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Dr. (Brig) Sunder Lal

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Guest Editorial

Enhancing Public Private Partnership (PPP) – an Imperative need.

Dr. (Brig) Sunder Lal,
Professor, Community Medicine, MMIMSR, Mullana (Ambala)

The "health" is a state subject and the State Government has the obligation to provide health care to its people. Over the years we have developed our own system of health care in India and achieved quite a few commendable landmarks.

The birth rate has come down to the level of 23.1, infant mortality has declined to 55, and maternal mortality has been reduced to the level of 254. Over the years several reforms have been introduced in the health system and notable of these was adoption of "Target free approach" or "Community need assessment" way back in 1996. The nation launched comprehensive Reproductive and child health programme phase 1 in 1997 as a follow up measure of landmark international conference on population and development held at Cairo in 1994. National population policy and revised National Health policy are there along with flagship programme of National Rural Health Mission (NRHM 2005)(1-3).India also committed to achieve millennium development goals. NRHM has made renewed commitment to further reform the health system by way of decentralized participatory planning keeping, "people or community" at the central stage, beginning of services at the village level by village health and sanitation committees with the input of ASHA and setting up of Rogi Kalyan samitis (RKS) at PHCs and CHCs so that the decentralized system is fully accountable to people/ users of the system. Similarly the District Health societies have been set up to plan, implement, monitor and control of health services in the district. In spite of all this the governance of the system and "power" rest with district collector or Deputy Commissioner and other members are subservient to his authority.

Devolution of responsibilities and powers to PRIs has been symbolic and much remains to be done to involve them in the system at health care-planning, implementation and evaluation of the services. The public health system has several drawbacks inspite of system of reforms, the planning is highly centralized, accountability is to the bureaucracy not to the people, institutions are based on population norms rather than habitations, utilization of the system is poor, inability of the system to mobilize actions in area of safe water, sanitation, hygiene, and nutrition (key determinants of health in our country) besides lack of convergence.

The growth of private health sector in India has been considerable in both provision and financing. There is diversity in the composition of the private sector, which ranges from voluntary, not-for profit, for profit, corporate, trusts, stand alone specialist services, diagnostic services to Pharmacy Shops and a range of highly qualified to unqualified providers, each addressing different market segments. Promotion of PPP for achieving public health goals is one of the strategies of NRHM (4).

The public spending on health in India is among the lowest in the world (about 1% of GDP), whereas its proportion of private spending on health is one of the highest.. Households spend about 5-6 % of their consumption expenditure on health (NSSO). Over 80% of spending on health is by way of out of pocket expenditure to be borne by poor people. The cost of services in the private sector makes it unaffordable for the poor and the underprivileged.

Despite a steady increase in public health care infrastructure, utilization of public health facilities by population for outpatient and inpatient care has not improved. The NSSO

(1986-2004) data clearly show a major decline in utilization of the public health facilities for inpatient care and a corresponding increase in utilization of the same from private health care providers in both rural and urban areas. With the exception of a few states, there has been very low utilization for outpatient care as well. Despite higher costs in the private sector, this shift shows the people's growing lack of trust in the public system.

NRHM is making determined efforts to increase the total expenditure to the level of 2% of GDP by the end of 11th plan period. In India, due to huge geographical area, very large population, and inequity of resources, ensuing good health for all, particularly the poor is a complex issue. Our health system is a mix of public and private sector, with the NGOs and civil society still playing a very marginal (though important) role.

We have a flourishing private sector because of failing retain in public health sector. The growth of private hospitals and diagnostic centers is also encouraged by the Central and State Government by offering tax holiday / exemption, and land, electricity & water at concessional rates in return for free treatment for the poor as a certain proportion of outpatient and inpatient. Apart from subsidies, private corporate hospitals receive huge amounts or public funds in the form of reimbursements from public sector undertakings, the Central & State Governments for treating their employees. These private hospitals have been accredited by the state /central Government. Most people often use services of private sector. The private sector is substantial entity and dominant sector to provide curative care and caters to 82% of ambulatory (outdoor) care and 55% of hospital care in India. This sector is financed primarily by out of pocket resources. Results from National Health Accounts (2003-04) show households expenditure amounting to 68.8 % of total health expenditure. The private sector is heterogeneous in nature and encompasses a variety of providers- ranging from traditional healers, birth attendants, registered medical practitioners of varied systems of health care apart from world class State of the Art care institutions and hospitals venturing to medical tourism in India. Within the non-governmental services there is a large commercial private sector and a much smaller but significant "not for profit" sector. The "not for profit" centers, will be further encouraged and used as role models. The cost of health care in the private sector is much higher than the public sector. Many small providers have poor knowledge base and tend to follow irrational, ineffective and sometimes even harmful practices for treatment. Therefore the quality of services is variable. By and large the private sector is unregulated. Bulk of the qualified medical practitioners and nurses are self regulated and in practice regulation of these professionals is weak and close to non-existent in almost all states.

Continuing with the reform system the NRHM has taken several initiatives to enhance PPP. The Centre and the State Governments have initiated a wide variety of PPP arrangements to meet peoples growing health care need in the in the area of maternal and child health. We have substantial involvement and partnership of private sector.

The private sector accounts for nearly 4/5 th of health expenditure in India in the absence of an effective Public Health System. Under National Family Welfare Programme, Private Practitioner & Institutions have been accredited for tubectomy vasectomy and IUD insertions as also social marketing programme in contraceptive has been promoted ever since 1968-69. This has led to enhancement of couple protection rate from 10 percent to 57 percent.

MTPs

Most of termination of pregnancies in almost all districts in Haryana are undertaken by Private Practitioners (>80%). The government share is below 20%. Safe abortion service is critical to reduce 10% of maternal mortality attributed to unsafe abortions. Most of all PHCs do not provide MTP services and CHCs provide symbolic MTP services. Illegal abortion is a flourishing business risking the lives of care seekers (women). Janani Surakha Yojna under

NRHM launched in 2005 has dual objectives of reducing maternal mortality and promoting safe and institutional deliveries among the poor women. Cash benefits are provided to the beneficiaries. Nearly 50% of deliveries are safe deliveries in India. The share of safe deliveries (institutional) done by accredited nursing homes and Practitioners and non accredited nursing homes and practitioners is substantial (nearly 50%). India does not have institutional capacity (11PS 2003) to receive 26 million women giving birth each year, hence it is a necessity to involve private sector/ NGOs for safe deliveries. In rural areas the need is much more as 60% or more deliveries occur at home. Accrediting rural practitioners and skilled birth attendance is imperative to reduce maternal mortality. JSY has enhanced access to ante-natal & post natal care Chirangeevi Yojna of Gujarat Govt., has taken sole responsibility of reimbursement of cost of deliveries done by private health care providers. NRHM encourages this partnership and money is available and now it is left to health system, how much advantage and leverage it can draw. Involvement of FOGSI and IMA in Vandematram scheme for antenatal care, prevention and treatment of anemia and safe deliveries is another push to reduce maternal mortality.

Many households have to seek health care from private sector. A variety of partnerships are being pursued under the RCH-II and independently by states with their own resources with non-governmental partners. “Contracting” is the predominant model for PPP in India under NRHM. The important strategies of PPP are contract in, contract out, outsourcing, management of hospitals facilities by leading NGOs, hiring staff, service delivery including family planning services, MTP, treatment of STI/RTI etc. Franchising and social marketing of contraceptive are already built into FW programme. The immunization and polio eradication programmes effectively make use of partnership with WHO, UNICEF, the Rotary International and NGOs etc. The disease control programme (Tuberculosis, leprosy, Malaria, Blindness, HIV/AIDS, vaccine preventable diseases, Goiter control and integrated disease surveillance programme) make use of NGO partnerships in a big way.

Various professional Associations like FOGSI, IMA, Indian Association of Preventive and Social Medicine and Public Health have been involved in RCH programme for continuing education, advocacy, awareness, training and human resource development. IMNCI training and training of ASHAs has been entrusted to professional association and NGOs. Many new medical collages are being setup in collaboration with Private sector. NRHM during eleventh Plan period will further encourage training and up gradation of skills of Private sector providers of health services for the poor. Standard treatment guidelines will be further promoted to Improve the quality of services and ethical practice NRHM attempts to ensure that more than 70% of the resources are spent through bodies that are managed by community organization and 10% of the resources are spent through grants in aids to NGOs. Standards treatment guidelines for National Programmes like tuberculosis, IMNCI, ARI, Malaria, RTI & STI Acute watery diarrhea, HIV/AIDS have been developed in Public sector. However in Private sector these guidelines are seldom followed for various reasons. A clear example: IMA was made responsible to train its members on promotion of Oral Rehydration Therapy but practices of practitioners did not change much even after training or reorientation in the State of Haryana . Continuing education programmes and provision of learning resources maternal to private sector for effective partnership is an imperative need.

Efforts will be made by the Government to enforce Indian Public Health Standards for governmental hospitals at all levels. Priority will be given for development of standard operating procedures and standard treatment guidelines for all specialties and all systems of medicine. The NRHM attempts to provide people’s friendly regulation framework that promotes ethical practice in Private sector. Household expenditure on Health care in India was more than Rs. 100,000 crores in 2004-05 and most of it was out of pocket expenditure in using private health facilities. In a country of over a billion people, barely 10 million are

covered under the private health insurance schemes. Even if we take into account Social Insurance Schemes like CGHS, ESIS etc, coverage does not exceed 110 million of which 30 million are poor. In order to reduce distress on poor households, there is therefore an imperative need for setting up risk pool system. Involvement of NGOs and Community based organization as insurance providers and third party administrators (TPA) can work in the interest of poor households. However introduction of such a system without the backup support of a strong, the curative public health infrastructure would not be cost effective. Such a venture would only end up by subsidizing private hospitals, will escalate demand for high cost curative health care. While the private insurance companies would be encouraged to bring an innovative insurance products, the NRHM would omit strive to set up a risk pooling system where the centre, states and local community would be partners. Community based health insurances is in the offing

In spite of all these efforts over the years, true partnership that means equality among partners, mutual commitment to goal, shared decision, and risk taking are rarely seen. Results of several case studies bring forth concerns such as absence of beneficiary in the entire process, lack of effective governance mechanism for ensuing accountability, non-transparent mechanisms, lack of appropriate monitoring and governance systems and institutionalized management structures to handle the task are common problems.

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