CHAPTER VII
PUBLIC PRIVATE PARTNERSHIP (PPP) IN
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VII.1 Introduction

No country in the world is committed to universal healthcare at affordable cost without active participation of the government. Even the World Bank and others who supported free market economy recognize that health is one of those areas where the public sector must continue to play an important role. Therefore, though the public sector continues to play a very important role, it has not delivered with that level of efficiency as it should have. It is plagued with serious bureaucratic hurdles and managerial inefficiencies. It has also had resource constraints and resultantly has major issues of inadequate performance. The primary healthcare services not being as efficient as they were designed to be. Many of the public primary health centres are not adequately staffed and resourced in terms of equipments and drugs.

The private sector is certainly far more efficient in its delivery mechanism and has been increasing its role and outreach. In recent years, 80 percent of healthcare expenditure in India is out-of-pocket expenditure and much of it goes to private healthcare providers. Often, even the poor tend to access private healthcare providers probably, because they may not want to lose a working day’s wage by queuing up in government hospitals. The private sector, however, has limitations because it is driven by profit maximisation. Hence, unless there are regulatory mechanisms which direct and discipline the private sector, this sector could become abusive.

In this scenario, collaboration with the private sector has emerged as an avenue to plug gaps of availability and accessibility of the public health system. After reviewing the health sector of India, several Indian policy documents now reveal the need to co-opt the private sector to meet the commitments of the government with regard to public health. The World Bank (2001), the 11th Five Year Plan, the Report of the National Commission on Macroeconomics and Health (2003, 2005) and the Mission Document of the NRHM, strongly advocated the harnessing of the private sector.
Collaborating with the private sector and fostering a partnership for providing health services to the underserved section of the population are crucial in Indian context. Due to the deficiencies in the public sector health systems, the poor in India are forced to seek services from the private sector, often borrowing to pay for them.

The main objective of this chapter is to study the concept of public-private partnership in healthcare services with special reference to experiments carried out in the state of Uttar Pradesh.

VII.2 Private Healthcare Providers in India

Over the years the private health sector in India has markedly expanded (Baru, 1998). At the time of independence, private sector in India provided only 8 percent of healthcare facilities (World Bank, 2001) but recent estimates indicated that 93 percent of all hospitals, 64 percent of beds, 85 percent of doctors, 80 percent of out-patients and 57 percent of in-patients are in the realm of the private sector (World Bank, 2004). Broadly speaking, the private sector constitutes healthcare providers, whose motives are spelt out as, ‘for-profit’ and ‘not-for-profit’. The ‘not-for-profit’ providers include charitable trusts, missionary or religious organizations; whereas, the composition of ‘for-profit’ providers is invariably more complex. They include individual practitioners, as well as institutional providers, pharmacy shops, polyclinics, diagnostic centres, nursing homes and hospitals with various capacities and levels of service. There are also corporate social responsibility units, professional associations and social entrepreneurs. Another vital segment of the private sector comprises informal providers – such as traditional healers, traditional birth attendants, faith healers, etc. It is presumed that they constitute the principal share of private providers in both rural areas and urban slums across India including Uttar Pradesh.

As is evident in other parts of India, the private healthcare sector in Uttar Pradesh represents a complex combination of non-state providers ranging from faith healers and quacks to super-speciality hospitals. The National Commission on Macroeconomics and Health (NCMH, 2005) indicated that of the estimated 1.3 million private healthcare providers in India, more than 80 percent are regarded as own account enterprises (OAE) and they constitute about 92 percent of the private health sector in rural areas. It highlighted the fact that out of 230,000 health establishments in India, around 2 percent offered tertiary care services. Corporate hospitals constitute a
negligible proportion of the private health establishments. In addition, the report brought to light that merely 17,000 non-profit health establishments existed in the entire country and the proportion of not-for-profit healthcare providers in Uttar Pradesh was less than one percent of all private healthcare providers. On the basis of the 57th round of National Sample Survey (2001-02), it could be inferred that in Uttar Pradesh there are more than 3,38,000 health providers (enterprises), employing nearly 450,000 staff. Of these 3,38,000 healthcare providers and enterprises more than 140,000 (41 percent) are unregistered providers (highest in the country). It is apparent that a large number of healthcare providers in the state are unregistered and unregulated. A predominant proportion of the people of the state are compelled to seek services from an expensive and unregulated private sector by paying out-of-pocket.

In order to meet the growing healthcare needs of the population, various state governments in India have been exploring the option of involving the private sector and creating partnerships with it. Although private healthcare sector is blamed for inequitable, expensive, overly indulgent in clinical procedures and without quality standards but the private sector is perceived to be easily accessible, better managed and more efficient than its public counterpart (Raman, 2008). It is assumed that collaboration with the private sector in the form of Public Private Partnership (PPP), will improve equity, efficiency, accountability, quality and accessibility of the entire health system. It is underlined that the public sector and private sector can potentially gain from one another in the form of resources, technology, knowledge and skills, management practices, cost efficiency and even a makeover of their respective images (ADBI 2000). Partnerships are expected to improve the resource constraints of the public sector by reducing investment in expensive tertiary care services.

VII.3 Public Private Partnership: Concept and Definitions

There are numerous definitions of Public Private Partnerships (PPP) because of the different ways in which each of its component terms public, private and partnership, have been used by different scholars.

In general, the public sector includes organizations or institutions which are financed through state revenues and which function under government budgets or controls. The private sector comprises those organizations and individuals which work outside the direct control of the state. Broadly speaking, the private sector includes all
non-state actors, some explicitly seeking profits (‘for-profit’) and others operating on a ‘not-for-profit’ (NFP) basis. The former are conventionally called private enterprise, the latter non-governmental organizations (NGOs). In the health sector, ‘for-profit’ providers may include individual physician, diagnostic centres, ambulance operators, blood banks, commercial contractors, polyclinics, nursing homes and hospitals of various capacities. They may also include community service extensions of industrial establishments, cooperative societies and professional associations. The ‘for-profit’ private health sector includes a most diverse group of practitioners and facilities. Likewise, the character of the NFP organizations varies in terms of their size, expertise level and geographical spread. NFP services are clustered in charitable clinics or hospitals. Some are established on a financially sustainable basis and are funded from user charges. Most of these require the support of grants or donations.

Not all interactions between the private and the public sectors are Public Private Partnerships (PPP). Public Private Partnership (PPP) denotes a loose to tight arrangement between actors in public and private sectors with a focus on achieving a specific objective. PPP may be arrangements between multiple partners or between just two. It may be global, national, sub-national or local in scope. The arrangements between the public and private sector could be traditional, such as, contracting-in or contracting-out, or entry of new entities that include representatives from the public and private sectors.

The concept of Public Private Partnership (PPP) covers all cases, situations and depends upon the interpretation one wants to make. A well known definition is the one given by the UK Commission on Public Private Participation, “A PPP is a risk sharing relationship between the public and private sectors based upon a shared aspiration to bring about a desired public policy outcome.”

The core of Public Private Partnership (PPP) encompasses a relative sense of equality between the partners, mutual commitment to public health objectives, mutual benefits for the stake holders involved in the partnership, autonomy for each partner, shared decision making and accountability and equity in fair returns.

Partnership is, therefore, a collaborative effort and a reciprocal relationship between two or more parties, with clear terms and conditions and well defined partnership structures to achieve mutually understood and agreed objectives by following certain mechanisms in a stipulated time period.
VII.4 Rationale for Public Private Partnership in Healthcare

Public Private Partnership (PPP) has emerged as a policy option across several countries including India due to a growing realization that public sector or private sector alone is not in the interest of the health system of a country and that a collaborative approach would be more efficient and cost-effective. It is presumed that PPP could overcome the inability of the public health system to meet the growing demand for quality healthcare of the people by (a) augmenting private sector’s resources to invest, manage and improve health infrastructure and health resources (b) improving access to health services for people in inaccessible geographical areas and underserved sections of population (c) preventing impoverishment of the uninsured poor while seeking expensive services from the private sector (d) leveraging the relative technical and managerial competence of the private sector to provide innovative and cost-effective health services and (e) encouraging adherence to quality standards and rational clinical practices through legal and regulatory supervision. Therefore, well-structured partnerships intend to leverage relative strengths of each partner to achieve public health goals. In India, there is a growing emphasis upon utilising private sector resources for addressing public health goals. The intent behind the initiative is to utilise the strengths of the government/public healthcare system and the private sector. The Major objectives of Public Private Partnerships are:

1. Improving access to essential Reproductive and Child Health (RCH) services i.e., increasing the penetration of RCH services in vulnerable and hard-to-reach areas and making affordable RCH services available at all places.
2. Improving the quality of available RCH services.
3. Monitoring the growth of private healthcare sector and directing it towards increasing its contribution towards the goal of improving RCH service delivery.
4. Exchanging of skills and expertise between the public and private healthcare sectors.
5. Mobilizing additional resources for RCH activities.
6. Improving the efficiency in allocation of resources i.e., making services available at a lower cost or making better services available at the same cost.
7. Strengthening the existing health system by improving the management of health within the government infrastructure.
8. Widening the range of services and number of services providers.
<table>
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<th>Five Year Plans</th>
<th>Details</th>
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<td><strong>First Plan (1951-56)</strong></td>
<td>Setting up of antenatal and postnatal clinics by NGOs. Licensing of private nursing homes for maternal and child health services. The Government of India entered into an agreement with the UNICEF and the WHO to carry out a countrywide BCG Programme. Non-official organizations encouraged to establish 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, aftercare colonies at suitable places in association with tuberculosis institutions. It should be possible, to provide adequate drugs through a combination of private enterprise.</td>
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<td><strong>Second and Third Plan (1956-61 and 1961-66)</strong></td>
<td>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 with the leprosy programme.</td>
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<td><strong>Fourth and Fifth Plan (1969-74 and 1974-79)</strong></td>
<td>NGOs to integrate family planning as a part of their other health services that they have extended to the community, distribution of contraceptives and education. 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. In order to create a sense of partnership with government efforts, voluntary contributions to be encouraged in the malaria programme. Encourage private medical professionals 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.</td>
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<td><strong>Sixth Plan (1980-84)</strong></td>
<td>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 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 state and voluntary organisations.</td>
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<td><strong>Seventh Plan (1985-90)</strong></td>
<td>Encourage private initiatives, private hospitals at secondary and tertiary levels. Role of NGOs, social marketing in RCH programme. Some contracting out of primary level services. Increased involvement of voluntary and private organisations, self-help groups and social marketing organizations in improving access to healthcare. Contracting in and out of clinical and non-clinical services. NGO sector to support the government in handling RCH services, like providing transport for emergency obstetric care for which fund would be devolved at the village level and FPPs introduced in several states. Preparation of IEC material and social marketing of contraceptives was handed over to the NGO sector.</td>
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Source: Five Year Plan, Planning Commission GOI (Various years).
VII.6 Challenges in Public Private Partnership

While the healthcare system as a whole has common objectives of equity, efficiency, quality and accessibility, public and private providers interpreted the contents of these objectives differently. Generally, the motive of the government is to provide health services to all at minimum cost, or free. It develops policies and programmes to provide equity of access to such services. From the point of view of the public sector, there are both merits and demerits in collaborating with the private sector.

'Not-for-profit' organizations have a special concern for reaching out to the poor and the disadvantaged but in many states they account for less than one percent of the health facilities (World Bank, 2004). Their existence depends on charitable donations or external funding. As a result, their interventions remain adhoc and their up-scalability remains doubtful. But they provide good quality care, need little regulation or overseeing from the government are able to attract dedicated staff and cater to the need of those who are otherwise excluded from mainstream healthcare. Moreover, they are also willing to undertake the healthcare challenges that the 'for-profit' sector is unwilling or is unable to take on. Given their non-profit motives and grass root level presence, NGO's can play a useful role as far as overseeing the system is concerned. Their size and flexibility allow them to achieve notable successes where governments have failed.

There are different opinions about the usefulness of the private sector. One extreme view is that the private sector is primarily motivated by money and has no concern for equity or access. However, another view suggests that the private sector is neither so easy to characterise nor so easy to neglect. Its strengths lie in innovativeness, efficiency and ability to learn from competition. Management standards are generally higher in the private sector. The private sector can play an important role in transferring management skills and best practices to the public sector. In India, the formal for-profit sector has the most diverse group of facilities and practitioners. Since it accounts for the largest proportion of services and resources in the health sector, it is argued, that future strategies to improve public health should take into account the strengths of the private sector (World Bank, 2004). India also has a large number of non-qualified rural medical practitioners in the informal private
sector. The pros and cons of partnering with each subgroup in the private sector are identified in the Table 7.2.

**Table 7.2: Pros and Cons of Collaborating with the Private Sector in Health**

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<th>Sub-sector</th>
<th>Pros</th>
<th>Cons</th>
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| Informal  | • Accessible  
• Client Oriented  
• Low cost | • Poor quality care  
• Difficult to mainstream  
• Provided by poorly educated people |
| For-profit | • High quality (in selected disciplines)  
• Huge outreach/coverage  
• Innovative  
• Efficient | • Ad hoc interventions  
• High cost  
• Variable quality  
• Clustered in cities |
| Not-for-profit | • High quality  
• Targeted to the poor  
• Low cost  
• Involves the community | • Small coverage  
• Lack of resources  
• Cannot be scaled up  
• Ad hoc interventions |

Source: As reported by Venkatraman, A.

**VII.7 Characteristics of Partnership**

Despite the differences, public and private sectors constantly interact with one another. While the government needs the support of the private sector in order to attract more resources, expand coverage and provide diversity of services; the incentive of the private sector is that it could approach the government in order to influence policies in terms of tax exemptions, accreditations and fee setting. Partnerships are more useful when the net benefits of partnership exceed the outcomes of net benefits of independent activities and when these partnerships result in the generation of more efficient and effective services in comparison with the outcomes that emerge from independent action (Venkatraman, A.)

The Ministry of Health and Family Welfare (MOHFW) in India presupposes that partnership could help in improving the problem of poor healthcare service delivery at two levels- firstly, in improving delivery mechanisms and in increasing mobilization of resources for healthcare (GOI, 2005) secondly, the presumed benefits of partnership are improvement in quality of services, reduced cost of care due either to competition or through economies of scale, redirecting the public resources to other areas, reduction in duplication of services, adaptation of best practices, services targeted towards the poor and better self regulation and accountability. The Asian Development Bank of India (ADBI) in 2000 identified the following enabling conditions for the success of a partnership:
• A clear understanding between the partners about mutual benefits
• A clear understanding of the responsibilities and obligations of the partners towards each other
• Strong community support
• A need for some catalyst to start the process of partnership
• Stability of political (government) and legal climate (law)
• A regulatory framework which is followed and enforced
• The capacity and expertise of the government at different levels in designing and managing contracts (partnership)
• Appropriate organizational and management system of partnerships
• A strong management information system
• Clarity in incentives and penalties.

VII.8 Types of Partnerships

Based on research literature, it is possible to identify various types and models of PPP in the health sector in the world. Among the types and models of partnerships are contracting (contracting out and contracting in), franchising, social marketing, joint ventures, subsidies and tax incentives, vouchers and service purchase coupons, hospital autonomy, build, operate and transfer, philanthropic contributions, health cooperatives, grants in aid, capacity building, leasing and social health insurance. Different models are useful under different circumstances. However, among all the partnership models, contracting has been the most common form.

The relevance of the types of Public -Private Partnerships for a particular state depends on prevailing conditions, needs and functional requirements. Various models can be utilized for putting these partnerships into action some of the possible mechanisms for implementation of PPP are given below:

1. Franchising: Franchise is a type of business model whereby a manufacturer or marketer of a product or service (the franchiser) grants exclusive rights to local, independent entrepreneurs (franchisees) to conduct business in a prescribed manner, in a certain place and over a specified period. Typically, the franchiser has developed specialized skills, knowledge and strategies and thus, is able to share its blueprint for a
financial returns, unless guarantees are given with regard to sustaining the model over a long period of time.

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

3. **Contracting Out:** Contracting out refers to a situation wherein, private providers receive a budget to provide certain services and manage a government healthcare unit as well. The two parties usually agree on some, or all of the following: the quantity and quality and duration of the contract. Fixing a common criterion for identifying those government health clinics that need to be contracted out is the first step in this direction. Large number of vacancies over a long period, high absenteeism and consistently low performance on all RCH indicators could be the critical criteria. Some states are more prepared for contracting out services as compared to others. Fear of losing jobs and the perceived shrinking role of government in the healthcare sector are the main reasons for resistance. There are several levels, at which the contracting out can be done, depending upon the degree of freedom given to the contractor. The following options are available for contracting out:

Option 1: Government hands over the physical infrastructure, equipment, budget and personnel of a health unit to the selected agency.

Option 2: Government hands over the physical infrastructure, equipment, budget but gives freedom to the selected agency to recruit personnel, as per their terms and conditions, but following the government norms such as one ANM per 5,000/3,000 population.

Option 3: Government hands over the physical infrastructure, equipment and budget but gives freedom to the select agency to have their own service delivery models, without following the fixed prescribed pattern.

Option 4: Government hands over the physical infrastructure, equipment and budget and gives freedom to the select agency to have their own personnel, service delivery models, freedom to expand types of services provided and freedom to introduce user fee to recover some proportion of the cost.
4. **Contracting In:** Contracting in, is done for a variety of services particularly in major hospitals. These include: maintenance of buildings, utilities, housekeeping, meals, medicine stores, diagnostic facilities, transport, security, communications, etc. Hospitals are given the freedom to choose the services to be given to contractors. In many cases, they lack comprehensive plans and sound financial analysis. Nevertheless, contracting in many hospitals has resulted in conservation of resources, improved efficiency and better quality of services. Contracting in services leads to surplus human resources and they need to be transferred to other health units to fill in vacant positions, if any. Contracting in does not work in some places for particular types of services. For instance, some state governments could not attract private sector participation for diagnostic services in hospitals in remote areas with low client load. One option is to subsidize the equipment purchased by private agencies and the other is to make services located in government hospitals open to all. Any person with a prescription from a private clinic should be allowed to use privately run diagnostic facilities in government hospitals. This increases the volume of transactions and makes the unit financially viable. Recruiting doctors, technicians and other staff on contractual basis, for a stipulated period of time is widely practiced in several states. In some cases, the contracted staff performs all duties of regular staff and in other instances their services are contracted for a few days in a month to provide services in a particular clinic. In many states, a large proportion of vacant positions were filled following this process.

5. **Social Marketing:** One of the earliest efforts at building Public-Private Partnerships was in the area of social marketing of contraceptives. For more than a decade, HLL, ITC, Indian Oil and other large FMCG companies, helped the government with the social marketing of contraceptives by piggy backing on Nirodh, in order to promote their products. Later, private social marketing companies emerged as a force to reckon with and gained considerable experience in marketing contraceptive products, both socially and commercially. The increasing trend now, is to enlarge the basket of products by including ORS, IFA tablets and other health products, to make the marketing efforts more self-sustaining. Government provides subsidized contraceptives and finances the brand and the point of purchase promotion schemes of selected marketing agencies.
6. **Build, Operate and Transfer:** Build, operate and transfer (BOT) models are highly successful in the infrastructure development sector in India. BOT requires part financing of projects by the government, financial guarantees when needed, subsidized land at prime locations, and assurance of reasonable returns on investment. These models could be useful to establish large hospitals and ensure quality services at reasonable rates to poor people. However, these hospitals should be able to withstand market competition to survive and to sustain.

7. **Joint Venture Companies:** Joint venture companies are companies launched with equity participation of the government and the private sector. The proportion of equity of each partner may vary from one venture to another. Joint venture companies, in most cases in the commercial sector, have not succeeded in India due to a lack of understanding and trust between partners, inordinate delays in decision-making, and dominance of government despite possessing low equity. There is even a lesser chance of them succeeding in the health sector.

8. **Voucher System:** A voucher is a document that can be exchanged for defined goods or services as a token of payment (tied-cash). This consists of designing, developing and valuing health packages for various common ailments/conditions (like ANC package/STI package/teen pregnancy package/family planning package etc), which can be bought by the people at specific intervals. These vouchers can then be redeemed for receiving a set of services, (like 1-2 consultations, laboratory tests, procedures, counseling and drugs for the condition from certified/accredited hospitals or clinics; and are required to be used within 2-3 months of buying them. This means that the package can be bought, used, as and when required at the same time the privacy of the client being ensured. Regular monitoring is required for maintaining quality standards, training of providers and networking with the people, in order to ensure the proper use of vouchers. The vouchers are redeemed to the clinics for the number utilized, depending on the price of the package of the services provided. Clinics that fail the quality standards of services and do not do well on patient satisfaction can be removed from the list of certified providers of services.

9. **Donations from Individuals:** Within a large country like India and with creditable high income and middle income groups, there are many instances of private donors willing to partner with the public sector. Rich philanthropists, individual
donors may be the crucial requirement to make the PPP initiative effective in delivering healthcare. Though in some states, mechanisms and provisions for utilizing these private donations for improving the local health situation exist but many states do not have these systems. Efforts have to be made to create simple and transparent institutional mechanisms to encourage donations which would be instrumental in contributing to the growth and improvement in reproductive and child health services in their area.

10. **Partnerships with Social Clubs and Groups:** Clubs like Rotary and Lions played a significant role in immunization campaigns, Pulse Polio Campaign and other healthcare services. Since these clubs have a nationwide network their involvement ensures better coverage. They also bring in their expertise and resources to healthcare services.

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

12. **Partnership with Professional Associations:** There are several professional associations, such as the Indian Medical Association, Gynaecologists Federation, Nurses Associations, etc. These associations from time to time extended help in launching new programmes such as Vande Mataram Scheme, Gaon Chalo project and the immunization programme, particularly the pulse polio endeavour. They have technical skills and expertise to provide advice on various other matters, such as setting standard protocols, quality assurance systems and accreditation. However, the managerial capacities of these professional associations have to be strengthened.
13. **Capacity Building of Private Providers, Pharmacists and Informal Providers:** Several initiatives have been taken by the government in the past to improve the technical and counselling skills of private medical practitioners, particularly Rural Medical Practitioners (RMPs) by providing them training. Since they have a huge presence in rural areas and urban slums and a large proportion of the population depends on them for services. There is a need to involve them in a significant way in order to create a demand for services and to making the referral system effective. Similarly, government medical officers and administrators benefited by participating in training programmes conducted by private institutions. Another area of partnership is, contracting out management of training institutions, such as ANM Training Centres, Regional Training Centres to NGOs and private agencies.

14. **Special “Category Campaigns” with the Private Sector to Improve Health:**

The **WHO-ORS campaign** and the **Goli- ke- Hamjoli campaign** are examples of the use of the commercial sector to advance national health goals. The ‘Category Campaigns’ expand the use of a health/family-planning product and increase the volume and the users for the product. In India, the **Goli ke Hamjoli** and **WHO-ORS campaigns** succeeded in increasing product awareness, its availability, sales and use. Initially, the programme used mass media vehicles to improve product awareness and contemplation. However, as the program developed, its emphasis should shift to encouraging product trial and use of an interpersonal approach to reach out to potential consumers.

15. **Partnering with Community Based Organizations and Non-Government Organizations (CBOs/NGOs):** For designing and implementing innovative approaches to RCH services, partnerships with Community Based Organizations (CBOs) and Non-Government Organizations (NGOs) is a significant step. Government, for long, encouraged participation of these grass root organizations in demand creation and delivery of services. These organizations often worked in remote rural areas where access to RCH services is difficult. The recent NGO policy of the Ministry of Health and Family Welfare (MOHFW) envisages a scheme where each district would have a mother NGO which would be linked to several field NGOs within the district, with a greater degree of autonomy and decentralization. Community
mobilization efforts yield effective results and community ownership of the programme is sustainable.

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

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

**VII.9 Existing Public-Private Partnership Models in Indian States**

Contracting (Contracting -out and contracting -in) is the predominant model of private partnership but there are other forms of partnership also. The private sector is represented by individual physicians, commercial contractors, large private and corporate super specialty hospitals and NFP agencies (NGOs). Some partnerships dealt with simple contracts (diet, laundry, cleaning) whereas other more complex contracts involved many stake holders (Yashasvini is a community based self-financed health insurance scheme). In almost all partnerships, the principal public partner is the Department of Health and Family Welfare, either directly, or through health facility-
level committees. In terms of monetary value, the least valued contract provided dietary services at the rate of Rs 27 per meal for about 30 meals in a day (Bhagajatin Hospital Kolkata) the most expensive contract engaged a corporate hospital to run a government built super-speciality hospital in Raichur, Karnataka (over Rs.600 million). The oldest partnership (Since 1996) is the Karuna trust which adopted and manages primary health centres in Karnataka, whereas, Chiranjeevi Scheme, which engages private doctors for deliveries in Gujarat is the most recent initiative (since December, 2005). Among the various successful PPP health schemes, a few experiments are as follows:

1. **Yeshasvini Health scheme in Karnataka**

   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-speciality 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 up to 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 (FHPL) is licensed by Karnataka’s Insurance Regulatory and Development Authority. The FHPL has the responsibility of administering and managing the scheme on a day-to-day basis. Recognized hospitals have been admitted to the network throughout Karnataka which are called network hospitals (NWH). These hospitals offer comprehensive packages for operations that are paid by Yeshasvini. A Yeshasvini Farmers Healthcare 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, appoints the Third Party Administrator (TPA) and addresses grievances of the insured members or doctors.

2. **Telemedicine Initiative by Narayana Hrudayalaya in Karnataka**

   The Government of Karnataka, the Narayana Hrudayalaya hospital in Bangalore and the Indian Space Research Organization initiated an experimental telemedicine project called Karnataka Integrated Telemedicine and Telehealth Project
(KITTH) which is an on-line healthcare initiative in Karnataka. With connections through satellite this project functions in the Coronary Care Units (CCU) 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 general doctors have examined patients. If a patient requires an operation, he/she is referred to the main hospital in Bangalore otherwise he/she is admitted to a CCU for consultation and treatment. Tele-medicine provides access to areas that are underserved or unserved. It improves access to specialty care and reduces both time and cost for rural and semi-urban patients. Telemedicine improves the quality of healthcare through timely diagnosis and timely treatment of patients. The most important aspect of telemedicine is the digital convergence of medical records, charts, x-rays, histopathology slides and medical procedures (including laboratory tests) conducted on patients.

3. Primary Health Centres (PHC's) in Gumballi and Sugganahalli, Karnataka

 Management of Primary Health Centres in Gumballi and Sugganahalli was contracted out by the Government of Karnataka to Karuna Trust in 1996, to serve the tribal community in the hilly areas. 90 percent of the cost is borne by the Government and 10 percent by the Trust. The Karuna Trust has full responsibility for providing the entire personnel at the PHC and the Health Sub-Centres within its jurisdiction maintenance of all the assets at the PRC and addition of any assets, if required, at the PRC. There has been rearrangement of the government staff in the PHCs while some do remain on deputation. 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 government and the Trust. The Gumballi district is considered a model PRC, covering the entire gamut of primary healthcare- preventive, promotive, curative and rehabilitative.

4. Rajiv Gandhi Super-Specialty Hospital, Raichur, Karnataka

 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 healthcare at
low cost to the people Below Poverty Line (BPL). The Government of Karnataka has provided the land, hospital building and staff quarters as well as roads, power, water and infrastructure. Apollo has provided qualified, experienced and competent medical facilities for operating the hospital. The losses anticipated during the first three years of operation were reimbursed by the government to Apollo hospital. From the fourth year, the hospital was to get 30 percent of the net profit. When no net profit occurred, the government paid a service charge (of no more than 3 percent of gross billing) to Apollo Hospital. Apollo is responsible for all medical, legal and statutory requirements. It pays all charges (water, telephone, electricity, power, sewage, sanitation) to the concerned authorities and is liable for penal recovery charges in case of default in payment within the prescribed period. Apollo is also responsible for maintenance of the hospital premises and buildings and maintains a separate account for funds generated by the hospital from fees for registration, tests and medical charges. This account is audited by a Chartered Accountant engaged by Apollo with approval of the Governing Council. Likewise, Apollo maintains separate monthly accounts for all materials used by patients below the poverty line (including diagnostic services), which are submitted to the Deputy Commissioner of Raichur for reimbursement. Accountability and responsibility for outsourcing the support services remain with Apollo.

5. Community Health Insurance Scheme in Karnataka:

The Karuna Trust, in collaboration with the National Health Insurance Company and the Government of Karnataka, 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 hospitalisation and health related issues and to establish insurance coverage for out-patient care by the people themselves. The scheme is fully subsidized for Scheduled Castes and Scheduled Tribes who are below the poverty line and partially subsidized for non-SC/ST BPL. Poor patients are identified by field workers and health workers who visit door-to-door to make people aware of the scheme. ANMs and health workers, visiting a village collect its insurance premiums and deposit them in the bank. The annual premium is Rs 22. If admitted to any government hospital for treatment an insured
member gets Rs100 per day during hospitalisation (Rs 50 against bed-charges and medicine and Rs 50 as compensation for loss of wages up to a maximum of Rs 2500 within a 25-day limit). Extra payment is possible for surgery. The insurance is valid for one year. If members want to continue the coverage, they must renew their membership and pay the full premium.

6. Arogya Raksha Scheme in Andhra Pradesh:

The Government of Andhra Pradesh has initiated the Arogya Raksha Scheme in collaboration with the New India Assurance Company and 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 pays an insurance premium of Rs.75 per family to the insurance company with the expected enrolment of acceptors being 2,00,000 in the first year. The medical officer in the clinics issues an Arogya Raksha Certificate to the person who undergoes sterilization. The person and two of her/his children, below the age of five years, are covered under the hospitalization benefit and personal accident benefit schemes. The person and/or her/his children could get inpatient treatment in the hospital up to a maximum of Rs 2000, per hospitalisation 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 is Rs 10,000.

7. Urban Slum Healthcare Project Andhra Pradesh:

In the Urban Slum Healthcare Project, the Andhra Pradesh Ministry of Health and Family Welfare contracts NGOs to manage health centres 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 Centres (UHC). Five ‘Mahila Arogya Sanghams’ (Women’s Well-Being Associations) were formed under each UHC and the self-help groups and ICDS
workers mobilize the community and adopt behavioural change communication strategies.

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

8. Sawai Man Singh Hospital, Jaipur: Contracting out Model

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

9. The Uttaranchal Mobile Hospital and Research Centre (UMHRC)

It is a three-way partnership between the Technology Information, Forecasting and Assessment Council (TIFAC), Government of Uttaranchal and the Birla Institute of Scientific Research (BISR). The motive behind the partnership was to provide healthcare and diagnostic facilities to poor and rural people at their doorstep in the
difficult hilly terrains. TIFAC and the State Government share the funds sanctioned to BISR on an equal basis.

10. Emergency Ambulance Services Scheme in Tamil Nadu

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 (MMR) in the rural area. The major cause for the high MMR is a non-medical one - 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 because of the collection of user charges. The government supports the scheme only by supplying the vehicles. Seva Nilayam recruits the drivers, trains the staff, maintains the vehicles, operates the programme and reports to the government. It bears the entire operating cost of the project, including communications, equipment and medicine and publicizes the service in villages, particularly with regard to the telephone number of the ambulance service. However, the project is not self-sustaining, as the revenue collection is lesser than anticipated.

11. The Chiranjeevi Scheme of Gujarat

The Chiranjivi Scheme was launched on a pilot basis in December 2005. This scheme was made operational in five most underserved districts in the state namely Kutch, Banaskantha, Sarbarkantha, Panchamahal and Dahod. The major areas of these districts were remote, with a large tribal population. The beneficiaries under the scheme are the pregnant women from BPL families. If the family is not enlisted in the BPL register, but still is below poverty line then the medical officer can provide scheme benefits based on the income certificate. The scheme is a cashless scheme for delivery services by trust hospitals/private gynaecologists and obstetricians. The beneficiary does not have to pay anything to the doctor.

Under the scheme, trust hospitals/private gynaecologists and obstetricians are enrolled after they are briefed about the Chiranjeevi scheme. The District Health Society signs a MoU with each of them. As per the MoU, they have to provide maternity services to the BPL/tribal (non income-tax paying) mothers as beneficiaries of the scheme at their nursing homes/hospitals. The Obstetricians were paid Rs 1,
79,500 for a package of 100 deliveries (at the rate of Rs 1795 per delivery) in the past. The package was revised to Rs 2,80,000 for 100 deliveries on dated August 17, 2010. The package of 100 deliveries includes normal and complicated deliveries and also caesarean section operations. There is no limit on the number of deliveries conducted by the doctor. Payment would be made on the basis of the number of deliveries conducted by the enrolled doctor. The package also includes payment of Rs 200 for transportation to the pregnant mother. Rs 200 would be paid to ASHA separately from the ASHA incentive fund for bringing a patient for institutional delivery. A 48 hours stay is advised after delivery and this is covered under the scheme.

If the private gynaecologist offers his/her services in the government hospital, then Rs 86,500 will be paid for every 100 deliveries (both normal and complicated). Out of all pregnant mothers attending Mamta Diwas (village health and nutrition day, usually on a designated Wednesday every month) those eligible for the scheme are identified by the health workers. 108 local ambulances are also given the list of local Chiranjeevi doctors and a monthly list of expectant mothers who are likely to deliver. Beneficiaries can avail free services of 108 ambulances to reach the Chiranjeevi doctors for delivery. For babies born under the Chiranjeevi Yojana, examination and treatment by private paediatricians in Special Newborn Care Units enrolled under Balsakha Scheme can be availed. Post natal visits would be carried out by ASHAs for the well being of the mother and the newborn under the ASHA scheme.

**VII.10 Public Private Partnership in Uttar Pradesh**

The Government of Uttar Pradesh like other state governments is committed to providing high quality, affordable and accessible, preventive, curative, primitive and comprehensive healthcare services to the population. But unfortunately the performance of the state on various health parameters is not encouraging. Although an extensive infrastructural network of medical and health services in the government as well as in the private sector has been created over the years, the available health infrastructure is inadequate to meet the demand for health services in the state. The problem is more serious in rural areas as compared to urban areas. The rural population primarily depends on government infrastructure and private health service providers mainly quacks. The availability of physical health infrastructure in the state still lags behind the national average. Apart from this, non availability of staff and
medical services at these health facilities is another issue of major concern. As a result, the state is facing a great challenge in the fight against communicable and non-communicable diseases, maternity and child health malnutrition and newly emerging fatal diseases like AIDS. Now, is realized that government is unable to provide qualitative, effective and adequate health services to the huge population of UP. As a result people are losing faith in the public healthcare system and diverted themselves to private health providers. The government cannot build many SGPGI and AIIMS. It cannot even bear their running expenses as the government has so many other priorities. However, people of the state should have access to health services. The district hospitals, operation theatres are in a pathetic condition, their instruments etc. are rusted and environment is so dirty that one wonders if it is hygienic to get the operation done there. The people of U.P. have also the right to get good operation theatres and they are willing to pay reasonable user charges. Our private sector is now capable and confident. The time has come now, when at this juncture we can facilitate the development of the country by giving a new dimension and a new confidence to Public Private Partnership. We can invite the private sector to invest and modernize these public hospitals and use government hospital buildings for delivering health services and allow them to charge some nominal fees.

Uttar Pradesh requires rapid expansion in speciality hospitals, diagnostic facilities, emergency transport, training and research institutions to meet the burgeoning demand for treatment of non-communicable diseases and the shortage of the supply of human resources. However, given the limitations of human resources, budgetary constraints and technical, organisational and managerial capacity, the state government alone will not be able to successfully address these issues. The state, thus, has demonstrated its willingness to work in close collaboration with the private sector in order to enlarge the scope of services and aid in attaining improved health outcomes for the state. The state health department has a rich experience of implementing a few schemes, in collaboration with NGOs, towards providing health services through donor-funded programmes. Some of the models include:

a) Contracting out sub-health centres
b) Franchised clinics/ hospitals
c) Hospital waste management
d) Voucher Scheme for Maternal Health Services
e) Saubhagyawati Yojana for safe motherhood  
f) Outsourcing of building maintenance, gardening and laundry services at hospitals  
g) Mobile Health Clinics for remote areas of the state  
h) Emergency Medical Transport Services

Table-7.3: Public Private Partnership in Healthcare Delivery System in Uttar Pradesh: Summary

<table>
<thead>
<tr>
<th>Project</th>
<th>Key Features</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health posts in remote/un-served areas by NGO</td>
<td>NGOs have been selected by IIM, Lucknow to support 195 health posts in 28 districts. This initiative has provided curative services to 1,40,000 clients i.e. 16 percent of project population &amp; institutional delivery has reportedly increased 5 folds in these areas.</td>
</tr>
<tr>
<td>Clinical RCH services through NGOs</td>
<td>Ongoing with 20 partner NGO covering 72,00,000 populations spread in 42 blocks across 12 districts. Key services: distribution of contraceptives, antenatal care &amp; infant immunization. The project has trained 7494 ASHA.</td>
</tr>
<tr>
<td>Social Franchising in health</td>
<td>Supported by SIFPSA &amp; implemented by HLFPPT as the franchisee, the project is responsible for developing, managing &amp; sustaining the Merry gold health network, in rural, semi urban, urban slum populations of the state, which comprises Merry tarang, Merry silver clinics &amp; Merry gold hospitals. So far, 8 hospitals, 68 clinics &amp; 967 Tarang partners have been franchised in 7 districts. The private partner provides routine healthcare, specialized healthcare, family planning, immunization, diagnostics, public health programmes (DOTS and ARV), chemist shops, health insurance &amp; telemedicine.</td>
</tr>
<tr>
<td>Saubhagyawati Scheme</td>
<td>Specifically directed at BPL families &amp; funded through the NRHM, this scheme promotes institutional deliveries under JSY. So far, 7 nursing homes have been accredited in 7 districts.</td>
</tr>
<tr>
<td>Voucher Scheme in Rural Agra and Slums of Kanpur Nagar</td>
<td>Under IFPS, the voucher scheme was designed to provide low-income people with a set of coupons to obtain free RCH services from designated providers. The providers are reimbursed on the basis of a previously agreed fee schedule and are monitored to ensure high-quality service provision.</td>
</tr>
</tbody>
</table>
| Hospital Waste Management Using PPP Model | Objectives-  
- To reduce hospital born infection  
- To dispose hospital waste using scientific techniques |
| Uttar Pradesh Health System Development Project (UPHSDP): World Bank Project | Provide curative and preventive healthcare services in the remote and un served areas of the state to serve poor and disadvantaged groups, particularly women, through private / NGO participation. Model health units: 28 districts, 117 Facilities |
| Uttar Pradesh Health Systems Strengthening Project (UPHSSP): World Bank Project | • Status: Active  
• Approved on: Dec 20,2011  
• Theme of the project: Child health, Health system performance, Population and reproductive health. |
VII.11 Evaluation of Merrygold Health Network in Uttar Pradesh

The Merrygold Health Network was launched in 2007 as a Public Private Partnership in Uttar Pradesh. The objective was to increase access to equitable, affordable and quality healthcare services for low income groups and working class by engaging the private sector through sustainable partnership and developing a network of franchised hospitals in metropolitan cities. The Merrygold comprised of fully franchised health facilities termed as first tier or Level 1. The agency is called State Innovation in Family Planning Services (SIFPSA), Innovation in Family Planning Services (IFPS) and Technical Assistant Project (ITAP). International experts and providers of health services are the stakeholders. Included in the L-1 fully franchised system are basic obstetrics care and C-section deliveries, normal delivery cases, ANC counseling on contraceptive methods and distribution of contraceptives and related products, including wellness products/over the counter medicines, advertising and promotional material and other additional services related to obstetrics/gynaecology and paediatric care. The schemes and programmes linked with the Merrygold Health Network (MGHN) are:

- **Voucher System**: A demand side financing mechanism is being made operational in five selected cities of UP from below poverty line (BPL) families. Eighteen Merrygold facilities in these cities have been accredited under the voucher system and BPL families could avail cashless FP/RH services by redeeming their vouchers.

- **Family Planning Sterilization Scheme**: The franchiser supported franchisees in getting accreditation for the centrally sponsored scheme, to compensate acceptors for sterilization for loss of wages. Sixteen Merrygold facilities were accredited in August, 2011 and were able to avail of this scheme.

- **Rashtriya Swasthya Bima Yojna (RSBY)**: A state implemented health insurance scheme for the poor, RSBY provides Rs 30,000 annual cover to a family. By February, 2012, thirty nine Merrygold facilities had been empanelled under RSBY.

- **Soubhagyavati Yojna**: Another conditional case transfer scheme, specifically for the private sector, is being revived in the state. Merrygold facilities that are not included under RSBY and wanting to be included in the Scheme, will be
accredited and empanelled. This process was being facilitated by the franchiser at the time of writing this report.

**Working of Merrygold Franchisees:**

The franchisee hospitals are owned and operated by the franchisee. These are L-1 hospitals in the Merrygold health network and they provide maternal, newborn and family planning services including a comprehensive emergency obstetric care. The key responsibilities of Merrygold franchisees are manifold like:

- Antenatal Care
- Delivery Care
- Post-Delivery care.
- Child Care
- Family Planning Counseling and Guidance.

**Investment Cost and Franchisees Fees:**

Investment to be made by a franchisee is approximately thirty five lakhs, depending on the various input costs. Most of the hospitals are given field projects and are set up by entrepreneurs. All franchisees are charged a onetime franchising license fee. This includes the right to use the franchisers brand name, setting up of the project, procurement guidelines, manpower planning and training and cost of providing the entire business plan to the franchisees. A continuing fee is also proposed.

**Success of the Scheme:**

Medical audits conducted from September, 2009 to August, 2011 indicate that facilities have improved. A comparison of data for L-1 facilities that have been in the network for two years indicated an increase in the service uptake. On an average, normal deliveries increased by 20 per month, caesarean by 9 per month and ANC checkups by 219 per month (Ernest and Young, 2011). Over the implementation period, Merrygold Health Network (MGHN) has demonstrated that social franchising as a model was capable of harnessing substantial private sector resources for health and could be rolled out and expanded very fast.

**Present Status**

A visit to a Level-1 Merrygold hospital was undertaken to see the present state of affairs in terms of providing healthcare services to the poor. The hospital is located
at the periphery of Lucknow metropolitan city. The data relating to the different infrastructural facilities available and utilized in this Merrygold hospital was obtained. It became evident that the hospital has the entire requisite medical infrastructure and received support under the Public Private Partnership (PPP) model of the Government of UP. However, the hospital authorities reported that during the last four years the support from the government has stopped. There has been no meeting between hospital authorities and stakeholders regarding the functioning of this Merrygold hospital. The situation as it existed today reveals the fact that the franchisee arrangement between the hospitals and the stakeholders has totally collapsed. No person is being treated under the scheme in the hospital. It was reported by hospital authorities that there is complete callousness and negligence on the part of the state stakeholders with regard to supporting the hospital. The authorities of the hospital expressed the opinion that the state stakeholders were not interested in PPP, which has reached to the state of collapse at present though it was conceived as an effective way of providing low cost health services to the poor. My observations also point to the fact, that the PPP model, developed in the form of the Merrygold Health Network in healthcare services could not be as successful as it was considered off.

VII.12 Key issues of Public Private Partnership

Public Private Partnerships are inevitable and have enormous potential in the Indian context more so in a state like Uttar Pradesh. However, in order to optimise the potential benefits of PPP, it is imperative that the government establishes certain basic foundations (groundwork). These entail:

a) PPP policy: Government should ensure that there is a clearly defined policy for engaging the private sector in the delivery of health services. The policy must give an assurance that mutually beneficial and harmonious relationships would be developed that would strive to achieve better health outcomes for the people of the State. The State of Uttar Pradesh is already embarking on finalising a PPP policy in the health sector in alignment with the state PPP policy regarding investment opportunities. The policy must also indicate the state’s willingness to promote harmonious growth of the private health providers in the state under the due regulatory system. A policy would ensure greater confidence in the private sector and pave the way for continuity, stability and openness.
b) Institutional Framework: Government needs to establish a dedicated unit or division, within the health department (which may be called the PPP cell) in order to:

i) Map the entire private sector health resources in the state (including informal, non-professional providers) and develop a live database of private providers. Mapping and developing the private sector database would enable the government to identify geographical and clinical areas where the private sector could be more useful.

ii) The cell/unit could identify the potential PPP models and accordingly design, implement and manage the contracts. In order to identify, design, implement and manage the PPP contracts, government staff should be provided adequate training and capacity building for handling PPPs. Government may like to appoint a new set of staff (professionals) or depute their own staff to man the PPP cell. Skills related to contract design, costing and tariff fixation, monitoring and evaluation, supervision, negotiation, payment, etc. should be provided to the staff.

iii) The state must allocate substantial resources (funds) to the PPP cell in order to initiate innovative PPP schemes for the state.

iv) It is debatable whether the PPP cell should undertake all the tasks related to contract design, contract award (procurement), supervision and monitoring, verification and payments, or these functions be carried out by different sections/departments of the government to avoid corrupt practices.

c) Regulation: It is not sufficient for the government to merely adopt the Clinical Establishment Act. Instead, it should develop detailed rules and a robust institutional mechanism to implement the Act. These detailed rules can be prepared in consultation with the private sector. The philosophy of regulation must move away from the image of a regulator/controller/enforcer to that of a promoter of a responsible and harmonious entity. There must be a dedicated institutional system to implement the provisions of the Act. Regulation should assume responsibilities such as licensing, registration, information sharing and adherence to legally-mandated standards. Regulation must take due cognizance of the role of informal providers who provide a substantially large volume of
health services in the remote parts of the state. Whereas, it may be impossible to completely ban them, there must be definitive strategies to engage them in a more fruitful manner with due careful consideration to quality of care.

d) Accreditation and Quality Assurance: All the healthcare providers in the state (public and the private sector) should be encouraged to adopt essential standards of care including physical standards, HR standards and clinical standards as prescribed by the National Accreditation Board for Health (NABH). Government could issue an advisory for voluntary accreditation, giving a timeframe. The government could further incentivise this voluntary compliance by deciding to engage only such accredited facilities for any future PPP contracts. In due course, the government may legally enforce the accreditation system. Accreditation must be undertaken by an independent agency. NABH along with a state level body could be assigned this task. NABH could handhold the state level agency for accreditation.

VII.13 Conclusion

Recently, national and international agencies /policies are putting pressure on low income states (low HDI ranked states) to improve their health indicators but for that they need huge resources which cannot be possible in short run as these states have no capacity to generate extra resources. These poor states have developed a huge physical public health infrastructure over the years but they have not sufficient manpower to deliver efficient healthcare services and their utilization is low, because of sub-standard quality. On the other hand, these poor states have huge private health personnel (health potentials) which are competent and are much in demand with the public, but they do not come forward to join the public health sector because of lack of incentives and a clear cut government policy. To get rid of this lacuna, Public Private Partnership (PPP) is becoming a popular mode of implementing government programmes and schemes, throughout the country. Over the last few years, there have been many initiatives to improve the efficiency, effectiveness and equity in provision of healthcare services in the country. Thus, it is not only the lack of funds but also lack of political, managerial and technical ability in the government healthcare delivery system that makes the Public Private Partnership more feasible and viable. 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, the question that what constitutes a PPP should be answered with providing conceptual clarity with a clear definition of the term.

Public Private Partnership (PPP) is the government’s way to shift its responsibility to private (for profit) partners and expect provision of public health services from them. It is contradictory in itself. There is also resentment that the government is focusing too much on PPP’s at the cost of other programmes. It is of paramount importance to identify gaps in the 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.

Policy innovations such as PPP are, of course, contextual. Partnership with the private sector is not a substitute for the provision of health services by the public sector. Also PPP initiatives cannot be uniform across all the regions or suitable to and in accordance with all kinds of political and administrative decisions. Administrative decisions must enjoy political and community support. In states, where the private sector is prevalent, partnership initiatives may be an alternative not necessarily because of competitive efficiency, but to prevent further impoverishment of the poor and deprived sections of society. There has to be a clear rationale for partnering with the private sector. It is important to understand, not only what services are to be provided under Public Private Partnership, but also the basis on which such decisions have been made.

Public Private Partnership has emerged as one of the options to influence the growth of the private sector with public goals in mind. Used judiciously and fitted to local circumstances, this clearly has the potential to drastically change the healthcare landscape in India and Utter Pradesh as well. PPPs will survive only if the interests of all stakeholders are taken into account. PPP is popular as far as engaging the private sector for delivery of services is concerned. A true partnership requires shared objectives, shared risks, shared investment and shared rewards.

Public-Private Partnerships have an enormous potential for a state like Uttar Pradesh. However, it must be understood that there are no fixed templates for appropriate PPPs or a set formula for the success of PPP contracts. In addition, a PPP
is not a panacea for all that ails the health system. PPP models invariably fail because of poorly drafted contracts or weak implementation / management of contracts and not due to the PPP strategy itself. Emerging evidence across the world indicates possible benefits of PPPs. However, PPP is neither an alternative to government provision of health services nor does it denote privatization. Ideological rhetoric that dominates the discourse on PPP should be replaced with pragmatic, evidence-informed arguments. Above all, the suffering patient who cannot afford expensive health services should be the focal point of such strategies.

Till date, Uttar Pradesh lacks an effective PPP model in healthcare delivery system. Government officials of the health department are making strategies for involving the private sector through Public Private Partnership (PPP). The State Government has already engaged consultants to explore the possibility and finalise the bid papers for handing over many projects to private companies. There is urgent need to devise a new pattern of Public Private Partnership in the healthcare delivery system in order to streamline the public health system so that it can reach the urban/semi-urban and rural areas of the state.