NATIONAL CONFERENCE REPORT

"Emerging health care models: Engaging the private health sector"

25th – 26th September 2009
YMCA, Mumbai

by
Tejal Barai – Jaitly

Organized by
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Padma Deosthali
Co-ordinator
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Introduction

It is now widely accepted that engaging the private health sector is essential to enhance quality and accessibility of health services. In this context, and particularly after it made its appearance in policy documents, there has been an upsurge of a large number of Public Private Partnerships (PPP) in healthcare. These are with the not-for-profit sector as well as with for-profit private sectors. PPP's have dominated discussions among policy makers, researchers and programme implementers.

However, the lack of regulation of the private sector, unethical practices, variable and unpredictable quality of care (across various private players within the sector itself) and violation of patient's rights; raises several concerns about its role in providing public health services through partnerships with the government. Private health sector has been one of the focus areas for research in CEHAT. This work has primarily focussed on regulation or lack of regulation of the sector - whether it is the nursing homes that operate without registration or norms for minimum standards or trust run hospitals that do not comply with the law to provide free beds to poor patients. One of its recent studies in Maharashtra illustrates the poor implementation of the Nursing Home regulation in the state. CEHAT has also worked with the medical profession to promote self regulation as a method for accreditation of their facilities. The not-for-profit sector, on the other hand, has limited reach. Between the reality of the private sector and the governments' designated role in providing healthcare, are contracts and partnerships; their nature, implementation, monitoring and impact. Research scholars have been studying PPP's and several health rights groups have been monitoring such partnerships. And yet, there is very limited literature and evidence emerging on the subject. Moreover, each PPP has their unique settings, goals, approaches and problems. It is necessary to gauge their relative success in adhering to the health goals and issues of quality, equity and access. These are the some of very grounds on which they are justified. We need to weigh their merits and demerits and debate and discuss the way forward. This is what prompted CEHAT to announce the present conference "*Emerging health care models: Engaging the private health sector".*

The conference was spread over two days and was divided into seven sessions. The announcement for the conference carrying an invitation to send abstracts and to participate was publicized widely. We received nearly 40 abstracts. The abstracts were studied and comments were sent to the selected authors along with an invitation to send us the full paper. There were some interesting mix of papers that bring forth perspectives and concerns on PPP's. There are some presented by NGO's that describe in detail their own work through PPP's. There are some evidence based papers that are grounded in studies conducted for the primary purpose of assessing the reality in some key PPP

projects. There are some papers by those who are part of various government agencies and departments and a paper that presents international experience in PPP's. cumulatively, a very interesting set of issues were raised and the much needed clarity was added in terms of the way forward for public private partnerships.

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Session I: PPP as a strategy: Issues and challenges

Key Speakers:
1. Dr. Rama Baru, "*PPP's as a strategy: issues and challenges - some reflections*".
2. Dr. Venkat Raman, "*Public Private Partnerships in health services*".

Presentation:
1. Dr. Ritu Khatri, "*Issues and Challenges in Regulation of Private Sector*", authored by Dr. Ritu Khatri and Ms. Padma Deosthali.

Chairperson: Dr. Vibhuti Patel

The conference began with a keynote address by **Dr. Rama Baru**. To begin with, she said that the state's engagement with the private sector, both 'for-profit' and 'not-for-profit', in health care has a long history and has undergone several transformations over the last six decades. The changing composition and role of these sectors in healthcare has given rise to a plurality of models that are broadly labelled as PPP's. These, however, do not necessarily fall within the purview of PPP's as described and accepted by the current literature on the subject. Moreover, the discussion around PPP's is often ideological – debating the role of the state in the changing scenario. However, Dr. Baru asserted that the problem with PPP's is much more than that. A review of available evidence on PPP, finds it fraught with numerous conceptual and methodological problems. Primarily, there needs to be a distinction between (rather than "lumping" together) the for-profit and not-for-profit sectors. Moreover, there is clubbing together of various forms of engagement between public and private sectors as "partnerships" due to lack of conceptual clarity. These are challenges for further exploration and debate towards which detailed and systematic study of PPP's is indispensable. Evaluation of the existing PPP's in terms of their efficacy and promotion of equity needs to essentially be based on theoretical frameworks (such as concepts of role, authority and power). This would also help determine whether they are sustainable, replicable and cost effective. This would also help decide if there is a need to revisit its primary rationale of cost effectiveness.

While Dr. Baru effectively opened up the debate on key conceptual and theoretical challenges of PPP, **Dr. Venkat Raman**, on the other hand, highlighted challenges within PPP projects per se. He begins by asserting the need for further studies in order to explore "partnerships" on the grounds of their justification and expectation. These justifications are - reducing out of pocket expenses and promote equity, increased accessibility to health care for difficult to reach areas and people, use of technologically advanced rational care and increased efficiency and deployment of more resources.

The various partnership models include contracting in, contracting out, franchising, social marketing, vouchers, social health insurance etc. Detailed and insightful descriptions of the various key landmark partnerships under these were also shared by Dr. Raman. Some of these include – Integrated Telemedicine and Tele-health in Karnataka, where there is free tele-diagnosis and consultation, treatment and medicines for cardiac and specialist care for all below poverty line (BPL) card holders; Uttranchal Mobile Hospital and Research Centre which provides free clinical diagnosis in the through health camps for BPL card holders in the hilly regions; management and of Primary Health Centres (PHC's) and sub-centres (SC) by Karuna Trust, Karnataka; the Yeshasvini Health Insurance Schemes for farmers who are members of the co-operative for hospitalization and care for more than 1600 surgeries; leasing of public hospitals (free or rental) in Bihar; etc. As evident, the various models of partnerships vary widely when it comes to the role played by the government, the private player, the "deliverable" through the partnership, the tangible impact, etc.

Most PPP projects face certain common challenges such as need for creation of enabling conditions, need for prior consultations, etc. Moreover, Dr. Raman observed, that partnerships based on mutually consulted arrangements are more effective than competitively selected partners. Moreover, according to him, the government does not have the technical and managerial skills as well as the willingness to take up an active oversight role in PPP. Successful PPP's today have been often driven by visionary leadership. The governments system of transfer of officials might lead to jeopardising the project in the absence of an overall enhancement of skills and expertise within the government departments. There is also the absence of specific performance or quality indicators and institutional systems for supervision and monitoring. Involving the private sector, according to Dr. Raman, has its own risks. The government has failed to regulate it, and in fact both "harmoniously coexist". Moreover, there is a serious lack of information about the private sector and the country has poorly implemented accreditation laws.

This lacuna is the premise of the study done by CEHAT as detailed in the next presentation by **Dr. Ritu Khatri**. It is a study based on the private hospitals in Maharashtra. The objectives were to assess the physical standards and quality of care and to understand the problems and the concerns regarding the existing BNHRA (Bombay Nursing Home Regulation Act, 1949) among the hospital owners in Maharashtra. Some of these relevant findings are - the average number of qualified nursing staff for each hospital is 1.68 per hospital. The rest of them are all either untrained or trained in-house. Even additional services like laboratory and x-ray are being provided by untrained staff. One-fourth of the hospitals do not give IPD (in patient) papers even on request, and half of them do not give OPD (out patient) papers. There is no independent mechanism for handling grievances and in fact in nearly 80% of the hospitals complaints had to be registered with the owner – doctor himself! The BNHRA, which is applicable to the entire state, has still not been implemented properly despite judicial intervention and civil society campaign. These findings clearly draw our attention to the question – is this the private sector we are willing to partner with for the provision of public services?

Discussion

In the context of power relationships, it was argued in the discussion with the participants of the conference, that if all the power lies with the government, there is a scope for corruption, in which case it was a better idea to have an equal partnership. However, in this scenario, the question of ownership of governance gets blurred. Moreover, if the strengths of the private sector need to be used positively then its weaknesses need to be managed first. It has to be made accountable. In this context it was argued at the conference that many of the present day high technology using corporate hospitals (including Apollo), have in fact come up through government subsidies and cooperation. These, profit making "businesses", as they are today, had been given the social responsibility to make services available to the poor strata of the people. This has been blatantly ignored. More studies need to be conducted in the specific context of PPP's – of PPP projects per se as well as the environment in which they are implemented particularly with reference to the paucity of information about the private sector.

Moreover, it was argued that if the private sector is going to be involved, then incentives and benefits become important. This is a critical reason why private sector is so obviously attractive to doctors than the public sector. In PPP's, the government retains its role as the financer with the consequence that the PPP might just not flourish.

There was also concern amongst the participants that the government is giving too much time towards PPP. Very pertinent problem of improving governance or improvising on the method of provision of these services is getting neglected.

Session II: PPP's – Perspectives

Presentations:

1. Ms. Ruhi Saith, "*Public – Private Partnerships in Delivering Health Services*" authored by Ms. Ruhi Saith and Dr. Santosh Mehrotra.
2. Ms. Rajsulochana, "*The Economics behind Public Private Partnerships (PPP) in Health Sector*" authored by Ms. Rajsulochana and Dr. Umakant Dash.
3. Dr. Avinash Deoshatwar, "*Vadu Rural Health Program [VRHP] a unique setting: Lessons to be learnt*", authored by Dr. Avinash Deoshatwar, Dr. H H Chavhan, Dr. Sanjay Juvekar, Dr. Shivaji Karad and Dr. Siddhivinayak Hirve.
4. Bibi Ishrat Jahan, "*Public Private Partnership in Uttar Pradesh Health Care - Delivery System – UPHSDP as an Initiative".*

Chairpersons**:** Dr. Ramu Baru and Dr. Amar Jesani

Ms. Ruhi Saith in her presentation identified multiplicity of definitions for PPP's and the problems arising therein. She argues that any government programme involving the private sector or involving the community or Panchayati Raj Institutions (PRIs) cannot be categorised as a PPP. Moreover, any relationship with the government irrespective of the duration and the terms may again incorrectly be termed a PPP. Corporate donations or single one-time grants given by government to NGOs are often wrongly referred to as PPPs. There also needs to be a distinction between privatization and PPP's. Ms. Saith reiterated the importance of a clear perspective on what constitutes a PPP and

identify certain characteristic features. These could include a long term commitment of the private sector towards the achievement of public goals, involving a formal contract, resulting in 'value added outcomes' which could not have been achieved by the public or the private partner working in isolation, autonomy (of each partner), joint-ness (at all stages with shared decision-making and accountability), and equity (fair returns in proportion to investment and effort), with the ultimate responsibility for delivery resting with the government. *Thus PPP's need to be secondary to a well developed public sector rather than be seen as a panacea for the shortcomings of the public sector* (italics added).

She also identified some key elementary issues about PPP's; such as lumping together of two very fundamentally different private players, i.e., for profit and not – for – profit. Moreover, the quality of services delivered and the outputs per se amongst various PPP's vary widely. Entering into partnerships with the private for – profit sectors, in the current scenario where they are largely unregulated, can in fact be viewed as "legitimization by the government" of the unethical practices by the sector. There is also an absence of prescribed standards and guidelines. As a consequence, provisions for free treatment and applying user fees may not be implemented properly leading to confusion and often depriving benefits due to people.

Working with private players, particularly the for – profit sector, often result undermining equity and access which are the main justifications for such partnerships due to non adherence to conditions by private sector in the partnership. Moreover, since the basic nature and functioning is different from the government, the very essence of any partnership, such as joint decision making is often jeopardized. There is therefore a strong need for a policy to guide partnerships in the social service sector. Along with this, systemic reforms are needed to support the various demands made by PPP's such as increased capacity related to management, legal (for framing of PPP contracts), arbitration and settlement, financial matters (including prior assessment of PPP's to provide value for money) and skills in regulation, monitoring and evaluation. According to Ms. Saith regulation is the foundation of a successful implementation of any partnership and monitoring is a crucial step to make sure that the PPP's are being implemented in adherence to the public health goals. Therefore there need to be guidelines for the formulation of contracts in order to factor in all the above concerns.

In the next presentation, Ms. Rajsulochana and Dr. Umakant Dash have in their paper explored the theoretical framework for PPP's. **Ms. Rajsulochana** begins with plurality of definitions. Looking at all definitions of PPP, three core elements of any PPP emerged: *autonomy of each partner, mutual commitment to agreed objectives, and mutual benefit for the stakeholders*. Moreover, they have differentiated between PPP's and privatization – where PPPs involve the concept of sharing whereas privatization is transfer of tasks, duties, revenue etc. PPP's have been classified on the basis of objectives – thus these include increasing access (e.g. voucher schemes and mobile health units); affordability (community health insurance); efficiency (autonomy to hospitals); financing (joint ventures, etc); outreach (partnering with grassroots organization); risk transfer (contracting) and PPP's based on the objective of enhancing technical strength (PPP's focusing on capacity building).

Amongst all the PPP models, contracting has been the most common form of partnership all over the world. Ms. Rajsulochana asserted that this form of PPP can lead to *opportunism* in the health sector. Thus it could take the form of adverse selection. The purchaser (government) may design the contract and services agreements to pass the risks associated with patient groups to the providers, while the providers may insert clauses that exclude high cost cases. Opportunism may creep into health contracts through the form of *moral hazard* (this is a situation in which one of the parties to an agreement has an incentive, after the agreement is made, to act in a manner that brings additional

benefits to themselves at the expense of the other party), that limits the ability to scrutinize the implementation of the contract. This leads cutting corners (doing less than one would expect given the terms of the agreement) and many health sector activities operate outside a framework of quality assurance and safety controls. Such problems of opportunisms can be overcome to some extent by *involvement of persons with specialist knowledge* while framing and scrutinizing of contracts.

Another important insight that the presentation provided from economic principles is that while *competitive bidding* in selection of the health service provider gives 'competition' a chance, it leads to a *monopoly-like* situation of a private health service provider. Thus, *the process of monitoring and evaluation of contracts in the health sector has to be continuous,* supplemented by an *independent regulatory system* to protect the patient's interest. Equally important is to have *explicit transparent and adequate governance mechanisms* in place to ensure involvement of all stakeholders, co-ordination across various departments within the government and various implementing agencies and provision of social safety measures to the underprivileged sections of the society.

Followed by a clarification of various theoretical aspects of PPP's, **Dr. Avinash Deoshatvar** presented a very interesting and old model of PPP, the Vadu Rural Health Program (VRHP). The VRHP has a dual role: with the public sector as a private partner and with the 'Private' practitioners as a proxy to the government. 22 villages were assigned to them by the government. The purpose was to establish a highly efficient, technically robust outreach program that would be a very good example for other PHCs. At the same time, good quality curative services would be administered through the King Edward Memorial Hospital (KEMH) management.

In this model, outreach activities of a Primary Health Centre (PHC) such as personnel, equipment and supply are financially supported by government. The designated PHC undertakes all activities that they were traditionally supposed to, except that the headquarters are at the KEMH. It was also unique in the sense that a privately owned funding agency provided additional financial support to create a program that would provide good quality healthcare to rural population at affordable costs. Moreover, routine operational costs are born by the patients. In this model, the government takes care of preventive measures - in other words tries to bear the costs to prevent direct and indirect economic losses due to preventable conditions and population pays for the curative care that it needs. In economic theories this might go as another kind of 'soft capitalistic- more socialistic' hybrid model. However, Dr. Deoshatvar clarified that in VRHP's perspective; it reflects the present mindset of our society and the current phase in socio-economic transformation. At present the hospital charges the patients fees that are much lower than those in private hospitals around. Moreover, governmental support makes it necessary that services are provided for almost no cost to people below certain socio-economic status. This way it is competing with the private sector for their share of the patients. A small part of the fees is paid to the specialist as an incentive. Compared to fees of specialists in private sector in the area this incentive is negligible, but the volume of patients makes up for it to some extent.

Efficiency and high service quality at affordable prices are the aims of all efforts at VRHP and these in turn are a function of incentives and market structures. Moreover, these are observed to be better here than in solely public and solely private institutes. Dr. Deoshatvar therefore asserted that the time and services of private practioners need to be reimbursed for any kind of cooperation and generation of goodwill. There also needs to be better regulation of the private sector.

Flexibility, professionalism, freedom to take initiatives, and less number of barriers in quick decision making are the attributes of private sector that are crucial for growth and efficient operation of healthcare facilities. On the flip side are - lack of self discipline in private sector (largely attributable to medical education culture in India where there is little scope for comprehensive thinking about medical field and practice as such) and lack of regulation. Moreover, lack of self discipline stems from a tacit general understanding that certain responsibilities are to be borne by the government only. Controlled freedom in PPPs can create environment conducive to new initiatives and innovations as it gives flexibility that is rarely seen in the public sector because of administrative structure. If distribution of risk is not considered during political decisions about partnerships, it is possible that probability and consequences of risks both are aggravated.

The authors have advocated the need for studies to understand the power relationships within PPP's and performance based incentives in the public sector. There also needs to be a broader understanding of integrated nature of 'health-economics and social aspects' in the medical education curriculum; making the medical education thought provoking rather than didactic.

In the next presentation**, Bibi Ishrat Jahan** asserts the need for health sector reforms and for harnessing the private sector. She rationalises this in the context of the state of Uttar Pradesh (UP). Since independence, the UP government has made a huge investment in health infrastructure and yet the government has been unable to provide qualitative, effective and adequate health services to the huge population of UP. In order to address this problem, the UP government launched the Uttar Pradesh Health Systems Development Project (UPHSDP) in collaboration with the World Bank. The objective of the project is to establish a well managed health system that delivers more effective services through policy reforms, institutional development and investment in health services. It also aims at providing limited curative and preventive health care services to the disadvantaged section of the society, especially women, and the poor in remote areas which are identified as un-served areas by the district health authorities. It sought to do so through policy reform, strengthening and renovation of existing resources, skill development of human resources, and PPP's. The project has had significant impact. For example, registration of pregnant women doubled, distribution of Iron Folic Acid tablets increased six folds and institutional delivery has shown an increase of over fivefold, amongst other indicators.

A significant observation made by Ms. Jahan was that the simultaneous operation of NRHM and other government health schemes diluted the idea and enthusiasm of UPHSDP in the state. Moreover, she felt that the UPHSDP cannot be replicated and adapted to urban areas.

Discussion

The participants at the conference pointed the role of NGO's in presenting market based models. VRHP is one such model, which has been successfully around for a long time. Moreover, it was pointed out that the shortcomings of the experiential papers were that they did not present or discuss learning on PPP.

Commenting on the VRHP's assertion that incentives were necessary to ensure posts are filled by doctors, it was questioned as to how quality be ensured by giving incentives. However, it was pointed out that there would be no doctors in the first place, if there were no incentives or if the incentives were not worthwhile. This way atleast the services are ensured.

The ideological debate continued about whether the state should involve private sector to reach out to people since there might be scope for privatization. However, if the initiating partner is the government and the objective is promotion of public health services and the government is not devolving all responsibility and at the same time implementing regular monitoring, then it cannot be categorized as privatisation.

There were others who feel that government is rather incapable, and PPP's are the only option. The underlying question therefore arises – who will monitor the PPP's and who in turn will monitor the "monitors"!

Session III: Existing PPP models

Presentations:

1. Ms. Sushma Shende, "*Public Private Partnerships formed by SNEHA: City Initiative For Newborn Health, ASK partnership, Arogya Sarita"*, authored by Sushma Shende, Jaya Nuty, Surekha Jagtap, Sapna Gaikwad, Trupti Kelkar , Garima Deveshwar- Bahl, , David Osrin, Wasundhara Joshi, Armida Fernandez.
2. Dr. Shilpa Jadhav Bhakre, *"Examining role of the State in health care: A study of Motikhavadi - Special Economic Zone (SEZ) – Jamnagar"*.
3. Mr. Deepak Milli, "*Public Private Partnership in Health: An Understanding of PPPs in Primary Health Care in Arunachal Pradesh*".

Chairpersons: Dr. Venkat Raman and Dr. Padma Prakash

The next presenter, **Ms. Sushma Shende** from SNEHA, explained three of their urban centric PPP's. Each of the PPP's are unique in terms of the roles of various partners. The first one is the City Initiative for Maternal and Newborn Health. The goal here is to establish a continuous quality improvement (CQI) cycle factoring in clinical and behavioural aspects of service delivery to enable facilities to provide designated level of quality care. The details have been drwan up through participatory consultations. The government (in this case the Municipal Corporation Greater Mumbai, MCGM) provids the services, infrastructure and monitoring. The community contributes towards problem identification, mobilisation and monitoring of the project. The ICICI Centre for Child Health and Nutrition is the corporate partner that provided funding, design inputs, networking and dissemination. The Centre for International Health and Development contributes towards design input, evaluation, networking and dissemination. While SNEHA, the NGO partner, is the one binding the whole PPP together and responsible for implementation and monitoring. It is interesting to note that three of the partners have played a role in monitoring. Some of the achievements of the partnership include 8 fully-functioning antenatal clinics with staff trained on antenatal, postnatal, and neonatal care and clinically trained staff across 14 health posts. They have also been able to develop standardised evidence based clinical protocols. Regional referral link has been established with three peripheral hospitals.

Ms. Shende then described their ASK partnership that aimed to upgrade public health facilities. Vital equipment was provided for 3 maternity homes and 1 peripheral hospital. Importantly, its utilisation was monitored and there are no user fees.

The third project was their "Arogya Sarita" initiative. The aim was to build a comprehensive and integrated model of primary health care. Interestingly, in the model here, not only were the government (as MCGM – Municipal Corporation of Greater Mumbai) and an NGO were partners but also, the corporate sector and private doctors participated in the PPP. All the partners contribute towards MCGM's infrastructure, services and monitoring. The corporate partner contributes towards the infrastructure, training, mobile and ambulance service. The community helps in identification of problems, forming health committees, mobilisation of community and contributing towards monitoring. Even the private doctors have been pooled in to provide services including emergency services. They were also responsible to share information about notified diseases. The NGO partner is responsible for the overall facilitation of the project, micro planning, capacity building and monitoring.

Through their experience of some very successful PPP's, two key findings evolved. One, it takes atleast two years for successful PPP to develop. And secondly, despite equal partnerships, one partner eventually ends up taking and performing a lead role.

However, while it might be natural for one partner to eventually take up a lead role in the partnership, the extent to which this happens is of critical importance. The need for a clear definition of PPP and the distinction between a PPP and privatisation are clearly highlighted in the presentation by Dr. Shilpa Jadhav – Bhakre. Her research on the Motikhavadi Community Health Centre run by Reliance in Jamnagar throws up these and other critical issues. Motikhavadi has an unconventional feature of public private partnership as there is no contribution of infrastructure or health personnel by government. What the government has done in this case to qualify it as a PPP is giving enormous tax concessions to Reliance for their project for creating a zone of excellence and in turn services are provided by Reliance Industries and are free of cost and there is no government PHC. The facilities are superior compared to the regular government run PHCs. The qualified doctors seem to be content as far as salaries are concerned. No one is unhappy about the state of affairs in Motikhavadi. Since it is totally cost free (consulting as well as medicines) peoples' perception about the clinic is like a charitable organization.

The argument however is that the government has no visibility whatsoever at Motikhavadi. In fact Reliance is referred to as "*sarkar*" (government). Moreover, there is non-interference by government to the extent that no monitoring by the government occurs at any level and there is no record kept of the social cost-benefit in terms of health hazards to the population from the largest petrochemical hub in the world! Thus the extent to which government can relinquish control of the health sector under a PPP is an area of serious concern. This case study clearly emphasizes the need for the government to have a clear and uniform policy on PPP.

From a dominant private "partner" to a non – existent private sector presence and government monopoly, **Mr. Deepak Milli's** presentation presents a sharp contrast. His research work is based in the hilly state of Arunachal Pradesh. The near absence of the private healthcare sector, especially in remote and rural areas, contributes in making the existing government health infrastructure monopolistic in its outlook. This adds to problems of inefficiency and lackadaisical approach. The state government has however, recognized the need to reform its health sector through PPP's. Mr.

Milli conducted an exploratory research study of PHCs run by NGO's as PPP's. The study was conducted across 6 districts. A SWOT analysis (Strengths, Weaknesses, Opportunities and Threat) revealed, among other things, that atleast one doctor was available at the PHC's, there was availability of medicines and better responsiveness. The study also revealed a number of weaknesses. These, to some extent can be common to other PPP's too. Thus, the problem of vacant posts continues to plague the health services due to insufficient remuneration or other incentives. *There seems to be an imbalance in the partnership, with the government playing the dominant role as well as being the judge* (italics added). Just as the case of many PPP initiatives, the success is in a large way contributed by the dynamic leadership of a single person. This can seriously threaten sustainability. Moreover, the successful performance by NGO run PHC's has lead to some amount of resentment amongst the government officials who have been blamed for the lack of results. This has led to their resistance and non – cooperation towards the programme. On the part of the NGO's too there have been lapses. Particularly towards commitment of resources (90% contribution from government, rest contributed by NGO) for filling up of vacant posts.

According to Milli, PPP's present a number of opportunities. He feels that indigenous systems of medicines can be introduced; paramedic staff can be given decent incentives to be present at the PHC's. He has suggested that the government's budgetary allocation can be modified when it comes to PPP's. Accordingly, money can be allocated on the basis of population needs, demand for services, quality of service provided and health outcomes achieved. The threats include – inadequate awareness about the PPP can lead to poor acceptance within a community, nepotism often threatens the filling of posts at the PHC's. Moreover, issues of accountability are sourced in the fact that the medical officers that have been appointed are by the NGOs and they are not accountable to the government. There is a highly lopsided risk sharing between the NGO and the government with the government contributing 90% of the funds. This can lead to sub-standard NGO's becoming a part of the PPP. Any kind of work with the private sector raises the issue of sustainability.

Discussion

The participants appreciated the work done by SNEHA and pointed out that even small interventions can lead to greater impact.

At the same time, there were concerns raised about the role of NGO's in a PPP. Was it to raise funds? Should good work done by NGOs' be integrated within the public health system? Running parallel services is surely not practical option. Value can be added to the services provided all the partners are engaged in it. NGO's for example, can contribute by facilitating new initiates and capacity building. At the same time it was felt that replication of NGO's work can lead to serious bureaucratic risk such as in the case of the Karuna Trust.

Mr. Milli's SWOT analysis was much appreciated. However, the question that was raised was whether handing over PHC's to be run as PPP's would in any way create competition for the PHC's under the government? What is the impact of this induced competition, if any, on the government run PHC's? Is there any improvement? Prior to considering PPP's, there should be other ways attempted to rectify a bad situation. There has to be other options that need to be looked into. A query was further raised as to why the government after shelling out 90% of the costs left 10% to NGOs to contribute? Dr. Milli clarified that this was specifically done in order to filter out inefficient NGO's from entering into public private partnerships.

In the centre run by Reliance, serious concerns were raised. There has been no data for 10 years about the health hazards on the workers working in the petrochemical industry. Moreover, there is no monitoring by the government of the PPP. Such an environment raises serious ethical and human rights issues. Simultaneously, Reliance seems to be trying to improve their image in the community as the sole health care provider in the area. In general, there is no study which analyses what the corporate sector give back to the community in real terms for the subsidies that they receive. In the case of Reliance here, while the services provided by the centre are commendable, there is a marked observed difference between what they provide for their own staff and to the villagers. The staff hospital is a multi-speciality hospital that runs 24x7.

Moreover, simply because the "benchmark" is an inefficient public sector thereby making the services provided by Reliance "commendable" (and they might truly be so); does not in any way justify a complete absence of regulation, monitoring and transparency. It was in fact questioned it was a PPP at all, since the governments role seems to have ceased as soon as subsidies have been provided.

Session IV: Engaging the private sector – scope

Presentations:
1. Dr. Sanjay Verma, "*Cooperative Health Care Models in India – Current Trends*".
2. Ms. Prachi Shukla, "Delivering (sustainable) services on scale. Anywhere.".
3. Ms. Lipika Bhuyan and Ms. Ankita Mendiratk, "Public-Private-Partnership in the Health Sector - Case Studies from Gujarat".

Chairpersons: Dr. Anant Bhan and Ms. Padma Deosthali

Going to the other end of the spectrum, **Dr. Sanjay Verma**, in his presentation argued that cooperatives present a strong alternative and can play an important role in the health sector of the country. In the context of PPP, the cooperatives primarily lack efficiency and financial soundness as compared to private commercial entities and public bodies. However, the cooperatives have extensive reach and accessibility. He presented four case studies of PPP's in cooperatives. The first one is the Yeshasvini Cooperative Farmers' Health Care Scheme. Here, any member who is a member of cooperative society in Karnataka can get the necessary treatment and have access to expensive medical procedures by paying Rs. 120 per annum. The public-private partnership model can be seen from the fact that the administration relies on various actors; the Government of Karnataka for partial subsidy benefit; the Karnataka State Cooperative Department for communication of the plan; cooperative societies enrolling members, cooperative banks to assist in premium collection; Family Health Plan Ltd, for the administration of claims and a network of hospitals to deliver the benefits. Moreover, the government provides a quarter of the monthly premium paid by members of the cooperative societies. The network of hospitals under the scheme include private hospitals where the facilities are of high quality. The incentive of getting treatment in a private hospital with the government contributing to the premium amount attracts more members to the scheme. A review of the scheme indicates that while the rights of the farmers have been taken care of, the scheme does not comprehensively cover all health related needs of the farmers. Moreover, a lot of standardisation is desirable. This scheme only covers the members of the agricultural cooperative societies. In order to help a larger population benefit from the scheme, it is necessary to widen the base and include a wider section of cooperatives.

Dr. Verma then cites the example of Self – Employed Women's Association (SEWA), which a union of 2,50,000 women working in the informal sector. SEWA has today grown to include a bank with 1,30,000 depositors and more than 80 cooperatives of various kinds, all owned and managed by themselves. SEWA's midwives and health workers have formed their own cooperatives which are run democratically and are sustainable both in financial terms and activity-wise. Each member has the option to join the programme by paying Rs. 60 per annum and is provided limited cover for risks arising out of sickness, maternity needs, accidents, floods, etc. These cooperatives make drugs available to SEWA members at low cost through outlets run by local women. Moreover, they have been entrusted to run RCH (Reproductive and Child Health) diagnostics and screening camps, especially village-based mobile RCH clinics under the programme of Ministry of Health and Family Welfare. SEWA has done a commendable job in enhancing the health security of its members. It has also helped in bringing down the health expenditure of the women thereby increasing their accessibility to healthcare. The partnership has resulted in widening the levels of services to women and their families further augmenting health security and accessibility. Design of the products catering to the lower income group at a reasonable cost is the biggest challenge. Partnerships need to be forged with the government and / or private sector which must make available new products for the poor and low middle class at low costs.

Dr. Verma also briefly talks about the Cooperative hospitals in Kerala and the National Co-operative Union of India. The economic feasibility of many of the co-operatives has been highlighted by him. He is of the view that if primary health care has to be provided in inaccessible areas and to tribal and weaker sections, profitability can not become the yardstick for performance. The cooperative sector in fact has not been able to undertake strong advocacy to popularise the cooperative model in the health sector. Lack of quality research studies has been a big hindering factor in this respect. Strong advocacy, research and lobbying are absolutely essential. Effective lobbying with the government must be undertaken so that the government policies and programmes lay emphasis on setting up cooperative hospitals, or the health schemes with focus on cooperatives. The replication of SEWA health model is the need of the hour as it will widely popularise the cooperative health model all over the country. Dr. Verma is of the opinion that the full potential and reach of co-operatives has not been explored. Moreover, there needs to be a clear strategy for building partnerships of co-operatives with government and private sector to maximise benefits to the poor. In this sense, co-operatives in the form of PPP can play a key role.

Ms. Prachi Shukla from World Health partners (WHP) echoes Dr. Millis' opinion about the monopolistic presence of the government in the public health services only makes them sub-standard. However, the solution offered by them through their work is in sharp contrast. They believe that it is *not* the NGO's that can fill the gap since they do not have such capacities, do not have a substantial presence and are not as sustainable as the for – profit private sector. However, even though the private sector has large resources, its interest in catering to the poor (an oxymoron in itself) and in preventive care would be minimal. For the private sector to be roped in profit is not enough, it needs to be adequate. Moreover, the challenge is to work along the already existing "DNA" of the public sector. They feel that curative care is easy to mount since if it is life threatening, clients will find their way. For low end curative care especially for chronic services, there is a need to have ongoing arrangement since the client will come provided the services are closer to home. Preventive services need to be as close to home as possible to have any uptake.

Accordingly, the essential strategy of WHP's model is to utilise existing human, financial, and physical resources of the *private sector* (italics added) to provide care to the needy. All providers earn for providing care, for facilitating care through an affiliate network through referrals, and for helping WHP provide care to clients by managing local arrangements. An auxiliary nurse- midwife from the public sector also visits the rural centres once a month to provide paramedical contraceptive services and in tele-consultation with the doctors, even gynaecological services. Project sustainability will be accomplished through i) collaborating with the public sector to make available an existing service delivery infrastructure that is currently underutilised ii) charging a fee, however small, for almost all services which would reduce dependence on donors iii) using financial instruments like risk pooling, insurance and vouchers to safeguard the interests of the poorest communities without compromising on the quality of service provision.

Through their experience, they learnt that rural clients look for one single contact point where all their health needs, preventive and curative, can be addressed. And when they need further care, they want advice and hand holding for the next step. WHP seeks to facilitate this gap and bring health services closer to the clients' doorsteps. Through the use of telemedicine technology, the project made health related services accessible for even the most remote rural clients. The benefits of this technology are ample: Easy accessibility by the patients through the Sky Health Centres, credible medical advice, saves patients' time and money as they don't need to travel to far flung areas. Another remarkable observation we made was that rural clients were not intimidated by the use of technology; they were quite at ease with their diagnosis in front of a computer.

Ms. Lipika Bhuyan and Ms. Ankita Mendiratk in their presentation clarified the definition of PPP as they have adapted in their work. It is a joint ownership of a program by two or more parties to achieve a common goal. They assert that PPP's should identify gaps in services and fill those gaps. This is the model followed by the Deepak Foundation in Gujarat. The barriers to PPP's include the fact that it can be seen as a threat to the existing system. Moreover, there is a need to standardise the Memorandum of Understanding (MOU). They have also identified some key challenges through their work. These include the need for optimal utilization of existing public resources as well as of private resources. There is a need for synergy between the private and public sectors to avoid any kind of duplication of services. It requires optimal resource mobilization and plan for sustainability.

Discussion

It was pointed out that cooperatives in general have earned a bad name. However, whilst it is true that corruption and power and money games have entered some of the cooperatives, this is not true for all. Moreover, there are number of smaller cooperatives that contribute significantly and need to be brought to the forefront. Serious advocacy and image building exercise are necessary. Concerns were raised about members of cooperatives getting health services at a nominal cost and non-members getting left out. Dr. Verma responded that cooperatives generally have a strong holding in the community and inevitably the rest of the community joins in. They are like a people's movement and membership is non-discriminatory. It was suggested that if cooperatives can help public hospitals towards capital cost then such an option should be explored.

The WHP model received some critical comments. Notably, it was pointed out that the work done by them seems to be independent and parallel and not in partnership to the government. In response it was pointed out that there is work done in partnership – such as sterilisations. However, this further became a point of contention since these services were already being provided well by the government independently and it is not area where services are lacking. It was explained that the

donor gives subsidies for this service and moreover this is not the only service provided in partnership. There are consultations too that are given. Queries were raised whether there were problems in terms of connectivity as a result of the heavy dependence on technology. This was not the case since the shift to ADSL and BSNL services. Questions on sustainability were put to rest by clarifying that the WHP model was a business model and that they would break even in a year. Concerns were raised about using ANM's from public facilities since if incentives were provided by WHP would not they leave the public facilities in favour of WHP? However, the incentives given by WHP for the same work was less than what ANM's get in the public sector. It was pointed out that was not unethical to exclude BPL population and only cover those with an ability to pay? It was clarified that a willingness to pay survey was conducted at the planning stages and in any case they are now slowly moving towards including BPL families.

The Infant Mortality Rate (IMR) and Maternal Mortality Rate (MMR) in the project area of Deepak Foundation (DF) had shown a significant improvement. It was questioned whether this was exclusively as a result of the work done by them? It was explained that this improvement was not just their contribution. The CY had also contributed to it. The participants of the conference wanted to know the difference in the work done by their foundation and by the CY. It was pointed out that CY does not cover post-natal care nor does it accept high risk pregnancies. These are referred to DF. Considering the fact that DF is a corporate trust, what would happen once their profit goes down? It was asserted that DF was confident of continued profits. Moreover, some part of the money came from the community and some from the industrial association.

Session V: PPPs under NRHM - Evidence based critiques

Presentations:

1. Ms. Mona Gupta, "*Public Private Partnership (PPP) Initiatives in Bihar: Successes and Failures*".
2. Dr. Sarika Chaturvedi, "*Rapid Assessment of Public Private Partnerships for Emergency Obstetric Care: Stakeholders Experiences from Maharashtra*", authored by Dr. Bharat Randive and Dr. Sarika Chaturvedi.
3. Dr. Akash Acharya, "*Can Public Private Partnership reduce Maternal Mortality? Assessing efforts made by the 'Chiranjeevi' scheme in Gujarat*".
4. Ms. Anuja Kastia, "*Investigating Public-Private Partnership Health Development Chiranjeevi Yojana in Sabarkantha District of Gujarat State*", authored by Ms. Anuja Kastia and Dr. Ramila Bisht.

Chairperson: Dr. Shyam Ashtekar

Ms. Mona Gupta in her presentation gave a detailed analysis of the various PPP's in Bihar. It is based on primary research as well as secondary research work. The Government of Bihar, she stated in her presentation, took the opportunity and initiated a large number of PPP's. Some of these were successful and others not so. Those that were successful, she observed, had led to increased accessibility of health services. However, hasty planning, delay in payments, lack of technical know-

how, limited number of private players interested in catering to grass roots and capacity to monitor the projects were the prime reasons for failure of the projects.

She observes that state governments, such as the Bihar government, were unable to absorb the funds made available by the government through its various programmes. This was one of the main incentives for getting into PPP's. Bihar was amongst the first states to initiate PPP's. NRHM provided an unprecedented flexibility in planning and execution and also encouraged innovative ways to improve service delivery. The structure of the State Health Society created to implement NRHM facilitated faster decision making. This led to planning of many projects within a short span of time, and majority of them were executed through the PPP model. The public were happy with the results. Some of the PRI's with whom the author interacted during the data collection expressed satisfaction in the fact that at least some basic services were now available to them. Some of the PPP projects include outsourcing of hospital maintenance, operationalisation and management of state and district data centre, radiology services, pathology services, etc.

However, as mentioned earlier, she has very clearly identified the reasons for the failures. The PPP projects widened the service provider base, and made services available to people in need. However a close scrutiny of issues associated show that for each project that came to implementation stage, there was at least one which either didn't go beyond its tender advertisement or was scrapped off within a year. Discussions with various stakeholders brought forward multiple reasons. Hasty planning with no market survey for available services and its cost, inadequate knowledge and experience in government about planning and executing projects in service delivery through PPP prevented many projects from taking off. Further, faulty planning without in-built mechanism of monitoring and assessment led to many controversies.

A major problem with planning was typical "Cookie –cutter approach" where almost all the initiatives were implemented in all the districts, in all the facilities. No distinction was made between the districts which already had the services. Thus, for example, many hospitals had good pathology or radiology facilities with trained staff operating them but even those facilities were contracted out rendering the trained government staff either idle or being used for a non-technical work. A more careful planning would have led to better utilization of existing facilities within the government system. Another problem was the method of selection of tenders. Tenders were awarded in most cases on the basis of lowest quote or to whosoever agreed to work on the rate given by government. Often private sector partners were selected without any noticeable criteria. E.g. A computer firm was awarded a contract of health service delivery. Moreover minimum turnover requisite in many cases kept the well meaning small NGOs out. Quality of services provided by the PSP (private sector partner) suffered because of low cost-criteria and negotiations carried out with the finalists of tender-process. Most of the reputed big private parties never bid and many bids were cancelled because of single bidder.

Moreover frequent transfers of bureaucrats led to change in the mode of working as the new incumbent came with new ideas. Many changes in course of project on hindsight led to disputes as the private party had not included those new things in their planning or cost. Though some of the bureaucrats had excellent vision, those who succeeded them had no clue leading to premature ending of many PPP projects and increase in complications in many others. Moreover, PPP was seen by the resource poor state as a panacea for all ills. On the ground it seemed like there was a transfer of all responsibilities to the PSP. The Government's responsibility seemed to end with finalisation of TOR and contract. Moreover, based on the terms dictated by government, there is no real partnership. The

symbiotic relationship (italics added) which should have been the base of PPP is missing. Moreover, PPP became a political bandwagon. As one stakeholder clearly put it,

"*Many projects were started to make the political bosses happy. There were no consolidations or strengthening exercises to make the projects sustainable. It was more like hopping from one case to other at break-neck speed."*

Decentralisation of decision making powers to local levels were absent in many cases which led to bizarre situations. In one of the district hospitals, hardly 100 kilometres from state capital, there were three X-ray units in adjacent rooms-one run by the government staff which didn't charge any fee from patients, second run by a charitable trust at subsidised cost and then came the third through PPP because the state government had entered with a Memorandum of Understanding (MOU) with the PSP!

Moreover, as Ms. Gupta points out, partnership between parties who were historically opponents is not an easy task. There are a number of constraints to building partnerships in health and these include the availability of an adequate number of players in the market, the framing and content of MOUs; the administrative and organisational capacity of the system to define roles and regulate these partnerships; the impact of these partnerships on comprehensiveness and equity.

As PPP is no alternative to poor governance and leadership, government has to build its capacity. If a government does have the capacity to contract out clinical services, it is likely that it will also have the capacity to deliver those services directly itself. Given the somewhat mixed evidence on the effectiveness of contracting in promoting greater efficiency or higher quality, developing country governments may be well advised to restrict contracting-out to those services where it is clear that they have the capacity to manage contracts and that contracting-out will be beneficial.

The PSPs providing radiology and pathology services collected user charges as fixed by the government. However concerns about the poorest being not able to avail the paid facility led to removal of all the charges for all patients visiting government facilities. Evidence also show that user charges deter those whose health needs are greatest. PSPs will now be paid by the state government. Payment of all the tests being performed in the government facilities is likely to weigh heavy on state. The options for charging those who can afford to pay, to finance those who cannot, should be explored for sustainability of such efforts.

The state should have a Strategy Development Unit within State Health Society with qualified and experienced personnel to plan, and study feasibility of PPP as suggested by the Task Force on PPP for NRHM. It also suggests prioritising of districts so that districts with higher needs could be taken up first. Piloting of a new project to know the practical problems should always be done before scaling it up in all the districts. Monitoring and periodic evaluations of projects should be clearly spelt out during the planning phase. Capacity building of personnel looking after PPP in government needs to be taken up as a priority. The state should also provide required training to the staff employed by the PSP as they too are part of the health service delivery system.

PPP is a very useful strategy for achieving public health goals provided the parties involved understand the symbiotic relation and its true spirit. Whether Bihar can make use of this strategy to improve its health service delivery and strengthen its systems remains to be seen. The public is enthusiastic about the recent changes and expects more from the government and PSPs.

Dr. Sarika Chaturvedi echoes the same thoughts about the usefulness of PPP as a strategy to achieve public health goals and as a mechanism to use private sector managerial expertise to do so. There is little documentation of the successes and failures of these initiatives or of their detailed processes and ethical issues. It is widely expected that PPP's could improve efficiency of the health sector by ensuring availability of affordable health care to the community and provide several other benefits as creating competition, creating synergies, economies of scale, targeting the poor, utilizing existing capacity, flexibility in action, resource mobilization and technical up gradation. However there are concerns as well: the focus of private sector on curative services leading to moral hazard. Moreover, contracting is unlikely to enable service delivery on a large scale and it might be more expensive than government provision of the same services.

There has been little empirical exploration of the perceptions and experiences of recent schemes in India that are based on a public private partnership. Many of these are for provision of emergency obstetric care services. In the rapid assessment study that they had undertaken, they studied the perceptions of key stakeholders in the public and private sector and the target clients of a PPP scheme for emergency obstetric care provision in Maharashtra state in Western India. The government of India, under the National Rural Health Mission launched the Janani Suraksha Yojana (JSY)[1] , a safe motherhood intervention that aims to reduce maternal and neo-natal mortality by promoting institutional delivery among the poor pregnant women.

Maharashtra is categorised as a high performing state where the JSY is applicable to only those women either living below the poverty line (BPL), or from the Scheduled Castes (SCs) or Scheduled Tribes (STs) and above 19 years of age for the first two live births.

The NRHM, in its expectation to address the gaps in the provision of effective health care, aims at fostering public private partnerships in its supplementary strategies. Adjuvant to the strategy, the JSY has a provision of subsidizing cost of caesarean section (CS) or management of Obstetric complications through partnership with the private sector. In such cases it provides an assistance of Rs. 1500 for hiring specialist from the private sector. The JSY therefore promotes the contracting-in model of PPP for EmOC provision and it is expected that a list of empanelled doctors is prepared and women are informed of this provision. This study used the rapid assessment of health programmes (RAHP) approach.

The respondents included implementers (BMO's, ANM's, etc), the providers- public and private (obstetricians who provide EmOC services in private facilities), the beneficiaries (eligible and received services) and non beneficiaries (eligible and not received services) of the scheme. There was a clear lack of ownership amongst "implementers" who have showed no motivation whatsoever to implement the scheme. There was a strikingly low motivation amongst district officials towards contracting in of private specialists for EmOC services. The monetary incentive for the private provider is itself low, with the result that none of them would leave their higher revenue earning facilities to conduct an EmOC service in the public sector, especially when his/her absence can affect the revenues of his own private practice. In fact the private EmOC providers were not even aware of such a possibility of a partnership with the public sector to start with. They became aware of it when patients started coming in to ask for their signatures for receiving subsidies. This probably explains the successful utilization of funds under the scheme.

The study finds payments being made to the private specialists in certain blocks, to the woman in others or to either in some determined by the interpretation of the guideline by the respective BMOs.

As per the scheme, to access the services from the private facility the woman in need of CS is expected to carry a referral slip from the ANM or MO and also a proof of her being either SC/ST or BPL. In case of emergencies, when the CS is not pre planned, the referral slip for the CS operation not being available with the patient, the implementors are expected to verify the patients address and her being from SC/ST/ BPL community. The guideline also mentions that the private facilities when demanding the honorarium (Rs.1500) should produce a proof to the MO of having operated on the beneficiary. Neither of these practices was found implemented in the field.

The subsidy of Rs.1500 serves a mere 10% assistance to hospital expenses for CS in private facilities. The beneficiaries find it grossly inadequate and see it as hardly sufficient even for the pharmacy bills. Women preferred having access to EmOC services rather than any amount of cash assistance. Subsidization therefore proves to be a very limited effort to increase access to EmOC as to prevent maternal deaths. However, the restraint was that the district and block administrators find the contracting-in option unfeasible because of the poor infrastructure particularly with respect to blood storage facility, crucial to any EmOC centre and the absence of electrical backup, which is crucial considering the long hours of power cuts. However, the in the present scenario, where the CS cost is subsidised through payment, there is no mechanism in the contract to implement accreditation norms, ensure quality control and sound accounting and information systems.

Moreover, the term "obstetric complication" is missing in the guidelines issued by the state. The scheme in Maharashtra is operational only for deliveries by caesarean section and not all complicated deliveries unlike the national scheme. National estimates suggest 15% of all deliveries would require EmOC and a minimum 5% would need a CS. The change in Maharashtra guidelines has resulted in barring about two third women in need of EmOC from eligibility for the scheme.

The findings reiterate the evidence which shows that successful PPPs require clear guidelines and dedicated experts on both sides to allow for smooth planning and transition. The skills required for the contracting process are high, and it is particularly important to well define each partner's risks and responsibilities, fix the terms in advance, and define expectations in a service-level agreement. The process of micro-birth planning that aims to ensure birth preparedness and complication readiness, an essential pillar to successful operation of the scheme, is however noticed to be hardly practiced leading to multiple operational failures of the scheme. Government's role lies in developing managerial skills and capacities whilst simultaneously creating an enabling environment. At the same time efforts are required to stimulate private providers to participate in the PPP scheme.

Institutionalising PPPs, if successful to provide EmOC and reduce maternal deaths is an interim solution, as it does not address the root cause - lack of specialists in the public sector. While developing the interim measures, it is also essential to bring about the long awaited changes in human resource policies in order to make the public sector capable enough to attract and retain specialists. Moreover, assuming there is adequate contracting-in of specialists in rural areas; the question then arises as to how long the public health system will continue such arrangements and sustain them.

They made recommendations towards the scheme as well as towards policy level changes. The scheme should be made inclusive covering all life threatening complications of pregnancy and child birth. The incentive to contract in specialists should be based on competitive bidding of tariffs rather than fixed rates. The choice between various models of PPP should rest on the local situations aiming at removing financial barriers to access EmOC services. Infrastructural inadequacies in the public

system need to be addressed to provide EmOC services by filling for the specialist gap. Capacity of public sector personnel to design and manage contracts needs to be built.

At the policy level, there is a need to define systems to overcome challenges relating to fund flow, logistical management, mutual trust, transparency, and sustainability of PPP initiatives. There should be mechanisms to innovate and evaluate with more emphasis on dialogue among partners by involving key stakeholders in a well-defined consultation and project development process early on. There should be more prominence given to the partnership with clear delineation of roles so that the focus is on health care provision of assured quality – and this should include monitoring, regulating and enforcement roles by the public sector. It is critical that the public partner develops sufficient capacity for oversight and for making timely adjustments as needed.

Effective dispute redressals mechanisms are necessary, particularly in view of the large disparity in size and influence of the public and private partners. It is necessary to evolve a mechanism for social auditing to ensure that equity and quality are not compromised.

Continuing our discussion on PPP's for EmOC services, the next presentation by **Dr. Akash Acharya** was based on a primary research study based on the Chiranjeevi Yojana (CY) Gujarat.

In rural area the problem is of access to EmOC as most CHCs are running short of gynaecologists and obstetricians as well as anaesthetists (India doesn't allow a nurse or even a doctor with post graduate degree to administer anaesthesia or perform EmOC services). The only option left is to travel to District Hospital, usually, several kilometres away. Once the women reach the hospital, problems of availability of relevant doctors, medicines, transport cost, attitude towards the poor etc. remain. Many women are hesitant to travel and die at home or in transit (>50%).

It is now widely believed that India won't reach the MMR related MDG (Millennium Development Goals) target by 2015 (reduce maternal deaths by 3 quarters). Chiranjeevi Yojana (CY), is a PPP model where poor women can their delivery done free and the cost will be borne by Government of Gujarat (GoG). Moreover Rs. 200 would be provided for transport and Rs. 50 for the accompanying person. Thus it aims to remove the financial barrier to access of qualified health care facility in vicinity. The scheme was launched in five poor districts in 2005 and since 2007 it has been extended to the entire state.

Qualified Empanelled Private Providers (EPPs) are paid Rs. 1,79,000 for 100 deliveries including Caesarean Sections (CS). The CS rate has been worked out at about 7 per cent and there is no separate payment for CS to discourage unnecessary and irrational CS - a practice widely prevalent in the private sector. Remuneration package has been designed by group of experts and EPPs get an advance payment of Rs. 15,000 while registering in the scheme. The Chief District Health Officer (CDHO) is responsible for EPP identification.

It is being claimed that through CY, Maternal Mortality Rate (MMR) and Infant Mortality Rate (IMR) have come down substantially. CY is by now a celebrated scheme and has also received Asian Innovations Award by the Wall Street Journal. It is flagship scheme of GoG's Ministry of Health and Family Welfare (MoHFW) and being recommended for initiation into other states. However, these claims need to be examined in detail before replicating the scheme.

To understand the scheme better, fieldwork was undertaken. Out of more than 200 gynaecologists in Surat *district* (italics added), only 56 were registered with CY. Most of those registered were located in Surat *city* (italics added), and remaining in the peri-urban areas. None of them were in remote rural areas. Moreover, of the 56 registered and having taken the advance from the CDHO, very few were found to be active in conducting deliveries under the scheme. It was found that there were two main motivational factors for EPPs to join the scheme. They were either new in their "practice" and joined the scheme to build "reputation" through "numbers" or they were at the end of the career wanting to do some "charitable" work for the poor. Some EPPs joined CY with the hope of getting a license for Medical Termination of Pregnancy! None of the EPP's considered CY as part of their mainstream activity. In fact leading gynaecologists and mid-career professionals were clearly not interested in being part of the scheme and in fact did not think highly of the scheme. Interestingly, none of the interviewed EPPs viewed the CY as a Public Private Partnership.

One of the most striking findings of the study was that some EPPs were taking only "safe" cases and diverting complicated cases to public hospitals. This has profound implications for the data set claiming high success. EPPs claim that the remuneration package is unjust especially in case of complications. Many also informed that CS rate of 7% is totally unrealistic and in their experience it was more than 30%. This has also resulted in some EPPs opting out the scheme. If EPPs are mostly treating safe cases, then the whole purpose of the scheme will be defeated as the need is to treat EmOC cases, main reason behind high MMR. If complicated cases are not part of the dataset, obviously MMR will drop but that might be a false indicator as the scheme might just be shifting the problem to public providers? This requires detailed evaluation of CY at the community level.

On the beneficiaries' side, BPL card is required to become beneficiary of the scheme but migrants don't have documentary evidences and therefore are left out of the scheme. Since most EPPs are located in the better of areas of city, poor also hesitate in approaching them fearing some latent charges. *Aanganwadi* workers are the links between poor households and EPPs but sometime the trust is broken as EPPs demand money. On the other hand EPPs claim that many of them were using fake BPL cards and therefore not really eligible under the scheme.

However, since the private sector has a potential to contribute towards public health goals (MMR, equity, health care financing for the poor etc.) through PPP, proper regulatory framework with continuous monitoring and evaluation is indispensable.

In the next presentation by **Ms. Anuja Kastia**, findings of her research study were presented. Again, her research was on the CY and revealed another facet of the scheme – she explored the reasons for non – adoption of the scheme by potential users. Her study was conducted in the tribal belt of Sabarkantha and Khedbhrama. Lack of knowledge about the scheme was one of the key reasons for non-adoption. Apart from that, the distance, high expenditure in travelling, various traditional beliefs, family pressure, etc; were cited as some of the other reasons. This stresses the need for region specific schemes. Moreover, it was found that even the EPP's under the scheme were not in a position to undertake serious cases. These invariably had to be referred. This highlights the need for technical backup for any scheme under PPP to be successful. She asserts that vigilant monitoring is required by the block and district health functionaries in order to see that no monetary gains are achieved by the associated doctors. This would further help in restricting any unpleasant experience to the women and help in promotion of the scheme.

The evidence based presentations of PPP's in the area of EmOC, particularly CY of Gujarat was contextualised and made particularly interesting by **Dr. Amarjit Singh's** presentation of the CY for the BPL population and its replication in other districts following its success. It presented, clearly, the governments side of the state of affairs. The CY, as pointed out by Dr. Singh, presented the right mix of the private and public sector resources. The estimated maternal deaths as per GoG statistics is 1236. Reported number of maternal deaths under CY is 64. Similarly, the estimated neo-natal deaths were 8207 and under the CY it showed a marked improvement of 1322. This initiative is a departure from previous practice in the sense that the GoG took sole responsibility for the reimbursement of private health care providers, rather than relying on intermediary parties such as insurers. The state government is working with professional agencies such as associations, obstetricians and academic organizations to plan and implement new arrangements.

Showing remarkable success, the programme has been expanded from five to all 25 districts of Gujarat. Between January 2006 and January 2009, 869 doctors were enlisted. Nearly 2,79,236 deliveries were performed, with each doctor performing an average of 322 deliveries.

The GOG has laid down clear criteria for selection of private partners – thus these could be professionals, reputed NGOs; with availability of funds or ability to raise funds. Special training is also given to senior health officials. There is training on public health, health management, team building, time management, change in attitude, service with a soul, etc. Dr. Singh showed conviction in his belief that PPP has a huge potential to deliver targeted services and ensure effective and equitable use of resources for greater economic as well as social return on public expenditure. It can also help promote use of state of the art technology based solutions to prevent morbidity and save lives and to ensure inclusive development and higher Human Development Index.

Discusssion

Monagupta's study on PPP's in Bihar was greatly appreciated. It presented a clear picture about the way governments are going about taking up PPP's beyond their need and capacity. This leads to shoddy work, particularly in the case of Bihar where most of the MOU's were just one page long! There is a need for capacity building of government authorities so that they understand how PPPs should function. The participants felt that Bihar presented a huge opportunity where the presence of anything is seen as a boon. The question is to do it in the best way possible, learning from lessons within the state and through capacity building, make these initiatives sustainable.

In the case of the presentation of the JSY scheme in Maharashtra, it was argued that the government reluctance to enter into PPP's with private doctors was simplly because there were services available in the public sector. It was clarified that this was not the case. There is an obstetrician available at the District Hospital – but those are not covered in this PPP. Another query that was raised was about the profile of women - whether there was a difference in profile of women who availed of the scheme and those who did not. The speaker said that this was not so, the beneficiaries and non-beneficiaries were of the same class (BPL) and caste (mostly SC, ST). The issues for not accessing were largely administrative or that the women were unaware of the scheme.

It was argued that the NRHM has provided a basket of reforms which gives the desired flexibility, but at the same time, it could be "interpreted" differently by different state governments. Thus it was mentioned that in some PPP's the "contracted in private doctor" was in fact a doctor working in the public facilities! Moreover, it was obvious that in a public facility if there is no obstetrician available,

why would a private doctor practicing in the vicinity enter into a PPP when he knows that the patient is going to come to him anyways!

It was pointed out that there are number of problems with the way NRHM is being implemented. Some governments are doing well, others are not. The findings of the present study should be disseminated widely and should even be published in the media.

With respect to the CY PPP, it was asked whether it was being treated as "cash assistance" scheme rather that for service provision (as with the case with JSY, Maharashtra). It was clarified that while this was not true for Gujarat, CY has its own problems. Here the patients were being told that if there are complications, then they would be charged. This is shocking, since remuneration for complicated cases is also covered under the scheme!

A participant queried about how the remuneration was fixed? Were the private providers involved? It was clarified (by Dr. Singh) that the remuneration was fixed in consultation with SEWA (Rural), FOGSI and IIM (A). It was also asserted that CY should be seen as a part of the larger comprehensive strategies and efforts of the government.

It was also noted that there has been a surge in the number of deliveries in the public health system – from 56% to 82%.

There was some clarification desired on the mode of payment, system and time limit. The doctors register with the CDHO where they get Rs. 15,000/-. One they complete 100 deliveries under the scheme, they receive Rs. 1,79,000/-. Most of the referrals are made by ANMs or ASHAs. Thus when the Block Health Officer receives a bill from the doctor, he checks it with the ANM and the PHC reports prior to making payments. Once a doctor does 200 deliveries, he gets Rs. 3,60,000/- . The idea was that once the trend starts where people see safe delivery as cost effective, they will go for it automatically. As for the perceptions of the private providers, the state offers a great scale in terms of numbers of deliveries to make up for the subsidised cost. The doctors who are active have made a lot of money and the 862 doctors who are active have remained constant. The GoG is also considering changes in the scheme to make it more acceptable to private doctors. Moreover, Gujarat has 12 lakh deliveries per year of which 25% are those in the BPL strata. GoG has been able to reach only 50% of the target population. Therefore efforts need to be made to reach out to the rest. There was also a need to address the issue of C - sections in the state. It was also pointed out that when it comes to regulation, accreditation of health facilities was being taken up very seriously in Gujarat. Already more than 100 facilities have received accreditation. The General Hospital in Gandhinagar, Gujarat, is the first one in the state to have been accredited by the National Accreditation Board for Hospitals and Health Care Providers (NABH). The NRHM has also allowed for a flexi budget. Prior to NRHM, the Medical Officer at the CHC had to run for even Rs. 200. Today, he has a budget of Rs. Two lakhs at his disposal. There is however, a need to develop model contracts for PPP's.

With respect to the study of the CY in the tribal blocks, some participants felt that the providers may not be keen on subsidization since the eligible population is vast (contrary to what was pointed out above)! Moreover, in the context where there is low awareness amongst women about the scheme, would the doctor be in fact willing to provide her with the information that she is in fact eligible for subsidization. It is the doctors' ethical responsibility to do so. These were clearly some of the deficient areas when it comes implementation of the scheme.

The issue of conflict of interest in PPP's is something that has never been discussed.

Session VI: Emerging health care models

Presentations:
1. Mr. Jerry La Forgia, "*International Experience in Improving Public Hospital Performance Through PPPs and The Case of OSS Hospitals in Sao Paulo, Brazil*".
2. Ms. Riya Dhawan, "*Contract Management*" authored by Gautam Charaborty, Arun B. Nair and Riya Dhawan.
3. Mr. Sunil Nandraj, Untitled. An impromptu talk on the private sector and issues in regulation at the request of CEHAT.

Chairpersons:
Dr. Amarjit Singh and Dr. Amar Jesani

The World Bank has hugely shaped the health sector of many countries, particularly in the third world. In his presentation, **Mr. Jerry La Forgia**, has identified two related questions that most governments today are asking two related questions: firstly, how to generate the incentives and accountabilities to raise performance, yet retain the public mission and "social benefits functions" of public hospitals? And secondly, how to move public hospitals out of the public bureaucracy and transform them into more independent entities with accountability for performance? Presenting elements of hospital governance in PPP's in international models, he stressed the need for laying down accountability clauses in the contract itself – such as performance targets with strong contract monitoring and enforcement. The payment mechanism involves a transfer of risk where there is activity based or quality based financing in the form of rewards or sanctions as per the performance indicators specified in the contract. All the hospitals have to retain their public function and focus on "public patients". The feasibility of it is of course related to broader public policies. In the Sao Paulo example presented by Mr. Jerry, the hospital is not permitted to charge user fees, nor is it permitted to sell services to private insurers. It may, however, outsource clinical, diagnostic and hotel services *without* (italics added) government permission. Very importantly, there is a positive information sharing arrangement in all contracts of hospital governance. This enables contract definition, performance monitoring, and enforcement, evaluation, design of budget and/or payment mechanism, effective cost control and transparency. Moreover, all the hospitals retain their "social function". There is public ownership and retention of the goal of public mission.

Analyzing the OSS hospital model in Brazil he asserted the key ingredients of success were – clear decision-making authority, government driven accountability arrangements – that covers strategic contracting performance and accountability built into well-formulated contract; contract enforcement; financing linked to performance, independent audits/reviews - both financial and technical; grievance redressal procedures – specified in contract; emphasis on accreditation; information sharing; comparative benchmarking of facilities over 17 indicators of costs, production, quality, efficiency, etc; and above all well-defined social functions.

Ms. Riya Dhawan in her presentation further emphasized the need for well thought out contracts. She gave a detailed critique of some of the contracts under PPP. There were some gaping flaws in the various MOU's. Many of them had no modification or exit strategy. There is need for incentive or penalty clause; there was blurred asset ownership, no tendering process (monopoly provider) and no transparency. Each of the contracts also needs to cover a mobilisation phase.

More specifically, in case of PPP's involving urban RCH centres, there was a lack of uniform treatment protocols and coverage has excluded a number of slums. The PPP for social marketing of sanitary napkins looked at only promoting one particular brand – rather than sanitary habits, selection of coverage areas not clear and consumer grievances have not been addressed. In case of PPP's in insurance, problem of risk shifting was not adequately addressed. However, in this case, she observed that there was an adequate grievance redressal system.

Many of the contracts involved input financing (such as human resources and drugs) rather than outcome financing. Moreover, in the terms of reference, deliverables are described very broadly. As a result, short-listing and empanelling of service providers become very difficult. There is also the complete lack of Standard Operating Procedures (SOP).

All in all she affirmed that it was necessary that the financing plan needs to be more flexible. The MOU should be based on a proper business plan (cost & financial projection) with a break even analysis. The costing may be reworked periodically in light of the actual expenses incurred. Monitoring and regulation by the government is very important and there needs to be a balance between monitoring and efficiency through payments. There should also be external evaluation for output or outcome indicators.

Mr. Sunil Nandraj, in an impromptu talk (and he clarified that his views did not necessarily reflect the views of the WHO), felt that PPP's is a term that has widely been misused and often even abused by the by the government, the private sector, and NGO's. According to him, it had become the "flavour of the month". He raised a fundamental question regarding PPP – what kinds of relationship can one have with the private sector? Since the fact is that the sector has a very vast multitude of players. Before one gets into a partnership with the private sector, one needs to necessarily have some clear estimate of its size and nature. Presently there is no information even about the actual number of cases being treated in the private sector, including the NGO sector. How can one get into a partnership when we do not even have a clear idea about who that partner really is! The lumping together a multitude of players under "private sector" is in itself problematic. Moreover, he added with some amount of witty sarcasm, considering the fact that the term PPP is used so broadly, government doctors with private practices should also be considered as a PPP!

The government has a poor history of playing a regulatory role. Furthermore, shockingly, there are states that do not even have legislation in place for registration of a health facility, and in the states that have such legislation, its implementation is poor. In the case of CY, for example, once the volume of the services increase, how is the GoG going to planning to monitor and regulate it?

The role of State in financing and provisioning of health care is limited. We do not even have standardised procedures and costs. From the trends it seems that we are heading for a situation wherein the state is going to become the purchaser of health from the private sector. That is the way it seems, for example, in the CY. In this scenario, it is just a matter of time when the private sector will begin to prescribe terms. Eventually, there will be a situation where the richer population with

access only private corporate hospitals, the middle class will be covered by insurance and the poor will be left with public facilities, and there were will specifically targeting population such as pregnant mothers – a situation that already exists – but will only become more ingrained. In such a situation, monitoring will become a bigger challenge.

However, the picture need not be so dismal. The central government is in the process of formalising the legislation, The Clinical Establishments (Registration and Regulation) Bill, 2007; wherein all forms of health facilities have to register. This is a critical step towards regulation and monitoring.

Discussion
There was clearly a need for a better negotiation with the private sector partner for PPP's. There also needs to be better monitoring and regulation across a wide range of issues. This should be done in a manner to ensure that overall health care is delivered.

Session VII: Way forward[1]

Presentations:
1. Dr. Gita Sen, "*Equity in the context of PPP's: Challenges ahead*"
2. Dr. Anant Bhan, "*Summing up*", authored by Dr. Anant Bhan and Ms. Padma Deosthali.

Chairperson: Mr. Ravi Duggal

Dr. Gita Sen is of the view that the many of the PPP's are a form of privatisation and far from promoting equity they actually result in "public pauperisation and private enrichment". She presented findings from three of her studies. First, involved stuyding the trends in utlisation across NSS rounds. The second study documents role of government - NGO partenerhsips in the country. Here she raised a lot of issues related to the role of NGOs and also commented on the community based monitoring (CBM) under NRHM which has become an NGO activity. She felt that the moniotring that is expected is too complex to be achieved. And finally the third study, is an ongoing project that moniors maternal health in districts of Karnataka.

A study by her team of the various rounds of the National Sample Survey revealed that in the 1980's and 90's there was an increasing trend amongst the better off not just to use private facilities but also public facilities. This leads to a two - tier system of services wherein quality of care provided is discriminatory. Thus, how much better or worse do the poor get from the public system is of concern, thereby raising issues of equity. The proportion of untreated illness due to financial reasons jumped dramatically in 1980s and 90s. It means that people were borrowing or going without treatment. She revealed that the NSSO analysis indicates that the middle and upper class are using public facilities contrary to the belief that this class does not use public services.

Her team had also undertaken a study wherein government – NGO partnerships (in the pre-NRHM era) were analyzed. It was found that two-thirds of these partnerships were for the implementation of government schemes, about 20% of them were towards service delivery and less than one-third of the partnerships were for training and capacity building. There was very poor information sharing from

[1] In this session, the paper "*Summing up*" (of the conference) has been covered under "Key Issues and Recommendations".

the government side and any kind of critique was felt unwelcome. The timeframes under which they worked too were very different since the government stressed on quick and visible outcomes. The government, during this period, was more into sub-contacting, rather than getting into any kind of partnership.

She is of the opinion that most PPP's get into trouble as a result of politics and not because of the lack of ability to make good contracts.

Maternal mortality is the simplest indicator to understand. And in most places it is not the distance that leads to the death of a woman or chronic anaemia, but it is because of a system failure or the "football syndrome", where she was sent from one public facility to another. The women have been in and out of the health system so many times. There is serious investigation and data needed supplemented with independent monitoring.

Morever, under NRHM, ASHA's came in trying to be the voice of the community. However, she feels that ASHA's are moving in a completely different direction.

She stresses the need for third party monitoring. The system of incentives and disincentives result in bogus data and bogus institutional deliveries. Bogus teams are sent for monitoring and everybody gets a cut. There is a strong need for civil society and academia monitoring. This is the most critical gap. Concerns about equity have always remained in healthcare and the only way to move forward towards equity is to have universal insurance, especially structured for those below the poverty line.

Discussion
It was commented that data based on district level monitoring is available on NRHM website. However, Dr. Sen expressed concern about the authenticity of the data as a result of the vested interests of the stakeholders.

The session ended on the note that there is a need to triangulate and validate the various health survey data. Moreover, there should be a universal approach rather than targeted approach should be used for health insurance. Also, additional provision is needed in order to promote equity.

Key issues and Recommendations

1. Need for conceptual clarity about public private partnerships: what constitutes a PPP?
While the state's engagement with the private sector has a long history, the present day public private partnerships require a *clarification of the concept* itself. Besides a lack of conceptual clarity, there is also the problem of plurality of definitions. Moreover, *PPP's involve lumping together of the "for profit" and "not for profit" sectors* which not only operate on different values but also on different scales. This clearly reiterates the need for PPP's to be better defined. It could be a long term commitment of the private sector towards the achievement of public goals, involving a formal contract, autonomy (of each partner), joint-ness (at all stages with shared decision-making and accountability), and equity (fair returns in proportion to investment and effort), with the ultimate responsibility for delivery resting with the government. *Thus PPP's can be seen to "supplement" a well developed public sector rather than be seen as a panacea for its shortcomings. A detailed and systematic study* of PPP's would contribute immensely achieving conceptual clarity.

2. Debating the role of the state

With the state opening up to involvement of the private sector, the ideological debate between the market and the state has deepened. Throughout the conference, *the "new" role of the state* was debated. Should PPP's be seen as privatisation; or as the state devolving part of their responsibility; or the state simply recognising the role of the private sector and using its potential towards its own laid down goals? The state cannot use PPP's as a political tool as has been seen to do. Government should initiate PPP's only after all other measures for rectifying a bad situation at their end have been exhausted. There are others who feel that the government is rather incapable, and PPP's are the only option. However, they cannot be seen as the panacea of all ills. The governments' responsibility cannot and should not end with the signing of the contract. PPP's, where essential, has to be in the form of a *symbiotic relationship* between the government and the private sector (for-profit as well as not-for-profit).

3. Need for policy and systemic reforms

There is a strong need for a *policy to guide partnerships in the social service sector*. Moreover, as the debate on the role of the state continues, it is necessary to accept the fact that PPP's are being entered into in a big way and are here to stay. *This necessitates a practical approach* to the upcoming scenario. As pointed out earlier, PPP's involve lumping together of the "for profit" and "not for profit" sectors which not only operate on different values but also on different scales. To evolve a synergistic relationship out of this and direct it towards the benefit of the majority of population is itself a challenge. This requires the *creation of enabling conditions*. The *government needs to enhance its own technical and managerial skills. Systemic reforms* are therefore needed to support the various demands made by PPP's such as increased capacity related to management, legal (for framing of PPP contracts), arbitration and settlement, financial matters (including prior assessment of PPP's to provide value for money) and skills in regulation, monitoring and evaluation. It is necessary to evolve a mechanism for social auditing to ensure that equity and quality are not compromised. There is a need to define systems to overcome challenges relating to fund flow, logistical management, mutual trust, transparency, and sustainability of PPP initiatives. Guidelines need to be put in place for the formulation of contracts in order to factor in all the above concerns.

4. Lack of information about the private sector

Throughout the conference lack of information on the private sector, emerged as one of the key concerns – who are we partnering with? The sector is itself very vast and not much is really known about its practices, the volume of cases, etc. We do not even have standardised procedures and protocols of treatment. The implementation of accreditation laws is poor and many states do not even have laws for registration of clinics! Moreover, the private sector (particularly the for-profit sector) also utilises the services of unqualified or in-house trained staff with rampant unethical practices and irrational care. All these issues raised two critical questions – *who really is the partner and two, by entering into a partnership with the private sector, is the government in a way accepting, legitimising or brushing under the carpet the ills of the sector*? These are critical questions that the government needs to deal with. It is also, under the circumstances, pertinent that *detailed studies of the private sector* are undertaken.

5. Regulation and monitoring of the private sector

If the strengths of the private sector need to be used positively then its weaknesses need to be harnessed first. *It has to be made accountable*. Presently, there is poor regulation of the private for-profit sector. For example, corporate hospitals have shown poor commitment towards their social responsibility despite what was promised in return for various exemptions from the government. This clearly highlights two points – one, it displays how unaccountable the sector is and two, the lack of

will on the part of the government to make it accountable and regulate it. In fact it almost seems that the government and the private for-profit sector harmoniously coexist.

The central government, however, is in the process of formalising the legislation, The Clinical Establishments (Registration and Regulation) Bill, 2007; wherein all forms of health facilities have to register. This is a small, yet critical step towards regulation and monitoring.

6. Regulation and monitoring of PPP projects

From the preceding discussion, the government comes across as the more benevolent partner in a PPP, particularly when it comes to partnerships with the "for profit" private sector. However, in the context of power relationships, it was argued that if all the power lies with the government, there is a scope for corruption. For example, there is concern about the authenticity of NRHM data publicly available. There is a need to triangulate and *validate the various health survey data.* In this context, since both the government and the private sector are involved in a partnership for the promotion of public health goals*, independent third party monitoring* is ideal for PPP projects. Thus the civil society and academia should play an important role in monitoring of the PPP projects. The government cannot play the role of partner and financer and at the same time play the role of regulator. Moreover, strategy for monitoring as well as adequate checks should be built within the contract. Thus monitoring is a crucial step to make sure that the PPP's are being implemented in adherence to the predetermined public health goals by the partners.

Moreover, *the process of monitoring and evaluation of contracts has to be continuous.* Equally important is to have *explicit transparent and adequate governance mechanisms* in place to ensure involvement of all stakeholders, co-ordination across various departments within the government and various implementing agencies and provision of social safety measures to the underprivileged sections of the society.

Indicators of success should be evolved on the basis of justification of the PPP's, besides their impact on the health indictors. Therefore, impact on equity, access, out-of-pocket expenses, quality, etc; should also form the basis of evaluations.

7. Attributes of the private sector that can be best used for PPP

While there are inherent challenges and threats working with the private sector, there are, however, certain attributes which make it an attractive proposition. Flexibility, professionalism, freedom to take initiatives, and less number of barriers in quick decision making, are some of them. These are crucial for growth and efficient functioning of healthcare facilities. Therefore c*ontrolled, yet adequate freedom in PPP's* can create an environment conducive to new initiatives and innovations as it gives flexibility that is rarely seen in the public sector without compromising on the public health goals and equity.

8. Role of incentives and benefits

The issue of incentives, benefits and user fees was brought up a number of times during the conference. Some felt that if the government is financing PPP's, then they might just not flourish. It was also felt that for the private sector to be involved, profit making is not only important, but it also needs to be adequate. Not all participants were comfortable with this. The area of incentives, benefits, user fees and profits is highly treacherous vis-à-vis equity and decidedly debatable.

9. The Role of PPP's contextualised

It was felt that the *government is giving too much time towards PPP*. Very pertinent problem of improving governance or improvising on the method of provision of these services through the public health infrastructure is getting neglected. Moreover, the NRHM as a programme is doing well, but it can do better. One should not lose sight of the fact that PPP's is a component – one of the strategies – under the programme. Furthermore, prior to considering PPP's, there should be other ways attempted to rectify a bad situation. NRHM has been introduced in parallel with other programmes and schemes (such as the UPHSDP); this not only sidelines other programmes, but also results in confusion and wastage of resources.

10. Planning of PPP's and policy level changes

Adequate preparation needs to go into the process of planning a PPP. Hasty planning with no market survey for available services and its cost, inadequate knowledge and experience in government about planning and executing projects in service delivery through PPP may prevent many projects from taking off or even failing.

In the system wherein tenders need to be filled for application, there should be *practical, standardised procedures and criteria* in place. *The Government's responsibility cannot end with finalization of Terms of Reference (TOR) and signing of contract.*

The state should have a *Strategy Development Unit* within State Health Society with qualified and experienced personnel to plan, and study feasibility of PPP as suggested by the Task Force on PPP for NRHM. There should be prioritizing of districts so that districts with higher needs could be taken up first. Piloting of a new project to know the practical problems should always be done before scaling it up in all the districts. *Monitoring and periodic evaluations of projects should be clearly spelt out during the planning phase.*

Evidence shows that successful PPP's require clear guidelines and dedicated experts on both sides to allow for smooth planning and transition. The skills required for the contracting process are high, and it is particularly important to well define each partner's risks and responsibilities, fix the terms in advance, and define expectations in a service-level agreement.

There should be mechanisms to innovate and evaluate with more emphasis on dialogue (rather than directives) among partners by involving key stakeholders in a well-defined consultation and project development process early on. There should be more prominence given to the partnership with clear delineation of roles so that the focus is on health care provision of assured quality – and this should include monitoring, regulating and enforcement roles by the public sector. It is critical that the public partner develops sufficient capacity for oversight and for making timely adjustments as needed.

11. Gaps in PPP

One of the most vital issues thrown up at the conference was the serious gap in terms of evidence emerging from the existing PPP projects on the ground. Apart from third party monitoring, there need to be specific studies commissioned, particularly by the academia, to evaluate the PPP's and measure their success against the laid down goals and their justification (access, equity, quality, etc). It is of critical importance that at this stage we assess the impact of PPP's on the public health sector and in particular on the shortage of health personnel. Comparative studies too would be essential in order to evaluate performances across the kinds of partnerships - bunched payment for purchasing care (Chiranjeevi Yojana) v/s insurance (Yeshashvini scheme) v/s contracting models (such as Bhabha and Karuna Trust).

12. Insurance and its role in promoting equity

Considering the fact that PPP's are here to stay, it becomes very essential that one of its most critical goals – of promoting equity in healthcare – is achieved. Insurance, universal as well as targeted, is one of the best ways to achieve this. Therefore, this should be an important component to be implemented within the programme itself.

13. Role of cooperatives

Cooperatives have extensive reach and accessibility that can be used to promote health. There are a number of cooperatives that are in PPP's that have promoted equity and access for the poorest. On the flipside, many cooperatives have been found to be corrupt. However, adequate checks, standardisation and advocacy can help make PPP through cooperatives a very beneficial option.

14. Redressal Mechanisms

Effective *dispute redressals mechanisms* are necessary, particularly in view of the large disparity in size, influence and assets of the public and private partners, as well as the large difference in perspectives and values of the partners. Moreover, it should be understood that for a successful PPP to evolve and have a significant impact and for a successful working relationship to develop amongst the partners, a considerable amount of time and energy needs to be invested too. During this period serious differences can come up. Redressal mechanisms are also needed to address the grievances of the target population within a PPP.

Conclusion

Public Private Partnerships are a welcome strategy in the health sector if they increase access and promote equity. For decades, the NGO sector has struggled to find a voice and a way to influence policy, decision making and a role in implementation. The Indian government through PPP's is not only welcoming the NGO sector, but also the private for-profit sector. However, what constitutes a PPP – clarity of the concept and a clear definition is warranted. It was argued that PPPs, as they are today, are like the blind elephant- providing free rides or discounted rides. What the blind elephant is trying to do and where it is heading, is of critical importance.

There are some who see this as a folly on part of the government or view PPP's as the governments' way of relinquishing its responsibility, since asking the private for – profit sector to partner with the government and provide public health services is an oxymoron in itself. There is also resentment that the government is focussing too much on PPP's at the cost of other programmes. The government has in place many successful umbrella programmes, particularly the NRHM. It has to continue improvising its own programmes and enhancing its own abilities and infrastructure to address the needs of the people. At the same time, while planning PPP's it has to put into place effective systems which would enable it to get the best out of the private sector in order to promote equity. This includes improvising on technical and managerial skills; open up the sector to independent monitoring and putting in place grievance redressal mechanisms. This all has to essentially happen simultaneously with making the private sector accountable per se; by putting in place and implementation of accreditation and regulation laws. It is of paramount importance to identify gaps in evidence of the PPP projects on the ground, understand and estimate their impact on the key objectives of improving quality, equity and access; and then move forward.