HEALTH SERVICE DELIVERY THROUGH PUBLIC PRIVATE PARTNERSHIP IN INDIA

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ABSTRACT: *Public Private Partnership means an arrangement between a government on one side and a private sector entity on the other, for the provision of public assets and related services for public benefit, through investments being made by and management undertaken by the private sector entity for a specified time period, where there is a substantial risk sharing with the private sector and the private sector receives performance linked payments that conform to specified, pre-determined and measurable performance standards. This Paper deals with public private partnership in delivery of health services in India. It outlines the Government of India's initiatives towards involvement of private sector in implementation of health care delivery process from the period of first five year plan to the eleventh five year plan period. This paper points out the weakness in the process of implementation of health programmes through Government agencies and the need for involvement of private sector in delivery of health services has been emphasized. The private sector participation in delivery of Government health programmes has been indicated in the paper. This paper identifies the problems and challenges in implementation of health programmes through public private partnership. This paper concludes with some policy measures to improve the performance of public private partnership in implementation of health programmes in India.*

INTRODUCTION

Public-Private Partnership or PPP in the context of the health sector is an instrument for improving the health of the population. PPP is to be seen in the context of viewing the whole medical sector as a national asset with health promotion as goal of all health providers, private or public. The Private and Non-profit sectors are also very much accountable to overall health systems and services of the country.

Therefore, synergies where all the stakeholders feel they are part of the system and do everything possible to strengthen national policies and programmes needs to be emphasized with a proactive role from the Government. However for definitional purpose, "Public" would define

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

PUBLIC-PRIVATE COLLABORATIONS IN INDIAN FIVE-YEAR PLANS

First Plan (1951-56)

During first year plan, setting up of antenatal and postnatal clinics by NGOs was initiated. Licensing of private nursing homes for maternal and child health services. The governments of India enter into an agreement with the UNICEF and the WHO to carry out a country wide BCG programme. Non-official organizations encouraged to established and run tuberculosis institutions and governments to give them building and maintenance grants provided these institutions are run on non-profit basis. Voluntary organizations to be stimulated to set up, with state aid, after-care colonies at suitable places in association with tuberculosis institutions in the first year plan period. It should be possible adequately to provide drugs through a combination of private enterprise.

Second and Third Plan (1956-61 and 1961-66)

Government subsidies and grants were given to states, local authorities, NGOs and scientific institutions for family planning clinics and research relating to demographic issues. Maternity and child welfare services provided by the primary health centres are supplemented by services provided by welfare extension projects and by voluntary organizations. A large number of voluntary organizations and social workers in anti-leprosy work to be associated in the leprosy programme.

Fourth and Fifth Plan (1969-74 and 1974-79)

NGOs to integrate family planning as part of their other health services that they extended to the community, distribution of contraceptives and education during the fourth year plan period and fifth year plan period. In urban areas it was proposed that private practitioners provide advice, distribute supplies and undertake sterilizations. Financial support from government to private practitioners and NGOs was initiated in the period. In order to create a sense of partnership with government efforts voluntary contributions to be encouraged in the malaria programme.

Sixth Plan (1980-84)

Sixth plan encouraged private medical professional and non-governmental agencies for increased investment. Government offers organized, logistical,

financial and technical support to voluntary agencies active in the health field. Encourage the participation of voluntary agencies through financial support in leprosy. Financial assistance to be provided to voluntary organizations which provide medical care facilities at the village level through doctors employed on part-time basis.

Seventh Plan (1985-90)

Voluntary organizations and local bodies encouraged to undertake responsibility for family welfare and primary healthcare services. NGOs involved in the extension education and motivation in FPP. Scheme for assisting private nursing homes for family planning work continued. Increased emphasis laid on MCH activities by supporting by NGOs, village health committees, and women's organizations. Priority would also be assigned to enlist community participation and the aid of voluntary organizations in the leprosy programme. Organized blood-bank and blood transfusion services will be further developed with the active participation of the centre, the states and voluntary organizations.

Eighth Plan (1992-97) and Ninth Plan (1997-2002)

Eight and ninth plan encouraged private initiatives, private hospitals at secondary and tertiary level. During the eighth and ninth plan period, role of NGOs, social marketing in Reproductive and Child Health programmes and some contracting out of primary level services was encouraged.

Tenth Plan (2002-07)

In Tenth plan period, increased involvement of voluntary and private organizations, self-help groups and social marketing organization in improving access to healthcare and contracting in and out of clinical and non-clinical services. NGO sector to support the government in handling Reproductive and Child Health services like providing transport for emergency obstetric care for which funds would be devolved at the village level and PPPs introduced in several states. Preparation of IEC material and social marketing of contraceptives has been handed over to the NGO sector.

RECENT INITIATIVES IN PUBLIC PRIVATE PARTNERSHIP

In the last two decades, there has been a growing concern over the performance of the healthcare delivery system in India. In the year 2006, a mere 0.9% of the GDP was allocated to public health. Peters *et al.* (2003) state that India's health system is being forced to adapt to changing health conditions, new technologies, transformations in society and evolving roles for government and the private sectors. In recent years, the Indian government has formulated a number of innovative policies and plans to address the issue of under-performance, especially in terms of healthcare delivery. The Indian government

has also introduced a number of reforms across different sectors, such as healthcare financing, health insurance, continuing medical education, and health information systems. Yet, the public healthcare delivery system is unable to deliver and meet the health goals of India.

The Government of India (GOI) Report of the National Commission on Macroeconomics and Health (2005), states that the principal challenge for India is building a sustainable healthcare system. Selective, fragmented strategies and lack of resources have made the health system unaccountable, disconnected to public health goals, inadequately equipped to address people's growing expectations and inability to provide financial risk protection to the poor.

According to the Organization for Economic Co-operation and Development (OECD) Report (2004), adequate and effective delivery of public services is also central to achieving the Millennium Development Goals (MDGs). The Planning Commission of the Government of India (GOI) has constituted a Working Group on PPPs to improve healthcare delivery for the Eleventh Five-Year Plan (2007-2012). According to the draft report prepared by the Group, the share of private players in healthcare delivery has grown tremendously. The GOI's Report (2006-7) by The Task Force on Medical Education for the National Rural Health Mission, states that the private sector provides 58 per cent of the hospitals, 29 per cent of the beds in the hospitals and 81% of the doctors. Nearly 78% of the rural and 81% of the urban population is provided medical treatment by private healthcare players. Also, according to the National Sample Survey Organization (NSSO) 60th Report (2004), use of public healthcare is lowest in the rural areas in the states of Bihar and Uttar Pradesh. This reliance on the private sector for healthcare delivery is highest in Bihar i.e 89% in urban and 95% in rural areas. Approximately 77% of OPD cases in rural areas and 80% in urban areas are being serviced by the private sector in the country. Bhat (1999) suggests that one must look at other options for healthcare delivery because there are no regulations to monitor the cost and quality of the private players. Apart from these negative consequences of the private sector growth, the cost of private healthcare cannot be afforded by most people from the lower strata of society and those who do use private services do so at an exorbitant cost. Bhat further comments that the cost of health care, access and quality problems will worsen with the growth of the private sector. The public policy response to check some of the undesirable consequences of this growth is critical and should focus on strengthening the existing institutional mechanisms to protect patients, developing and implementing an appropriate regulatory framework, and strengthening the public health care delivery system.

NEED FOR PUBLIC–PRIVATE PARTNERSHIP

Apart from the private players, many civil society organizations have also entered the arena of healthcare delivery. The Indian government is encouraging

Public Private Partnerships (PPPs), and is also acknowledging their role and contribution in meeting the health goals of the country. Promotion of these PPPs is also important to lessen the burden on the government in terms of providing the outreach as well as to alleviate the funding constraints. Under the 10th Five Year Plan (2002-2007), initiatives have been taken to define the role of the government, private and voluntary organizations in meeting the growing needs for healthcare services and meeting the goals of National Health Programmes. The mid-term appraisal of the 10th Five Year Plan also advocates partnerships subject to suitability at the primary, secondary and tertiary levels. The contemporary National Health Policy of India, formulated in the year 2002, and the ambitious National Rural Health Mission (NRHM) formulated for the period 2005-2012, takes into consideration the important role played by private players and civil society organizations in meeting the health goals of the country. At the national level for India, the MDGs have been integrated into the 10th and 11th Five Year Plans as well as form an integral part of the National Rural Health Mission (NRHM). The National Health Policy of India envisaged the participation of the private sector in primary, secondary and tertiary care and recommended suitable legislation for regulating minimum infrastructure and quality standards in clinical establishments and medical institutions.

PARTNERSHIP BETWEEN THE GOVERNMENT AND THE FOR PROFIT SECTOR

The Government contracted the Sawai Man Singh Hospital, Jaipur. The SMS hospital has established a Life Line Fluid Drug Store to contract out low cost high quality medicine and surgical items on a 24-hour basis inside the hospital. The agency to operate the drug store is selected through bidding. The successful bidder is a proprietary agency, and the medical superintendent is the overall supervisor in charge of monitoring the store and it's functioning. The SMS Hospital has also contracted out the installation, operation and maintenance of CT-scan and MRI services to a private agency. The agency is paid a monthly rent by the hospital and the agency has to render free services to 20% of the patients belonging to the poor socio-economic categories.

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

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

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

The Government of Andhra Pradesh has initiated the Arogya Raksha Scheme in collaboration with the New India Assurance Company and with private clinics. It is an insurance scheme fully funded by the government. It provides hospitalization benefits and personal accident benefits to citizens below the poverty line who undergo sterilization for family planning from government health institutions. The government paid an insurance premium of Rs. 75 per family to the insurance company, with the expected enrollment of 200,000 acceptors in the first year.

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

PARTNERSHIP BETWEEN THE GOVERNMENT AND THE NON-PROFIT SECTOR

The involvement of NGOs in the Family Welfare Programme could be observed in India. The MOTHER NGOS (Mother NGO) and SNGO (Service NGO) Schemes are being implemented by NGOs for population stabilization and Reproductive and Child Health. 102 Mother NGOs in 439 districts, 800 FNGOs, 4 regional Resource Centers (RRC) and 1 Apex Resource Cell (ARC) are already in place. The Mother NGOs involve smaller NGOs called FNGOs (Field NGOs) in the allocated districts.

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

The SNGOs provide an integrated package of clinical and non-clinical services directly to the community. The Govt. of Gujarat has provided grants

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

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

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

The Government of Tamil Nadu has initiated an Emergency Ambulance Services scheme in Theni district of Tamil Nadu in order to reduce the maternal mortality rate in its rural area. The major cause for the high MMR is anon-medical cause - the lack of adequate transport facilities to carry pregnant women to health institutions for childbirth, especially in the tribal areas. This scheme is part of the World Bank aided health system development project in Tamil Nadu. Seva Nilayam has been selected as the potential non-governmental partner in the scheme. This scheme is self-supporting through the collection of user charges. The Government supports

the scheme only by supplying the vehicles. Seva Nilayam recruits the drivers, train the staff, maintain the vehicles, operate the program and report to the government. It bears the entire operating cost of the project including communications, equipment and medicine, and publicizing the service in the villages, particularly the telephone number of the ambulance service.

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

PARTNERSHIP BETWEEN THE GOVERNMENT AND A PRIVATE SERVICE PROVIDER

Several examples for the above partnership could be quoted from the Indian experience: Partnership between the Department of Family Welfare and Private Service Providers:

The Department of Family Welfare has appointed one additional ANM on contractual basis in the remote subcenters which constitute 30% of all sub centers in C category districts in 8 states to ensure better emergency obstetric care under the Reproductive and Child Health programme. Similarly 140 ANMs could be appointed in Delhi for extending their services in the slum areas. The scheme has been extended to the North Eastern states with effect from 1999-2000.

A scheme for reservation of sterilization beds in hospitals run by government, local bodies and voluntary organizations was introduced in 1964 with view to provide immediate facilities for tubectomy operations in hospitals. At present too, beds are sanctioned to hospitals run by local bodies and voluntary organizations and grant-in-aid is provided as per approved pattern of assistance. The Haryana Urban Reproductive and Child Health Model is being implemented in 19 urban slums and benefits 15 lakh beneficiaries. In this model, a private health practitioner (PHP) has been identified to provide comprehensive primary health care service to a group of 1000-1500 targeted beneficiaries.

A proposal has been submitted by PSS, Rajasthan to the GOI for establishing a comprehensive Reproductive and Child Health clinic in 3 districts, wherein PSS would provide services like sterilization, MTP, spacing, ante/post natal care, immunization, RTI/STI. The cost to be borne by the Govt. is Rs. 18 to 20 lakhs p.a. per clinic. With a view to ensure project sustainability, the user fees is sought to be deposited in a bank account. The Samaydan Scheme in Gujarat aims to ease the problem of vacancies of specialists in health and medical services. About 125 honorary and part-time specialists have been appointed in rural hospitals under the scheme and the removal of age-eligibility criteria for appointment of doctors in government services is also being considered.

PARTNERSHIP BETWEEN THE GOVERNMENT AND A PRIVATE SECTOR AND/OR THE NON-PROFIT SECTOR AND A PRIVATE SERVICE PROVIDER AND/OR MULTILATERAL AGENCIES

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

The GOI has initiated a Public Private Mix (PPM) pilot project with technical assistance from WHO in 14 sites across the country viz. Ahmedabad, Bangalore, Bhopal, Chandigarh, Chennai, Delhi, Jaipur, Kolkata, Lucknow, Patna, Pune, Bhubaneshwar, Ranchi and Thiruvananthapuram. The areas of collaboration with the NGOs include: community outreach; health education and promotion; provision of DOTS and in-hospital care for TB disease; The Rajiv Gandhi Super-specialty Hospital in Raichur Karnataka is a joint venture of the Government of Karnataka and the Apollo hospitals Group, with financial support from OPEC (Organization of Petroleum Exporting Countries). The basic reason for establishing the partnership was to give super-specialty health care at low cost to the people Below Poverty Line.

The Govt. of Karnataka has provided the land, hospital building and staff quarters as well as roads, power, water and infrastructure. Apollo provided fully qualified, experienced and competent medical facilities for operating the hospital. The losses anticipated during the first three years of operation were

reimbursed by the Govt. to the Apollo hospital. From the fourth year, the hospital could get a 30% of the net profit generated. When no net profit occurred, the Govt paid a service charge.

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

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

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

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

The Yeshasvini Co-operative Farmer's Healthcare Scheme is a health insurance scheme targeted to benefit the poor. It was initiated by Narayana

Hrudayalaya, super-specialty heart hospital in Bangalore, and by the Department of Co-operatives of the Government of Karnataka. The Government provides a quarter (Rs. 2.50) of the monthly premium paid by the members of the Cooperative Societies, which is Rs.10 per month. The incentive of getting treatment in a private hospital with the Government paying half of the premium attracts more members to the scheme. The cardholders could access free treatment in 160 hospitals located in all districts of the state for any medical procedure costing upto Rs. 2 lakhs.

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

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

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

The quality of services increased in terms of 24-hour availability of doctors and medicine, diagnostic facilities, better infrastructure, cleanliness, maintenance and timeliness of services. Through RKS, the hospital has also been able to provide free services to patients below the poverty line.

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

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

Rashtriya Swasthya Bima Yojana (RSBY) is India's first social security scheme that embraces a profit motive, and is a good example of public-private partnership in the social sector. The insurer (public or private) is paid premium for each household enrolled for RSBY. Therefore, the insurer has the motivation to enroll as many households as possible from the BPL list. A hospital has the incentive to provide treatment to large number of beneficiaries as it is paid per beneficiary treated. Insurers in contrast, monitor participating hospitals in order to prevent unnecessary procedures or fraud resulting in excessive claims. Moreover the scheme provides for the inclusion of intermediaries such as NGOs which have a greater stake in assisting in the sea Reproductive and child health for BPL households since they are paid for their services. The government by paying a maximum sum upto Rs. 750/- per family per year, allows access to quality health care to its BPL population fulfilling its commitment to one of the important Millennium Development goals.

If all goes well, according to plan, 30 crore people or one third of India will be covered in five years (2008-13) through the RSBY scheme. In other words, health of both the financial and labour markets are positively co-related. In a country like India where 86% of the total labours force exists in the unorganized sector and contributes around 50% to the national GDP. (NCEUS Report 2008); health of the labour force becomes a vital area of investment for

private and public sector stakeholders. This becomes even more imperative when just about 2% of the total population of India is covered by health insurance (Chandra Shekar Hemalatha 2009) and public spending is just 0.9% of the GDP.

It is estimated that around 4% of BPL population requires hospitalization every year and cost per episode (at 1995-96 prices) was estimated at Rs. 2,100 (Ahuja, ICRIER 2004). Currently total expenditure on health in India is around 6% of the GDP. Government spending is less than 25% against the average spending of 30-40% in other developing countries. Indian health insurance industry stands at INR 5125 crores with only a small section (2%) being covered so far. The health insurance sector has the potential to become a Rs. 25,000 crore industry by 2012 (Health insurance sector estimates 2010).

THE PANCHAYAT RAJ INSTITUTIONS AND THE HEALTH SECTOR – WORKING AND THE LESSONS LEARNED

There are a number of studies that help us get some idea of what has worked and what has not worked. A recent study, using the empirical evidence from India shows that fiscal decentralization plays a significant role in reducing infant mortality rate in India. The study further shows that the effectiveness of fiscal decentralization can be affected by other complementary factors such as the level of political decentralization. States which have good fiscal and political decentralization index are twice more effective in reducing IMRs than states with high fiscal but low political decentralization index.

A study of Karnataka experience found that creation of elected councils (at local level) have helped in reducing absenteeism and in enhancing employees' work rate when they were on the job, although they felt that these achievements sometimes tend to be exaggerated. It is also suggested that moral pressure from councils at both district and block levels have been more important than formal disciplinary action. The power of district councils to move formally against civil servants was limited in that they could suspend but not dismiss. A study of West Bengal shows that the panchayats have helped, among other things, in efficient and cost effective implementation of several rural development programmes including the construction of health centres.

In yet another field based study linking primary health care and Panchayat Raj Institutions in the states of Gujarat, Maharashtra, Karnataka, and West Bengal it is seen that there is a definitive role for Panchayat Raj Institutions in improving the quality of health care services. It shows that Panchayat Raj Institutions (Village Government Institutions) have a significant role in improving the functioning of the health care system at the local level.

All evidence clearly suggests the positive role of Panchayat Raj Institutions in improving the quality of health care services, especially through ensuring better attendance of health care functionaries at the local level, as well as exerting moral pressure on health staff not to shirk from work. Also watchful

participation of local communities has contributed in some measure in improving the supplies of drug and equipment by assisting the local health staff by bringing the deficiencies in the supplies to the attention of higher authorities. In addition the Panchayat Raj Institutions can play a significant role by assuming responsibilities of monitoring and supervision in preventive health care. The Panchayat Raj Institutions have yet another role which they are capable of playing; this concerns participation in programmes of health education and awareness creation.

VILLAGE HEALTH COMMITTEE

The VHC is intended to be a part of the local self-governance structure of the *Panchayati Raj* Institutions specifically the Village Council called the *Gram Sabha*. The purpose of the VHCs is to build and maintain accountability mechanisms for community-level health and nutrition services provided by the Government. The National Rural Health Mission provides guidelines on the framework, functions and responsibilities of VHCs and has provided for a flexible "untied fund" of Rs. 10,000 per health sub center facility to support local actions.

The role of the VHCs, as mentioned in the National Rural Health Mission guidelines is to create awareness in the village about available health services and their health entitlements. To develop a Village Health Plan based on an assessment of the situation and priorities of the community to maintain a village health register and health information board and calendar. To analyze key issues and problems pertaining to village level health and nutrition activities and provide feedback to relevant functionaries and officials; and to present an annual health report from the village to the *Gram Sabha.*

VILLAGE OWNERSHIP OF THE VHC AND THE VILLAGE HEALTH PLAN

It takes time and skills in facilitation and communication to lead to a village's understanding and ownership of a VHC and Village Health Plan. There are challenges, but the VHC can improve the functioning of the Government service delivery at Primary Health Centers and Community Health Centers. The VHC may function better and have better relationships with the Government health services if the VHC is established and able to help select their own health and nutrition functionaries for example ASHA. Regular meetings of the VHC are associated with more successful outputs and outcomes.

LINKING VHCS WITH GOVERNMENT SYSTEMS AND SERVICES

The VHCs can consider using the citizen's charter mechanism to establish linkages with the Government systems and institutions [including the *Panchayati Raj* Institutions Village Government Institutions, as well as with Government health services for transport, referrals etc. The VHC seems to

work better when it supports and serves as an ally with the health system in terms of supporting the community-level health and nutrition workers such as the AWW and ANM, rather than acting mainly as an outside critic or activist group.

It is helpful if there is seed money available to use for start-up activities of the VHC. One model for use of the "untied fund" of Rs. 10, 000 (made available under the National Rural Health Mission) that appears successful is for a village health worker (e.g., ANM) and the VHC to have a joint account with the elected head of the *Gram Sabha* or *Sarpanch*. Existing groups like SHGs and livelihood groups can help form a VHC or form the basis for a VHC.

VOLUNTARY HEALTH ASSOCIATION OF INDIA

Voluntary Health Association of India (Voluntary Health Association of India) is a Delhi-based national network of more than 4000 non-governmental organizations spread across the country. It is one of the world's largest associations of voluntary agencies working in the areas of health and development. Village Health Association of India was founded in 1970 with the goal of "making health a reality for all the people of India." To achieve this goal, Voluntary Health Association of India promotes social justice and human rights in the provision and distribution of health care, with an emphasis on the disadvantaged millions. Voluntary Health Association of India believes that such an equitable health care system should be culturally acceptable, universally accessible and affordable. Voluntary Health Association of India envisions a sustainable, rational and dynamic health planning and management system in the country with the active participation of the people. Voluntary Health Association of India is a federation of 24 state-level voluntary health associations. Over 400 member organizations of these State Voluntary Health Associations form the democratic base of Voluntary Health Association of India. Elected representatives of these organizations manage the affairs of Voluntary Health Association of India.

VOLUNTARY HEALTH ASSOCIATION OF INDIA'S PARTNERSHIP WITH THE GOVERNMENT

Given Voluntary Health Association of INDIA's presence in almost every corner of India and its technical and professional competence, It has been able to develop a relationship of mutual trust and confidence with the government. This has resulted in a situation where in many areas of common concerns, like Reproductive and Child Health, HIV/AIDS, people-centered community health care as well as health promotion, Voluntary Health Association of India is working closely with the Government of India, very often supported by the government financially and otherwise. This relationship has not been without its frustrations but given the size and complexity of the government machinery and its old bureaucratic tradition, the relation has not been too unfulfilling.

On the other hand, Voluntary Health Association of India has also taken up issues with the government on many areas of major concern, starting from its five-year report on the status of the nation's health. The Report of Independent Commission on Health in India, which Voluntary Health Association of India sponsored and coordinated as a major document of national importance that was released by the Prime Minister of India, covers all aspects of health and medical care in the country.

PROBLEMS AND CHALLENGES IN PUBLIC PRIVATE PARTNERSHIP

The existing evidence for PPP do not allow for easy generalizations. However it appears that despite additional efficiencies, the objective of additional resources is not met, as State revenue remains the bedrock of all services. The evidence also reveals great disparity in services and in remuneration. As is evident the objectives of the initiatives have been to overcome some of the deficiencies of the public sector health systems. Donations, introduction of user fees, insurance schemes are methods to augment resources. Contracting out is resorted to when health facilities are either underutilized or non functional while contracting in is used to improve quality of services or improve accessibility to high technology service or to improve efficiency. Contractual appointment of staff aims to reduce the negative impact of vacant positions. Voucher schemes and community based health insurance etc are invoked to reduce the adverse effects of health care costs on poor patients and improve equity in health system. Mobile health schemes, involvement of CBOs, health cooperatives etc are models in improving accessibility, both physical and to the health system. Some of the partnerships are for a short duration while the other is longer. The thrusts of the partnerships also vary. Some focus on service delivery, some to augment resources and infrastructure, some towards organizational and systemic improvements while others are simply advocacy oriented.

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

It is seen that in most partnerships, the State Health Department is the principal partner with rare stakeholder consultation. In most cases it signs contracts with very few cases of Hospital Management Societies signing the contracts in a decentralized manner. In terms of monetary value the contracts at Kolkottta's Bagha Jatin General Hospital provided inexpensive dietary services at the rate of Rs. 27 per meal for about 30 patients a day and cleaning service at Rs. 24000/- per month. The most expensive partnership was the

Rajiv Gandhi Super Speciality Hospital in Raichur where the Government of Karnattaka has paid several hundred million rupees to the partner as start up cost plus an assurance to cover future losses. The above initiatives also show that more than 75% of the projects have been located in backward areas of the states. However true partnerships in sense of equality amongst partners, mutual commitment to goals, shared decision making and risk taking are rare. The case studies also bring to fore genuine concerns summarized in terms of absence of representation of the beneficiary in the process, lack of effective governance mechanisms for accountability, non transparent mechanisms, lack of appropriate monitoring and governance systems and institutionalized management structures to handle the task It is seen that the success or failures of the initiatives are as much dependent upon the above issues as on the political environment, legal framework of the negotiation, the capabilities of the partners, the risks and incentive each party incurs, funding and the payment mechanisms, cost and price analysis prior to negotiation, standardization of norms, performance measurement and monitoring and evaluations systems.

CONCLUSION

As is evident from above, Public Private Partnerships are emerging as a novel approach for extending the reach and scope of the healthcare delivery systems throughout the world. The government is extending support to the civil society and the civil society and the government is being supported by private companies and corporate entities. This is creating synergistic collaborations with the private sector extending support in terms of finances, technical and managerial expertise for enhancing healthcare delivery. A PPP is a collaborative arrangement with give-and-take relationship between two or more parties, with shared goals, defined stakes, and expected outcomes. These configurations may define their own structures, processes, set of deliverables, and performance indicators. All this needs to be achieved through a set of predefined resources. With the given set of resources (money, manpower, technology), these partnerships need to bring out the best. Therefore, identification of the factors that improve the efficiency of healthcare delivery via PPPs will be very useful.

Apart from the above examples of successful PPP's instrumented by healthcare sector in India there are numerous examples wherein innovative models are being envisaged to provide a robust healthcare framework in the country. Some of the projects in the pipeline include setting up of the diagnostic centres at the district hospitals of Pithoragarh and Kotdwara in Uttaranchal, establishing 200 bedded secondary level hospitals in Delhi under the PPP model. KPMG is the advisor for both these projects and is involved in designing of the PPP model. KPMG is the advisor for both these projects and is involved in designing of the PPP model, financial and project structuring, detailing scope of services, technical advisory, tendering process and eventually short listing of private partner.

In today's context, PPPs are contributing in most sectors of development, be it education, health, or telecommunications. This new trend has several advantages over the conventional setups as the expertise of the government and industry is brought together. From this study it is evident that the presence of healthcare delivery providers is the most crucial input for better functioning of a healthcare unit. In terms of input factors, the number of healthcare professionals rather than the cost of specialized high-end equipment, are important in calculating the efficiency of a healthcare delivery unit.

SUGGESTED ACTIONS

Public Private Partnerships should be taken as innovative joint alliances which function on the joint parameters of risks and rewards with appropriate re-source allocation to meet the needs of public health delivery. It is important to clearly define the input and output factors that ultimately affect the expected outcomes of the venture.

A strategic framework of healthcare delivery through these partnerships needs to be developed. This framework should take into account the varied health needs of the country and the health determinants that can influence and govern the performance of the healthcare delivery system. The key system components or potential areas where partnerships can enhance the whole system's outcomes need to be identified. Once these factors are identified, they can be used to develop Public Private Partnership models that are efficient and provide cost-effective quality health services. These can then be integrated in a comprehensive framework for delivery of healthcare services.

PPPs constitute an area that brings together public and private players to ad-dress common challenges. With the constraints in public healthcare funding versus the health investment needs, the performance improvements versus cost effectiveness; one has to seek an appropriate balance between the healthcare needs of the country and the interests of the private players.

PPPs should not only provide a means to meet the development agenda, but also be a sustainable and mutually advantageous collaborative arrangement. This holistic approach through Public Private Partnerships will help develop health care delivery mechanisms that have inclusive strategies to improve the quality of care as well as ensure the sustainability of these partnerships.

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A PPP is a collaborative arrangement with give-and-take relationship between two or more parties, with shared goals, defined stakes, and expected outcomes. These con-figurations may define their own structures, processes, set of deliverables, and performance indicators. All this needs to be achieved through a set of pre-defined re-sources. With the given set of resources money, manpower, technology, these partnerships need to bring out the best. Therefore, identification of the factors that improve the efficiency of healthcare delivery via PPPs will be very useful.

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