and consumer outreach. Initially, the program should use mass media vehicles to improve product awareness and contemplation. But, as the program develops, its emphasis should shift to encouraging product trial, and use interpersonal approaches to reach out to potential consumers.

These special campaigns in partnership with the private sector can focus on demand generation for refurbished and revitalised public sector, generic promotion of health products (life saving ORS, Menstrual Hygiene with Sanitary Napkins etc).

### **15. Autonomous Institutions**

Giving autonomy to public institutions within the system can lead to improvement in quality, accountability and efficiency. It also ensures greater involvement and ownership at the level of the institution, ensuring greater morale and encouragement to the work-force. Many such projects have been implemented and have shown to yield excellent results, as the need for the change in management systems is self-driven. This is also sustainable and easy to replicate.

### **16. Partnering with CBOs / NGOs**

For designing and implementing innovative approaches to RCH services, partnerships with community based organizations and non-government organizations are a significant step. Government for long encouraged participation these grass roots organizations in demand creation and delivery of services. These organizations often worked in remote rural areas where access to RCH services is difficult. Recent NGO Policy of the MOHFW envisages a scheme where each district would have a mother NGO and linked to several field NGOs within the district with greater degree of autonomy and decentralization. Community mobilization efforts yield effective results and community ownership of the programme is sustainable.

### **17. Mobile Health Vans**

In geographical areas with difficult terrain with no transport facilities and poor road connectivity usually the outreach and institutional services of PHCs are not to the expected standards. This has resulted in gross under utilization of services. To overcome this problem, in some states private sector agencies have taken a lead in launching mobile vans. These vans go to clearly identified central points on fixed days and provide comprehensive health services including RCH services to a cluster of villages. While private sector resources were put to use to purchase vans, the government contributed to these services by deputing medical officers and medicines. This approach has significantly helped to improve access to quality services.

### **18. Insurance and Public-Private Partnerships**

In one of the recently planned schemes, the government insures and pays health insurance premium for families below poverty line. These families in turn are insured against expenses on health and hospitalization, up to a certain amount. On similar principle, it is possible to develop sustainable health insurance schemes that are community based. In such schemes, the community members pay a minimum insurance premium per month and get insured against certain level of health expenditure. This protects them from sudden and unexpected expenditure on health. Such community based schemes also ensure that the local needs and expectations of the people are met, by preferentially reimbursing local trained healthcare providers.

### **CLASSIFYING PPPs**

Since public-private partnerships vary significantly, it is necessary to categorize them in order to understand their nature and thrust areas of partnerships. Some of the partnerships are for short duration or one time activity and others are for long term. These partnerships also work in specific thrust areas. Some of the partnerships may cover all thrust areas and others one or more.

<b>Nature of PPP</b>	<b>Examples</b>
One time /Short term Partnership	Donation of land, money, equipment etc Participation in campaigns
Continuous / Long term partnership	Social franchising of service Contracting In and Out Social marketing Capacity building

Thrust areas of partnership	Examples
Service oriented	Social Marketing Social Franchising Contracting healthcare providers Mobile vans
Information oriented/Advocacy oriented	Contracting out IEC activities to NGOs Category Campaigns with Private Partners
Infrastructure oriented	Construction of buildings Repairs to buildings Equipment, Vehicles
Capacity building oriented	Training for skill development and counselling Systems development Managerial capacity

### **CRITERIA FOR INITIATING PPPs**

Types of public-private partnerships relevant for a particular state depend on prevailing conditions, needs and functional requirements. Some criteria by which the public-private partnerships should be selected are given below, as follows:

Form of Partnership	Criteria for initiation
<b>1. Franchising</b>	<ul style="list-style-type: none"> <li>• The effort to revitalize the complete govt. infrastructure is time consuming and a slow process</li> <li>• Resources required to expand public health infrastructure is enormous.</li> <li>• Need for services is enormous and the government health institutions are not in a position to cater to needs</li> <li>• Availability of vast network of private hospitals in places needed</li> <li>• When objective is to improve access to services on immediate basis.</li> <li>• Improve quality standards of private sector and provide high quality care at affordable prices.</li> </ul>
<b>2. Branded Clinics</b>	<ul style="list-style-type: none"> <li>• Need to expand services rapidly</li> <li>• Provide high visibility to clinics</li> <li>• Offer a package of services selected for the purpose</li> <li>• High quality services at affordable prices</li> </ul>
<b>3. Contracting Out</b>	<ul style="list-style-type: none"> <li>• Difficult to manage government health units in remote and inaccessible areas</li> <li>• Utilization of services and performance levels are consistently low due to non-availability of staff</li> <li>• Aim is to put government health facilities to optimum use</li> <li>• Increase responsiveness of government health facilities to local needs through community involvement</li> </ul>

<b>4. Contracting In</b>	<ul style="list-style-type: none"> <li>• Improve efficiency levels of services provided</li> <li>• Make management of services more effective</li> <li>• Conserve scarce resources by cutting costs</li> <li>• Try out innovative approaches to improve efficiency and effectiveness</li> </ul>
<b>5. Social Marketing</b>	<ul style="list-style-type: none"> <li>• Combine service delivery with demand creation</li> <li>• Availability of products in a vast network of easily accessible retail outlets</li> <li>• Encourage brand choices and competition to improve penetration levels</li> <li>• Perceived value attached to priced products than products distributed free of cost</li> </ul>
<b>6. Build Operate Transfer (BOT)/ Joint Ventures</b>	<ul style="list-style-type: none"> <li>• An enormous number of service delivery points whether hospitals, labs or diagnostic centres have to be constructed within a short span of time.</li> <li>• When the cost of building and maintaining a unit is prohibitive for the govt. to bear alone</li> <li>• When returns on investment are guaranteed.</li> <li>• Government treats health as infrastructure industry.</li> </ul>
<b>Voucher System</b>	<ul style="list-style-type: none"> <li>• Improve access to services and provide choice</li> <li>• Costs act as a major barrier to services</li> <li>• Existing service delivery points do not have provision to all types of services</li> <li>• Inadequate knowledge about the value of service (eg importance of antenatal care)</li> <li>• Generate demand for services particularly among poor and disadvantaged sections</li> </ul>
<b>8. Donations from individuals</b>	<ul style="list-style-type: none"> <li>• Presence of affluent families, philanthropic organizations</li> <li>• Identified needs to improve quality of services</li> <li>• Clear procedures and guidelines to accept donations</li> <li>• Transparent and accountable systems that enhance image of institutions</li> </ul>
<b>9. Partnerships with Social Clubs and Groups (eg. Rotary Club)</b>	<ul style="list-style-type: none"> <li>• Partnerships to popularise revitalized service points, communication campaigns and logistics management</li> <li>• Organization of camps on a large scale</li> <li>• Need for additional resources and also management and technical expertise</li> <li>• Need to step up advocacy efforts</li> </ul>
<b>10. Involvement of Corporate sector</b>	<ul style="list-style-type: none"> <li>• Resources to outreach services through NGOs in remote areas</li> <li>• Effective services to employees in organized sector</li> <li>• Policy advocacy efforts</li> <li>• Adoption of villages or CHCs/PHCs by corporate health sector to improve services.</li> </ul>

<b>11. Partnership with Professional Associations</b>	<ul style="list-style-type: none"> <li>• Presence of active professional associations with clear guidelines</li> <li>• Internal committees to promote ethical practices</li> <li>• Management expertise to implement projects</li> <li>• Need to prepare standard protocols, quality assurance system by building consensus</li> <li>• Improvement of technical skills of professionals in both private and public sectors</li> <li>• Improve professional response to programme needs</li> </ul>
<b>12. Capacity Building of Private providers, pharmacists and Informal providers (RMPs)</b>	<ul style="list-style-type: none"> <li>• High dependence of people on private sector for services</li> <li>• Technical knowledge and skill levels are not to a desirable standard</li> <li>• Improve quality standards of providers and increase access to quality services</li> <li>• Put in place an effective referral system</li> <li>• Involve services providers in social marketing efforts</li> </ul>
<b>13. Special "Category" Campaigns with the Private Sector to improve health</b>	<ul style="list-style-type: none"> <li>• When the need to promote a service or health care product is established</li> <li>• Multiple partner involvement is required to promote a product</li> <li>• Advocacy efforts to make product acceptable at all levels</li> </ul>
<b>14. Autonomous Institutions</b>	<ul style="list-style-type: none"> <li>• Need to upgrade quality of services and initiate use of state-of-the-art technology in health care delivery</li> <li>• Provide enough flexibility to health units</li> <li>• Improve efficiency and effective levels of management</li> <li>• Reduce costs and facilitate quicker decision-making</li> <li>• Allow institutions to generate alternate sources of funding</li> </ul>
<b>15 Partnering with NGOs/CBOs</b>	<ul style="list-style-type: none"> <li>• Encourage community involvement</li> <li>• Improve community ownership of programme</li> <li>• Test innovative and cost-effective approaches to service delivery</li> <li>• Cover inaccessible and remote areas</li> </ul>
<b>16. Mobile Clinics</b>	<ul style="list-style-type: none"> <li>• Provide access to services people living in inaccessible terrain</li> <li>• Make services available at central location to reduce travel time and costs of clients</li> <li>• Improve utilization of services in remote areas</li> </ul>
<b>17. Insurance Schemes</b>	<ul style="list-style-type: none"> <li>• Focus on poor and disadvantaged</li> <li>• Provide services at affordable costs</li> <li>• Long term solution to health problems</li> <li>• Improved choice of health units</li> <li>• Reduce indebtedness among poor due to health costs</li> </ul>

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## CHIRANJEEVI-THE CONCEPT

- For reduction in maternal and child deaths / access and equity
- In five backward districts
- For EmOC and Em transport services
- With weak Public Health Facilities in Obstetric care
- In Partnership with FOGSI
- For making available private specialists to BPL pregnant woman
- Unit cost Rs 1795/- based on package of services includes:

## CHIRANJEEVI-THE CONCEPT-II

- Rs200/- for transport to pregnant mother
- Rs 50/- for midwife or attendant
- Pvt gynaecologist pays above and avails reimbursement
- ANC Registration in a Govt facility a must
- Advance of Rs 15000/- to the pvt gynaecologist
- CDMHO empanels and monitors

**DISTRICT-WISE PERFORMANCE OF  
DELIVERIES UNDER CHIRANJIVI YOJANA,  
GUJARAT  
Progress Dec 05- March06**

District	Total number of Private specialists	Number of Private specialists enrolled	Deliveries under Chiranjivi Yojana till	Average performance per Doctors
Panchmahal	29	27	2313	86
Sabarkhanta	73	46	1897	41
Banaskhanta	50	52	1436	28
Kutch	47	20	726	36
Dahod	16	18	1421	79
Total	215	73.6%	7793	48

## CHIRANJEEVI-OUTCOMES

- 163 MoUs signed. 76% enrollment
- 87% Normal and 5% Caesarian delivery
- Avg Delivery per specialist is 48
- 31% (2415)of 7793 BPL pregnant mothers have delivered
- No maternal death reported. As per MMR 30 mothers would have died
- 9 infant deaths reported. As per IMR 350-450 infants would have died
- Access of BPL pregnant mothers to institutional delivery

## ARUNACHAL PRADESH EXPERIMENT : THE CONCEPT

- Pilot Project: 90% Govt 10% NGO
- State hand over infrastructure of PHC/SC to Agency
- State to provide cost towards personnel, drugs and consumables

## THE CONCEPT(2)

- **Agency to engage its own staff and ensure availability 24X7**
- **Staffing Pattern**
  - ⇒ **MO - 2**
  - ⇒ **Pharmacist - 1**
  - ⇒ **Staff Nurse – 2**
  - ⇒ **ANM – 2 (PHC)/ 6 (SC)**
  - ⇒ **LHV – 1**
  - ⇒ **lab tech – 1**
  - ⇒ **Driver – 1**
  - ⇒ **HA (Jr.) – 1**
  - ⇒ **Group D - 4**

## THE CONCEPT (3)

- Agency to provide all services expected of a PHC
- PHC Management Committee-RKS
- State Steering Committee
- National level NGOs
- Exit policy for Agency and Govt
- Audit and Accounting
- Output based performance indicators
- Outreach Activity
- Implementation of National Programmes
- External Evaluation/Concurrent evaluation

## PARTNERS IN AP

- Karuna Trust : 9 Districts
- VHAI :5 Districts
- JAC(Prayas) : 1 District
- FGA, Itanagar : 1 District