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PPP in Health

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Background

I come from Uttar Pradesh, where I work primarily on women's right to maternal health. There are around 3.5 or 4 million live births in Uttar Pradesh each year, since an estimated 14% of the 26 million Indian births occur here (RGI, 2006). Beyond that there are a number of unwanted pregnancies, miscarriages and still births or maternal deaths before birth. Based on SRS[ii] estimates, the MMR of Uttar Pradesh was 517 in 2002-2003, which means roughly around 20,000 maternal deaths in a year in this state alone. According to estimates, the proportion of ill-health to maternal deaths is 20 times, giving a staggering total of women who are in need of maternal health care.

This situation has been in evidence since the last few decades, warranting special planning and provisions for ensuring service provision to all women to prevent deaths or ill-health. As India enters the twenty-first century with a bang, it is relevant to ask why this has not happened. It is neither for lack of state funds[iii] nor for lack of donor interest[iv]. Using maternal health service provision in Uttar Pradesh as a case study, I interrogate the service provision facilities for these health needs of women and what are the public and private sector roles involved.

Who provides the services?

An overwhelming percentage of births occur in the private sphere in UP: according to the SRS figures, 89.9% of deliveries in Uttar Pradesh occurred at home in 2001-2003 (a slow decline from the 92.2% in 1997-98). Among the births surveyed during NFHS-3 of 2005-2006[v] in Uttar Pradesh, around 88 % were handled at home (the figure is 82.5% for rural UP). Around 70.8 % of the births in UP (76.2% in rural areas) appear to have been handled by non-health personnel: perhaps including family members and neighbours as well as traditional birth attendants or TBAs.[vi]

Despite this vast provision of maternal health care by private individuals, the health system has so far neither adequately acknowledged this resource, nor researched the role of TBAs[vii] nor made provisions for a 'public private partnership (PPP)' with organized groups[viii] of TBAs in order to make home-births safer for women. This warrants a question as to how we define or locate the private sector when we talk of PPP: is 'private' equated with 'for-profit'? Can we think of a partnership where the state recognizes the role that TBAs are playing and encourages them to form organizations, so to promote standardized training, accreditation, and linkages with referral institutions as well as support speedy communications and transport?

What other services are available?

Evidence from case studies collected in 2003-2004[ix] and 2005-2007[x] indicates that families in rural UP do seek institutional care when they suspect complications. What is the situation regarding these institutions? In terms of facilities, UP has 7 Government Medical Colleges & Hospitals, 53 District Hospitals, 13 Combined Hospitals, 388

Community Health Centres, 823 Block PHCs, 2817 Sub Block PHCs apart from 20521 Sub Centres. The private sector has four Medical colleges & Hospitals and 4913 male / female hospitals/ nursing homes at district level[xi]. Thus there appear to be a far larger number of private hospitals than public health care institutions, excluding of course the sub-centres.

What is the state of these public hospitals? Ten years after the CSSM programme of 1992, with the further addition of the Reproductive and Child Health programme in 1997, well into the 2000- 2005 World Bank assisted health systems development programme[xii], less than 20% Community Health Centres (CHCs) surveyed[xiii] in Uttar Pradesh had even the minimum (60%) basic equipment needed to handle an obstetric emergency, and barely a third had 60% of the qualified medical staff required[xiv]. Additionally, there is a great rural-urban gap in terms of qualified personnel such as doctors who are supposed to provide most of the emergency services[xv].

How does this damaged state of the public sector affect the health service users? The State Planning Commission[xvi] points out that "only 9 percent of the State's population actually makes use of (state) facility for treatment of ordinary ailments and people mostly have to depend on private healthcare." Families of hospitalized persons borrow heavily or sell assets to cover expenses and 34 % fall below the poverty line because of hospital expenses. In actual figures[xvii] this means that although households in UP spent around 17158 crores in 2004-2005, the government spent only 2650 crores; spending by NGOs, foreign agencies and private firms was merely 550 crores.

What choices exist?

The National Rural Health Mission makes promises to strengthen the quality of state health services provided to the people in the far-flung areas. But for the rural women of Uttar Pradesh, the quality of state healthcare provision is hardly different from the private for-profit sector, which is generally labelled as expensive, unregulated and often providing irrational therapy in order to maximise profit.

In Uttar Pradesh, health care providers drawing full salary from the state appear to be routinely demanding informal payments from low-income women who approach them for maternal health services; they may even deny admission to women on the basis of these payments. The scale of payment is open to some level of negotiation but services are not provided free[xviii] as the following post-NRHM instances of maternal health services show:

- Babita of Chandauli (March 2007) was asked for Rs 500 as a share of the JSY money by the ANM at the PHC
- Sharmila of Kushinagar (January 2007) was asked for Rs 500 by the ANM at the PHC for her delivery but never given the JSY
- Manju of Lucknow (January 2007) was asked for Rs 10,000 by the doctor at the urban maternal health centre before her case could be admitted to the hospital
- Jaydevi of Mirzapur (August 2006) was asked for Rs 600 by the ANM at the PHC to manage the retained placenta

- ☞ Nirmala of Gorakhpur was asked for Rs 500 by the ANM at the PHC to do her abortion and then Rs 1000 by another ANM to treat post-abortion complications
- ☞ Durmati of Kushinagar (August 2006) was asked for Rs 1000 by the ANM at the PHC for doing her delivery
- ☞ Alimun-nisha of Chandauli (October 2005) was asked for Rs 5000 by the doctor at BHU before he took her case

Moreover irrational therapy appears to be used both by state providers like ANMs and private non-formal sector (quack doctors) who regularly use intra-muscular oxytocin injections in the intra-partum stage to speed up contractions. Oxytocin intra-muscular injections were given during labour to several women without medical supervision by ANMs – Sahidun (Feb 07), Alimun-nisha of Chandauli (October 05), Savita of Chandauli (February 2007), Nirmala of Azamgarh (Feb 2007), Parvati of Banda (November 2006) among others.

PHC staff's including ANMs are unable to provide skilled maternal health services to rural women, which sometimes lead to fatal consequences or force them into debt through expenses:

- ☞ 18-year-old Nirmala of Azamgarh (Feb 2007) and Jaydevi of Mirzapur (August 2006) both died because the ANM was unable to recognize a life-threatening complication (retained placenta) or refer it in time: in both cases the ANMs preferred to manually remove the placenta without anaesthesia, leading to almost immediate death
- ☞ Hazrat died after her seventh delivery (Sept 2006) at the PHC because the providers were unable to refer her in time as a high-risk case;
- ☞ Asha of Azamgarh (Sept 2006) died because the ANM consulted was unable to recognize her life-threatening ante-natal complication or refer her in time
- ☞ Maya of Kushinagar died (December 2006) because the PHC was unable to treat her post-abortion complication
- ☞ Savita (Feb 2007) and Mamta of Chandauli (April 2006) both lost their babies because the ANM was unable to recognize that labour had already started.
- ☞ Salenta of Purkazi, Muzaffarnagar has spent Rs. 50,000 trying to repair a vesico-vaginal fistula caused during her childbirth (Feb 2007) at the local PHC. Her husband works at a brick-kiln.

Differing objectives

The state when faced with a record of its own shortcomings has usually capitulated by suggesting the withdrawal of state roles and increased hand-over to a 'more efficient' private sector. However, given the fact that the state is now accountable to stop the impoverishment of the people due to deprivation of state health care services, there should not be any kind of PPP that strengthens the private for-profit health sector, which has already pocketed huge benefits. Neither should the private non-profit sector be used as sub-contractor of state health services or salesmen for private sector products: rather its credibility should be built up to ensure rights based approaches in health care.

Duggal suggests[xix] that we differentiate between the various kinds of PPP as follows: in PPP where forms of exchange are involved like services being offered for payments or

contracts being awarded, vested interests come to the fore and/or the lack of capacity of the public health system to handle such partnerships is exposed. What the present version of PPP is doing is that it is taking these exceptional or occasional and sporadic subsidies and trying to organise it into a systematic program which will marketize public goods like health and healthcare and reduce or even undermine the role of the state. Partnerships can only be meaningful if there is a well developed regulatory framework and where professional ethics are also strong. Duggal proposes an alternative terminology: where the private partner has nothing to gain materially we could call Partnerships in Strengthening Public Systems (PSPS). The second category of partnerships is where services are offered or contracts are awarded and there is a clear financial dimension to it and hence various vested interests also emerge. This PPP we could call Private Sector Oriented Initiatives (PSOI).

The term Public Private Partnership (PPP) has also been questioned by Ravindran and Weller who suggest it would be more accurate to use the term Public Private Interaction (PPI) to encompass all relationships between the public sector and any private sector, within which PPP would be seen as a specific form of PPI. They suggest that PPI be defined as 'all relationships between public and private sector that have emerged as part of the privatization effort in the health sector', mainly as a result of the increased policy support provided since the 1990's by international agencies and governments[1]. These would include both complementary and collaborative/cooperative interactions, and may involve the not-for-profit sector as well. When public and private sector actors work together collaboratively on the basis of shared objectives, strategies and agreed monitoring and evaluation criteria, this may be called a PPP[xx].

The Approach paper to the 11th Five Year Plan[xxi] mentions PPP strategies such as giving pregnant women 'choices' of skilled providers thereby creating competition, contracting-out of services, and pre-payment systems with individual and government contributions. There is no separate mention of the not-for profit sector. The Approach Paper suggests encouraging multiple experiments to see what works best.

The way forward

One may logically conclude that the weakening of the public sector through neglect and under-funding has led to vastly increased usage of the private sector. The private sector in turn reaped enormous profits as a result of huge household spending, while poor households are pushed into deep debt. In this the healthcare issue becomes one of social justice and state responsibility. It is clear that a large amount of state resources are needed to strengthen the basic healthcare facilities in UP and ensure that at least the trained staff, equipment and supplies are in place to serve the health needs of the people. Along with this is needed a strong system of accountability, including oversight and strong governance so that the money is not siphoned off before it reaches the people.

Partnerships with the private **non-profit sector** may be further strengthened to build community-based oversight mechanisms; these could include:

[1] See Appendix One for a detailed analysis of these

- Information dissemination about rights and entitlements to quality of care such as IPHS, concrete service guarantees and citizen's health charters, all of which must apply to the private sector as well as the public sector health centres with penalties for breach of standards
- Organizing stakeholder dialogues to build ownership of the NRHM objectives, encouraging local media and people's elected representatives (including Panchayat leaders) to take an interest in the state of healthcare and the quality of service provision (including absentee staff, parallel clinics, informal payments etc)
- Facilitating forums where communities of users and other stakeholders may directly participate in planning for improved health outcomes and monitoring improvement of the quality of services (for example through Village Health Planning, Social Audit of health services, verbal autopsy of maternal deaths, etc)
- Building capacities of PRI leaders to manage health centres and ensure accountability of health staff (payments to be made dependent on health services provided)
- Encouraging civil society groups to evaluate the implementation of the NRHM programmes (provided they are not directly part of it)

Some **innovative PPP** to ensure that the health outcomes improve for rural women could include:

- Working with organized groups of TBAs for accreditation, linking them to communications and transport networks to speed up referral, and doing substantial evidence gathering regarding how home births actually take place
- Working with rural practitioners and quacks for skill-building, rational therapy, infection prevention and some form of social franchising or accreditation
- Universal social health insurance for comprehensive health coverage for rural women (on the lines of the Thailand 30 Baht scheme) who are part of a large unorganized labour force, with state subsidy for the premium, and a modest pre-payment or co-payment (to prevent misuse of health services)
- Working with local management institutes to strengthen output-based administration of health service provision at primary and secondary level (since doctors should not use their time administering health programmes); especially to improve oversight skills in regulation of the for-profit private health providers of the area

Thank you.

Annexure One: Analysis of different PPI for health care

Ravindran and Weller classify a large number of PPI in health care on the basis of financing and service provision components:

- Social marketing: where the product is sold at subsidized prices but distributed by commercial distribution systems, while health education is integrated with brand advertising. In India, social marketing of condoms for example goes back to 1968
- Social franchising: a network of service providers use a shared brand name guaranteeing a certain quality of a package of health services with a fixed price line: providers might benefit from training, referral systems, technical support and subsidized supplies. The Janani programme of India that was started in Bihar and has now spread to other states used the 'Surya clinics' and 'Titli centres' to offer reproductive health services including contraception and safe abortion
- Public contracting of private services: in which private providers may be asked to supplement services at public health centres (for example asking female doctors to attend rural clinics) or public health services may be contracted out to private bodies such as non-profits to run more effectively, or provide improved coverage. These have been introduced within health sector reforms in several states of India
- Resource mobilization through partnerships with the private (corporate) sector for health care services or products. This form of PPI has been strongly encouraged by the international financial institutions and bi-laterals/ multilaterals since the 1990s.

Additionally Ravindran and Maceira have examined the reforms in health financing[xxii] that also involve PPI such as social health insurance schemes and pre-payment schemes, that were meant to prevent households from falling deep into debt because of catastrophic episodes of ill-health.

- Social health insurance schemes: in which formally employed persons have compulsory membership in a fund created by standard contributions by both employers and employees; the fund is used to pay for health services. The Chiranjeevi scheme being used in Gujarat to ensure skilled attendance at childbirth is an example of the latter, with a 'voucher system'. The state pays each provider in a district a fixed amount to conduct 100 deliveries in their institution, within which costs for normal, assisted and surgical procedures are included.
- Pre-payment schemes: These are risk-pooling mechanisms with voluntary enrolment through a modest one-time contribution, especially to enable poorer families to access health services without having to pay high fees at the time of health-seeking. The SEWA Social Security Scheme started in 1992 in Ahmedabad, India covered 25,000 low-income self-employed women in 1999-2000 for in-patient care at private, public and non-profit hospitals in the city.

The promotion of PPIs in healthcare has raised questions about equity especially in the access of low-income or marginal groups to reproductive health services, or the right of communities to participate in decision-making regarding health care priorities. The social franchising and social marketing models have been studied in Bangladesh and the issues of subsidy withdrawal and cost recovery have emerged as a significant challenge. Quality control of franchised health service provision is difficult when the nature of services

varies with each individual user and the evaluation of rational and high-quality care cannot be done by the user. Similarly there is a concern with contracting of public health services in the absence of strong pro-consumer and regulatory laws, and of sufficient managerial capacity within the public sector to regulate and monitor the process in a transparent and effective manner so as to ensure accountability of the contractor.

With social health insurance schemes, it has been found that when providers are paid 'fees for service' they tend to increase the tests, drugs and the length of hospital stay. But if the providers are paid on a 'capitation basis', they are motivated to contain costs and adhere to rational prescriptions and therapy. The other issue relates to health insurance for the vast informal sector in India, especially women who are largely outside the ambit of the formal sector employment. Pre-payment schemes may not be sufficiently financially viable, since risk-pooling by poor populations has to be cross-subsidized by either the government or by enrolling higher-income groups. Moreover it may exclude the poorest and those without access to cash incomes such as adolescents, the elderly or disabled.

Endnotes

[i] With contributions from A. Das, R. Duggal, Leila C. Varkey, Asha George and Ranjani Murthy

[ii] Sample Registration System, Maternal Mortality in India, 1997-2003: Trends, Causes and Risk Factors. Registrar General, India, in collaboration with Centre for Global Health Research, University of Toronto, Canada, 2006 – gives data on 462547 women of UP and UK who had 62659 live births in 2001-2003

[iii] According to the State Planning Commission, state allocation on health increased from Rs.89.91 per capita in 2002-03 – first year of the Tenth Plan – to Rs.152.04 in 2005-06. But the per capita expenditure on health in UP is Rs 924 in 2004-2005.

[iv] The last few years have seen donor programmes like Innovations in Family Planning Services (IFPS) project supported by USAID – Phase 1 1994 to 2004 – IFPS was designed as a ten year project with a funding of $325 million over its Life of Project (LOP), which was matched by a $400 million host country contribution (HCC) from the Government of India (GOI); the Uttar Pradesh Health Systems Development Project (UPHSDP) is a five year $110 million World Bank–assisted project designed to improve the quality of and access to health services in the state, but has been extended due to under-spending

[v] Ministry of health and Family Welfare Government of India, 2005-2006 National Family Health Survey (NFHS-3) Fact Sheet Uttar Pradesh (Provisional data), International Institute for Population Sciences, Mumbai – gives data on 12183 women between 15-49 years interviewed in UP

[vi] These TBAs of UP would be of varied caste composition, and provide services such as facilitating the birth, identifying complications, suggesting referrals, disposing of the placenta and providing immediate post-partum care to the secluded mother and child (washing and massage, etc) according to Matrika, (n.d.) Hearing Dais' Voices: Learning About Traditional Birth Knowledge and Practice, MATRIKA, PLAN International

[vii] Whatever training modules for TBA training were developed in Uttar Pradesh (as by the USAID project SIFPSA) were not based on any primary or anthropological study of existing TBA practices and evidence-based assessment of safe or unsafe interventions by TBAs. Neither was there a distinction made between the varied roles played by TBAs according to caste composition in Uttar Pradesh.

[viii] In Gujarat, the NGO sector has innovatively set up a TBA organization (Dai Sangathan) to ensure standardized training, TBA accreditation and facilitate honoring of referrals.

[ix] Women's Voices, KRITI and other organizations, Lucknow (SAHAYOG: unpublished) 2004, prepared towards the National Shadow Report for CEDAW

[x] Dasgupta, J. Experiences with Janani Suraksha Yojana in Uttar Pradesh: Analysis of case studies by SAHAYOG and partners, Centre for Health and Social Justice (forthcoming) 2007

[xi] Department of Planning (GoUP), Note on Health Sector in Uttar Pradesh, Government of Uttar Pradesh, December 2005

[xii] This was a WB loan of 110 Million USD for 2000 to 2005

[xiii] International Institute for Population Studies, Facility Survey National Report under Reproductive and Child Health Project Phase II. 2003, IIPS. http://www.rchindia.org/fs_india.htm

[xiv] According to the RCH Facility Survey 256 CHS were surveyed - see Table below

[xv] More than 94% of doctors and 68.5% of hospitals in India are located in urban areas where 27.8% of the population resides, and only 10% of government beds and 30% of private beds are in rural areas

[xvi] Department of Planning (GoUP), Note on Health Sector in Uttar Pradesh, Government of Uttar Pradesh, December 2005

[xvii] Ibid: These figures are based on National Health Accounts 2001-2002 and extrapolated for 2004-2005

[xviii] Dasgupta, J. Experiences with Janani Suraksha Yojana in Uttar Pradesh: Analysis of case studies by SAHAYOG and partners, Centre for Health and Social Justice (forthcoming) 2007

[xix] Duggal 2007, forthcoming in SID publication, Rome

[xx] Ravindran, TKS and S Weller, 'Public Private Interactions in Health' (pages 90-136), in The *Right* Reforms? Health Sector Reforms and Sexual and Reproductive Health, Ravindran TKS and de Pinho H (eds), Women's Health Project School of Public Health, University of Witwatersrand, South Africa 2005

[xxi] Planning Commission - Towards Faster and More Inclusive Growth An Approach to the 11th Five Year Plan 2007-2012, Government of India Planning Commission New Delhi December 2006

[xxii] Ravindran, TKS and D Maceira, 'Health Financing Reforms' (pages 26- 89), in The *Right* Reforms? Health Sector Reforms and Sexual and Reproductive Health, Ravindran TKS and de Pinho H (eds), Women's Health Project School of Public Health, University of Witwatersrand, South Africa 2005