Chapter X

The areas from which Government could withdraw from direct involvement so as to focus on the core sectors of governance and what should be Government Policy for such withdrawal.

The areas from which Government could withdraw from direct involvement so as to focus on the core sectors of governance and to suggest as to what should be Government Policy for such withdrawal.

Recommendations

The main reason for the macro-economic crisis in our country is the growth of public spending, as a result of which fiscal deficit as a proportion to GDP rose considerably. Unless these yawning gap between revenue receipt and revenue expenditure is contained, and reduction in capital expenditure is allowed to continue, there would be irreparable adverse impact on the economy. What is really needed is cut in revenue expenditure, for which a reduction in the role and scope of Government is essential. This, all India macro-economic scenario is applicable to our State also. In fact, in view of limited scope of mobilisation of additional resources, the impact is more severe in Assam. Moreover, recent decades have seen a shift towards a reduced role for the Government in all the countries. It has been accepted all over the world that the Government should confine itself primarily to the core functions that cannot be performed by non government initiatives. Experts in Public Administrations have suggested in this context that before undertaking any work by the Government the following pertinent questions are to be asked:

1. Does the job need to be done at all ?

2. If the activity needs to be carried out, does the government have to be responsible for it ?

3. Where the government needs to remain responsible for the activity, does the government have to carry out the activity by its own department or it could be outsourced ?

   Time has come to redefine the role of the Government in the context of the scenario described above. But on the other hand, we cannot afford to ignore the cardinal principle of economic growth that investments in primary education, health care & nutrition as well as rural infrastructure tend to enhance the productive capacity of the whole economy, boosting the incomes of all groups particularly the **Poorer Section**.

The role and relevance of Government pale into insignificance in the context of tremendous financial crisis, which Government has been undergoing. Government needs resources to carry out its functions, and when the Government is unable to generate the required quantum of

resources, it will be forced to reduce its presence even in needed areas and go for a kind of privatization.

In fact in present context, the question is less about the role of government, but more about the mode of its functioning. Even here, whether Government should directly provide all services and if so at what cost and if not which are the services Government has to provide directly and which are the services it has to facilitate; these questions need to be viewed from the point of view of both public interest & efficiency.

It is to be admitted that Government is circumscribed by practical limitations rather than conditioned by social ideas. Probably in such a situation, it would be advisable for the State to get a human face, reaches out to the people, enables the community to participate in development process, provide for more and more social control in use of resources as well as legitimacy of Government, even while it does not expand in size or directly perform all activities. The ultimate success of Government in administering responsive governance depends on its capacity to provide rapid equitable development and greater participation to all its citizens in as many as walks of life as possible.

Against this background, Commission is of the opinion that the broad parameters for Government's role should be:

1. The Government should tone up its regulatory role –both economic and social with special focus on taxation, financial displines, law and order and maintenance of standard and quality.
2. Government has to protect the natural resources and ensure only sustainable developments in different fields.
3. Government has to directly provide the basic human needs and services to the people who are poor and in the event of shortage of funds the poorest of poor section should come first.
4. Government has to create jobs rather than provide jobs, and for this, quality human resource development accompanied by a policy, facilitating economic growth would be required and careful planning can ensure pro-poor growth.
5. Government should be responsible for creation of physical infrastructure.
6. Government should protect the vulnerable and disadvantage section of the society in times of need.

Another important responsibility of the State Government is to provide safety net to citizens particularly to disadvantaged sections as well as to place **Regulatory System** with clear-cut guidelines regarding-

(i) Standard for delivery of goods & services by both public & private sector,
(ii) Accountability, transparency of service provider,
(iii) Regular monitoring and evaluation system to ensure desired goals.

Regulation need not be always from Government side, it can be some form of self regulation through professional bodies with proper code of conduct and ethics as well as orientation to uphold social needs and need not be turf protection activities.

In the short run till such time, as the resources of the government are limited, severe rationing of the Government services is essential with only the poor getting the services free or below cost. What is required is cross subsidies and not subsidies.

The focus of attention should be more on how a Government functions rather than on what it does. With efficient and effective functioning Government can reflect popular aspirations and expand their role gradually in future.

Commission after a series of discussion with Government Officials and other stakeholders makes following recommendations:

1. Core Sector

- Government should focus on the core sectors of Governance which should include Law and Order and maintenance of Justice, Public Finance Management and Infrastructure development.

2. Health Sector

(i) Primary Care Level:

- Government should concentrate on providing free or affordable heath care to the indigent and needy segment of the population with focus on primary and preventive health care programmes and eradication of widespread communicable diseases.

- The Government should utilise private sector as well as NGOs for improving reach of heath delivery system.

(ii) Secondary & Tertiary Care Level:

- There can be a mix of public and private initiatives in health care in secondary and tertiary segments.

- The Civil Hospitals at District and Sub-Divisional level could be partially corporatised and operated with greater autonomy. Public-Private Partnership in secondary care level could be thought of for up gradation of technology in the existing civil hospitals in partnership with private sector through a time bound agenda.

- In the Tertiary care sector steps be taken for tie up with private parties to upgrade technology at their expenses with the agreed revenue sharing model with the provision for poorer section in an economically sustainable system.

(iii) Medical Education:

- Eminent practitioners fulfilling IMC norms may be requested to enrich teaching faculty of medical colleges to take part in teaching as honorary teachers as in case of Maharastra Government.

- There should be Public-Private Partnership for establishment of medical institutions like Medical College, Dental College, Nursing College, Degree/Diploma Institutions for para medical disciplines, and also super speciality hospitals for specified disease like Cancer, Mental Health etc.

For ensuring access to quality health care services in areas or for groups that the State Government cannot adequately cover, as well as for improved health care infrastructure and facility for the benefit of the people of the State, particularly in rural areas, **the Commission recommends** that Public-Private Partnership in the health care sector should be tried to supplement State Government's efforts to improve the health status of all the people of Assam specially the poorer and those in greatest need. This would involve collaboration with not only private sector but also with NGOs / CBOs and other interested persons of civil society with proper tract record.

The Commission further recommends that the Policy for Public Private Partnerships in Health Sector accepted by West Bengal Government may perhaps be considered as the model with required modifications (West Bengal Policy at Annexure I). National Health Policy 2002 also states that "in principle National Health Policy 2002 welcomes the participation of private sector in all areas of health activities – primary, secondary or tertiary."

3. Education Sector:

(i) Primary & Secondary Education

- As per amended provisions of the Constitution of India, the management and administration of education up to middle level could be entrusted to PRIs / Urban Local Bodies for better peoples participation and better lower level supervision as well as accountability.

(ii) Higher Education

- Higher-level educational institutions could be granted functional autonomy. They could be allowed to raise funds through fees, grants etc so that they become self –sustaining to the extent possible. To ensure access for poor to these educational institutes Government can however provide scholarships entirely based on economic criteria cum merit. Further these institutes could be allowed to accept donation / contribution from private charitable sources.

(iii) Adult Education:

- Adult education could be entrusted to reliable NGOs.

(iv) Technical Education:

- ITIs and such other institution providing vocational training could be handed over to Industrial houses /Industrial associations for management as to link them with private employment / self employment ultimately.

4. Sectors from which Government could withdraw:

As regards other sectors the services where from Government could withdraw and which could be transferred to Co-operatives, PRIs, ULBs, NGOs / CBOs, Autonomous Bodies and private agencies are indicated below. **Self Help Groups can also play a very significant role in this context.**

(a) Co-operatives :

Properly organized Cooperative societies should be promoted to handle activities like –

⇒ Agriculture farming and marketing of agricultural produce in Agriculture sector.

⇒ Animal, poultry farming, marketing of Veterinary and Poultry produce Dairy farming, Town milk supply scheme and Marketing of milk produce in Veterinary and AH Sector.

⇒ Fish farming and Marketing of fish produces in Fishery sector.

⇒ **Sericulture farming and marketing of sericulture produces in Sericulture Sector.**

⇒ Marketing Handloom, handicraft, and textile products in H&T Sector.

(b) PRI & Urban Local Bodies:

In order to ensure better construction and maintenance of assets it is suggested that

⇒ Minor Irrigation schemes under Irrigation Department could be handed over to PRIs, who should manage the schemes realizing users' charges on sustainable basis,

⇒ All water supply Schemes under Government sector could be handed over to PRIs and Civic body, who should realize water charges from the users.

⇒ Other than State Highways and National Highways as well as arterial roads other roads could be given to PRI in rural areas and to civic bodies in urban areas, for construction and maintenance.

(c) Autonomous Bodies with professionals:

In order to promote professional sectors, it is suggested that

⇒ All cultural activities under Cultural Department could be administered through Autonomous bodies managed by professionals.

⇒ Schemes under Sports and Youth Welfare Department could be implemented through Autonomous Sports and Youth Welfare Bodies managed by professionals.

(d) Outsourcing to Private Sector:

Following sectors could be outsourced to private sectors to take advantage of their resources, expertise in their respective field of specialization.

⇒ Survey works under Economics & Statistics Department could be outsourced.

⇒ Public transport system could be privatized ensuring functioning of public transport in interior areas and uneconomic routes.

⇒ Schemes under Tourism Department should be implemented through private entrepreneurs.

⇒ Media publicity of the Government, and social marketing of Government programmees could be entrusted to private media agencies.

⇒ Manufacturing /production units and marketing organizations should be handed over to private sector.

(e) NGOs:

The NGOs could be utilized to provide training /capacity building in the following fields:

⇒ All Social sector training could be entrusted to NGOs

⇒ Implementation of Social forestry schemes and creation of environment awareness could be handed over to NGOs.

⇒ Social Welfare schemes other than statutory and mandatory ones under Social Welfare Department could be entrusted to NGOs

Government of India

National Rural Health Mission

The **National Rural Health Mission**, approved by the Government of India in January 2005, has been designed to realize the commitment enshrined in the National Common Minimum Programme for improved public health services. It is also the blue-print for a comprehensive re-structuring of the current strategies.

Goals:

- Provision of an Accredited Social Health Activists (ASHA) selected by the community in each village
- Preparation of inter-sectoral village health plans that include determinants of health like water, sanitation, nutrition etc, to be aggregated into a District Health Plan
- Creation of Village Health Committee headed by local Panchayat representative
- Untied pool for every Sub-centre for local level action for health
- Strengthening of Community Health Centres as full-fledged referral units for assured quality hospital care
- Integration of existing vertical schemes: District Health Mission Plan supported by District Health Fund

Supplementary Goals:

- Facilitate multiple health insurance initiatives
- Promotion of private sector participation for public health goals
- Development of Indian Public Health Standard (IPHS) and its enforcement across the sector
- Other supportive policy reforms

Capacity Building in Health & Family Welfare Sector

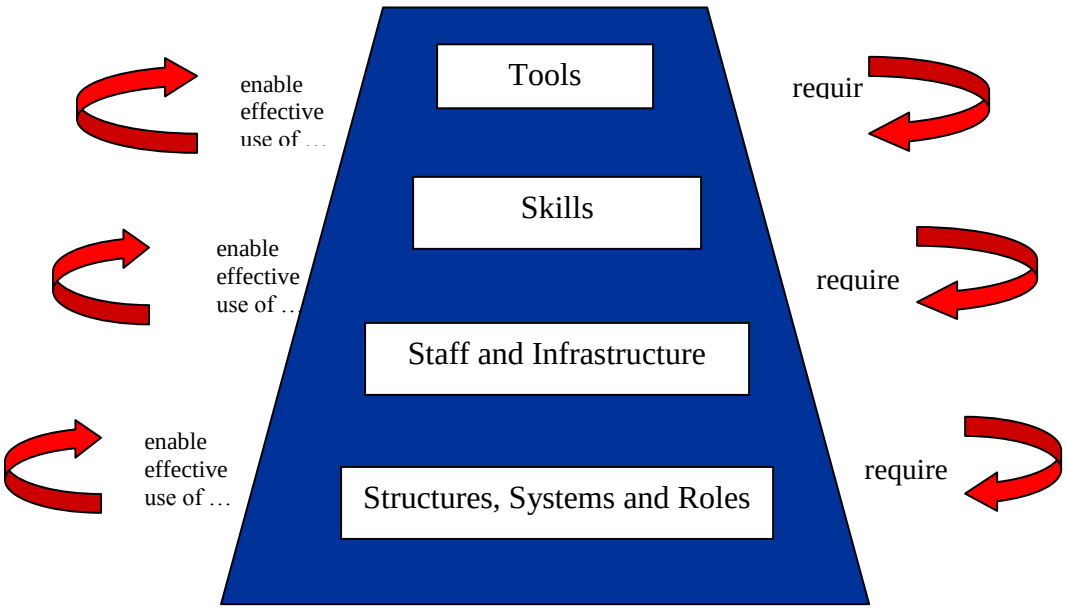
- Most development concerned with 'capacity building' (often merely a synonym with 'training')

- The capacity of an organization to be efficient and effective can be built in several ways :

  - By supplying tools (eg. equipment for a hospital)
  - By providing training (eg. in use of hospital equipment)
  - By expanding staff and infrastructure (eg. more medical specialists and hospital extension)
  - By reorganizing structure, re-defining roles and modernizing systems (eg. introducing hospita;l management board and upgrading information systems)

In the course of the programme, the concept of the 'capacity pyramid' has been developed; in essence, a four level hierarchy of some of the main capacity building needs: (1) tools; (2) skills; (3) staff and infrastructure; (4) systems, roles and structures. The pyramid assists in judging which inputs (and combination of inputs), in what order over time, will be most effective in terms of building capacity at national, state, district and sub-divisional levels.

Capacity Pyramid



(Extracts from Health & Family Welfare Sector Investment Programme of Government of India in Partnership with European Union)

National Rural Health Mission
(2005-2012)

Mission Document

Preamble

Recognizing the importance of Health in the process of economic and social development and improving the quality of life of our citizens, the Government of India has resolved to launch the National Rural Health Mission to carry out necessary architectural correction in the basic health care delivery system. The Mission adopts a synergistic approach by relating health to determinants of good health viz. segments of nutrition, sanitation, hygiene and safe drinking water. It also aims at mainstreaming the Indian systems of medicine to facilitate health care. The Plan of Action includes increasing public expenditure on health, reducing regional imbalance in health infrastructure, pooling resources, integration of organizational structures, optimization of health manpower, decentralization and district management of health programmes, community participation and ownership of assets, induction of management and financial personnel into district health system, and operationalizing community health centers into functional hospitals meeting Indian Public Health Standards in each Block of the Country.

The Goal of the Mission is to improve the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women and children.

1. State of Public Health

- Public health expenditure in India has declined from 1.3% of GDP in 1990 to 0.9% of GDP in 1999. The Union Budgetary allocation for health is 1.3% while the State's Budgetary allocation is 5.5%.

- Union Government contribution to public health expenditure is 15% while States contribution about 85%

- Vertical Health and Family Welfare Programmes have limited synergisation at operational levels.

- Lack of community ownership of public health programmes impacts levels of efficiency, accountability and effectiveness.

- Lack of integration of sanitation, hygiene, nutrition and drinking water issues.

- There are striking regional inequalities.

- Population Stabilization is still a challenge, especially in States with weak demographic indicators.

- Curative services favour the non-poor: for every Re.1 spent on the poorest 20% population, Rs.3 is spent on the richest quintile.

- Only 10% Indians have some form of health insurance, mostly inadequate

- Hospitalized Indians spend on an average 58% of their total annual expenditure

- Over 40% of hospitalized Indians borrow heavily or sell assets to cover Expenses

- Over 25% of hospitalized Indians fall below poverty line because of hospital expenses

2. National Rural Health Mission –the Vision

- The National Rural Health Mission (2005-12) seeks to provide effective healthcare to rural population throughout the country with special focus on 18 states, which have weak public health indicators and/or weak infrastructure.

- These 18 States are Arunachal Pradesh, Assam, Bihar, Chhattisgarh, Himachal Pradesh, Jharkhand, Jammu & Kashmir, Manipur, Mizoram, Meghalaya, Madhya Pradesh, Nagaland, Orissa, Rajasthan, Sikkim, Tripura, Uttaranchal and Uttar Pradesh.

- The Mission is an articulation of the commitment of the Government to raise public spending on Health from 0.9% of GDP to 2-3% of GDP.

- It aims to undertake architectural correction of the health system to enable it to effectively handle increased allocations as promised under the National Common Minimum Programme and promote policies that strengthen public health management and service delivery in the country.

- It has as its key components provision of a female health activist in each village; a village health plan prepared through a local team headed by the Health & Sanitation Committee of the Panchayat; strengthening of the rural hospital for effective curative care and made measurable and accountable to the community through Indian Public Health Standards (IPHS); and integration of vertical Health & Family Welfare Programmes and Funds for optimal utilization of funds and infrastructure and strengthening delivery of primary healthcare.

- It seeks to revitalize local health traditions and mainstream AYUSH into the public health system.

- It aims at effective integration of health concerns with determinants of health like sanitation & hygiene, nutrition, and safe drinking water through a District Plan for Health.

- It seeks decentralization of programmes for district management of health.

- It seeks to address the inter-State and inter-district disparities, especially among the 18 high focus States, including unmet needs for public health infrastructure.

- It shall define time-bound goals and report publicly on their progress.

- It seeks to improve access of rural people, especially poor women and children, to equitable, affordable, accountable and effective primary healthcare.

3. Goals

- Reduction in Infant Mortality Rate (IMR) and Maternal Mortality Ratio (MMR)

- Universal access to public health services such as Women's health, child health, water, sanitation & hygiene, immunization, and Nutrition.

- Prevention and control of communicable and non-communicable diseases, including locally endemic diseases

- Access to integrated comprehensive primary healthcare
- Population stabilization, gender and demographic balance.
- Revitalize local health traditions and mainstream AYUSH
- Promotion of healthy life styles

4. Strategies

(a) Core Strategies:

- Train and enhance capacity of Panchayati Raj Institutions (PRIs) to own, control and manage public health services.
- Promote access to improved healthcare at household level through the female health activist (ASHA).
- Health Plan for each village through Village Health Committee of the Panchayat.
- Strengthening sub-centre through an untied fund to enable local planning and action and more Multi Purpose Workers (MPWs).
- Strengthening existing PHCs and CHCs, and provision of 30-50 bedded CHC per lakh population for improved curative care to a normative standard (Indian Public Health Standards defining personnel, equipment and management standards).
- Preparation and Implementation of an inter-sectoral District Health Plan prepared by the District Health Mission, including drinking water, sanitation & hygiene and nutrition.
- Integrating vertical Health and Family Welfare programmes at National, State, Block, and District levels.
- Technical Support to National, State and District Health Missions, for Public Health Management.
- Strengthening capacities for data collection, assessment and review for evidence based planning, monitoring and supervision.
- Formulation of transparent policies for deployment and career development of Human Resources for health.

- Developing capacities for preventive health care at all levels for promoting healthy life styles, reduction in consumption of tobacco and alcohol etc.

- Promoting non-profit sector particularly in under served areas.

(b) Supplementary Strategies:

- Regulation of Private Sector including the informal rural practitioners to ensure availability of quality service to citizens at reasonable cost.

- Promotion of Public Private Partnerships for achieving public health goals.

- Mainstreaming AYUSH – revitalizing local health traditions.

- Reorienting medical education to support rural health issues including regulation of Medical care and Medical Ethics.

- Effective and viable risk pooling and social health insurance to provide health security to the poor by ensuring accessible, affordable, accountable and good quality hospital care.

5. Plan of Action

Component (A): Accredited Social Health Activists

- Every village/large habitat will have a female Accredited Social Health Activist (ASHA) - chosen by and accountable to the panchayat- to act as the interface between the community and the public health system. States to choose State specific models.

- ASHA would act as a bridge between the ANM and the village and be accountable to the Panchayat.

- She will be an honorary volunteer, receiving performance-based ,compensation for promoting universal immunization, referral and escort services for RCH, construction of household toilets, and other healthcare delivery programmes.

- She will be trained on a pedagogy of public health developed and mentored through a Standing Mentoring Group at National level

incorporating best practices and implemented through active involvement of community health resource organizations.

- She will facilitate preparation and implementation of the Village Health Plan along with Anganwadi worker, ANM, functionaries of other Departments, and Self Help Group members, under the leadership of the Village Health Committee of the Panchayat.

- She will be promoted all over the country, with special emphasis on the 18 high focus States. The Government of India will bear the cost of training, incentives and medical kits. The remaining components will be funded under Financial Envelope given to the States under the programme.

- She will be given a Drug Kit containing generic AYUSH and allopathic formulations for common ailments. The drug kit would be replenished from time to time.

- Induction training of ASHA to be of 23 days in all, spread over 12 months. On the job training would continue throughout the year.

- Prototype training material to be developed at National level subject to State level modifications.

- Cascade model of training proposed through Training of Trainers including contract plus distance learning model

- Training would require partnership with NGOs/ICDS Training Centres and State Health Institutes.

Component (B): Strengthening Sub-Centres

- Each sub-centre will have an Untied Fund for local action @ Rs. 10,000 per annum. This Fund will be deposited in a joint Bank Account of the ANM & Sarpanch and operated by the ANM, in consultation with the Village Health Committee.

- Supply of essential drugs, both allopathic and AYUSH, to the Sub centres.

- In case of additional Outlays, Multipurpose Workers (Male)/Additional ANMs wherever needed, sanction of new Sub-centres as per 2001 population norm, and upgrading existing Sub-centres, including buildings for Sub-centres functioning in rented premises will be considered. COMPONENT

Component (C): Strengthening Primary Health Centres

- Mission aims at Strengthening PHC for quality preventive, promotive, curative, supervisory and Outreach services, through:

- Adequate and regular supply of essential quality drugs and equipment (including Supply of Auto Disabled Syringes for immunization) to PHCs

- Provision of 24 hour service in 50% PHCs by addressing shortage of doctors, especially in high focus States, through mainstreaming AYUSH manpower.

- Observance of Standard treatment guidelines & protocols.

- In case of additional Outlays, intensification of ongoing communicable disease control programmes, new programmes for control of noncommunicable diseases, upgradation of 100% PHCs for 24 hours referral service, and provision of 2nd doctor at PHC level (I male, 1 female) would be undertaken on the basis of felt need.

Component (D): Strengthening CHCs for First Referral Care

A key strategy of the Mission is:

- Operationalizing 3222 existing Community Health Centres (30-50 beds) as 24 Hour First Referral Units, including posting of anaesthetists.

- Codification of new Indian Public Health Standards, setting norms for infrastructure, staff, equipment, management etc. for CHCs.

- Promotion of Stakeholder Committees (Rogi Kalyan Samitis) for hospital management.

- Developing standards of services and costs in hospital care.

- Develop, display and ensure compliance to Citizen's Charter at CHC/PHC level.

- In case of additional Outlays, creation of new Community Health Centres (30-50 beds) to meet the population norm as per Census 2001, and bearing their recurring costs for the Mission period could be considered.

Component (E): District Health Plan

- District Health Plan would be an amalgamation of field responses through Village Health Plans, State and National priorities for Health, Water Supply, Sanitation and Nutrition.

- Health Plans would form the core unit of action proposed in areas like water supply, sanitation, hygiene and nutrition. Implementing Departments would integrate into District Health Mission for monitoring.

- District becomes core unit of planning, budgeting and implementation.

- Centrally Sponsored Schemes could be rationalized/modified accordingly in consultation with States.

- Concept of "funneling" funds to district for effective integration of programmes

- All vertical Health and Family Welfare Programmes at District and state level merge into one common "District Health Mission" at the District level and the "State Health Mission" at the state level
- Provision of Project Management Unit for all districts, through contractual engagement of MBA, Inter Charter/Inter Cost and Data Entry Operator, for improved programme management

Component (F): Converging Sanitation and Hygiene Under NRHM

- Total Sanitation Campaign (TSC) is presently implemented in 350 districts, and is proposed to cover all districts in 10th Plan.

- Components of TSC include IEC activities, rural sanitary marts, individual household toilets, women sanitary complex, and School Sanitation Programme.

Similar to the DHM, the TSC is also implemented through Panchayati Raj Institutions (PRIs).

The District Health Mission would therefore guide activities of sanitation at district level, and promote joint IEC for public health, sanitation and hygiene, through Village Health & Sanitation Committee, and promote household toilets and School Sanitation Programme. ASHA would be incentivized for promoting household toilets by the Mission.

Component (G): Strengthening Disease Control Programmes

- National Disease Control Programmes for Malari a, TB, Kala Azar, Filaria, Blindness & Iodine Deficiency and Integrated Disease Surveillance Programme shall be integrated under the Mission, for improved programme delivery.

- New Initiatives would be launched for control of Non Communicable Diseases.

- Disease surveillance system at village level would be strengthened.

- Supply of generic drugs (both AYUSH & Allopathic) for common ailments at village, SC, PHC/CHC level.
- Provision of a mobile medical unit at District level for improved Outreach services.

Component (H): Public-Private Partnership for Public Health Goals, including Regulation of Private Sector

- Since almost 75% of health services are being currently provided by the private sector, there is a need to refine regulation

- Regulation to be transparent and accountable

- Reform of regulatory bodies/creation where necessary

- District Institutional Mechanism for Mission must have representation of private sector

- Need to develop guidelines for Public-Private Partnership (PPP) in health sector. Identifying areas of partnership, which are need based, thematic and geographic.

- Public sector to play the lead role in defining the framework and sustaining the partnership

- Management plan for PPP initiatives: at District/State and National levels

Component (I): New Health Financing Mechanisms

- A Task Group to examine new health financing mechanisms, including Risk Pooling for Hospital Care as follows:
- Progressively the District Health Missions to move towards paying hospitals for services by way of reimbursement, on the principle of "money follows the patient."

- Standardization of services – outpatient, in-patient, laboratory, surgical interventions- and costs will be done periodically by a committee of experts in each state.

- A National Expert Group to monitor these standards and give suitable advice and guidance on protocols and cost comparisons.

- All existing CHCs to have wage component paid on monthly basis. Other recurrent costs may be reimbursed for services rendered from District Health Fund. Over the Mission period, the CHC may move towards all costs, including wages reimbursed for services rendered.

- A district health accounting system, and an ombudsman to be created to monitor the District Health Fund Management , and take corrective action.

- Adequate technical managerial and accounting support to be provided to DHM in managing risk-pooling and health security.

- Where credible Community Based Health Insurance Schemes (CBHI) exist/are launched, they will be encouraged as part of the Mission.

- The Central government will provide subsidies to cover a part of the premiums for the poor, and monitor the schemes.

- The IRDA will be approached to promote such CBHIs, which will be periodically evaluated for effective delivery.

Component (J): Reorienting Health/Medical Education to Support Rural Health Issues

- While district and tertiary hospitals are necessarily located in urban centres, they form an integral part of the referral care chain serving the needs of the rural people.

- Medical and para-medical education facilities need to be created in states, based on need assessment.

- Suggestion for Commission for Excellence in Health Care (Medical Grants Commission), National Institution for Public Health Management etc.

- task group to improve guidelines/details.

6. Institutional Mechanisms

- Village Health & Sanitation Samiti (at village level consisting of Panchayat Representative/s, ANM/MPW, Anganwadi worker, teacher, ASHA, community health volunteers

- Rogi Kalyan Samiti (or equivalent) for community management of public hospitals

- District Health Mission, under the leadership of Zila Parishad with District Health Head as Convener and all relevant departments, NGOs, private professionals etc represented on it

- State Health Mission, Chaired by Chief Minister and co-chaired by Health Minister and with the State Health Secretary as Convener-representation of related departments, NGOs, private professionals etc

- Integration of Departments of Health and Family Welfare, at National and State level

- National Mission Steering Group chaired by Union Minister for Health & Family Welfare with Deputy Chairman Planning Commission, Ministers of Panchayat Raj, Rural Development and Human Resource Development and public health professionals as members, to provide policy support and guidance to the Mission

- Empowered Programme Committee chaired by Secretary HFW, to be the Executive Body of the Mission

- Standing Mentoring Group shall guide and oversee the implementation of ASHA initiative

- Task Groups for Selected Tasks (time-bound)

7. Technical Support

- To be effective the Mission needs a strong component of Technical Support

- This would include reorientation into public health management

- Reposition existing health resource institutions, like Population Research Centre (PRC), Regional Resource Centre (RRC), State Institute of Health & Family Welfare (SIHFW)

- Involve NGOs as resource organisations

- Improved Health Information System

- Support required at all levels: National, State, District and sub-district.

- Mission would require two distinct support mechanisms – Program Management Support Centre and Health Trust of India.

(A) Program Management Support Centre

- For Strengthening Management Systems-basic program management, financial systems, infrastructure maintenance, procurement & logistics systems, Monitoring & Information System (MIS), non-lapsable health pool etc.

- For Developing Manpower Systems – recruitment (induction of MBAs/CAs /MCAs), training & curriculum development (revitalization of existing institutions & partnerships with NGO & private sector. Sector institutions), motivation & performance appraisal etc.

- For Improved Governance – decentralization & empowerment of communities, induction of IT based systems like e-banking, social audit and right to information.

(B) Health Trust of India

- Proposed as a knowledge institution, to be the repository of innovation –research & documentation, health information system, planning, monitoring & evaluation etc.

- For establishing Public Accountability Systems – external evaluations, community based feedback mechanisms, participation of PRIs /NGOs etc.

- For developing a Framework for pro-poor Innovations
- For reviewing Health Legislations.

- A base for encouraging experimentation and action research.

- For inter & intra Sector Networking with National and International Organizations.

- Think Tank for developing a long-term vision of the Sector & for building planning capacities of PRIs, Districts etc.

8. Role of State Governments Under NRHM

- The Mission covers the entire country. The 18 high focus States are Uttar Pradesh, Bihar, Rajasthan, Madhya Pradesh, Orissa, Uttaranchal, Jharkhand, Chhattisgarh, Assam, Sikkim, Arunachal Pradesh, Manipur, Meghalaya, Tripura, Nagaland, Mizoram Himachal Pradesh and Jammu & Kashmir. GoI would provide funding for key components in these 18 high focus States. Other States would fund interventions like ASHA, Programme Management Unit (PMU), and upgradation of SC/PHC/CHC through Integrated Financial Envelope.

- NRHM provides broad conceptual framework. States would project operational modalities in their State Action Plans, to be decided inconsultation with the Mission Steering Group.

- NRHM would prioritize funding for addressing inter-state and intradistrict disparities in terms of health infrastructure and indicators.

- States would sign Memorandum of Understanding with Government of India, indicating their commitment to increase contribution to Public Health Budget (preferably by 10% each year), increased

devolution to Panchayati Raj Institutions as per 73rd Constitution (Amendment) Act, and performance benchmarks for release of funds.

9. Focus on the North Eastern States

- All 8 North East States, including Assam, Arunachal Pradesh, Manipur, Meghalaya, Mizoram, Nagaland, Sikkim and Tripura, are among the States selected under the Mission, for special focus.

- Empowerment to the Mission would mean greater flexibilities for the 10% committed Outlay of the Ministry of Health & Family Welfare, for North East States.

- States shall be supported for creation/upgradation of health infrastructure, increased mobility, contractual engagement, and technical support under the Mission.

- Regional Resource Centre is being supported under NRHM for the North Eastern States.

- Funding would be available to address local health issues in a comprehensive manner, through State specific schemes and initiatives.

10. Role of Panchayati Raj Institutions

The Mission envisages the following roles for PRIs:

- States to indicate in their MoUs the commitment for devolution of funds, functionaries and programmes for health, to PRIs.

- The District Health Mission to be led by the Zila Parishad. The DHM will control, guide and manage all public health institutions in the district, Sub-centres, PHCs and CHCs.

- ASHAs would be selected by and be accountable to the Village Panchayat.

- The Village Health Committee of the Panchayat would prepare the Village Health Plan, and promote intersectoral integration

- Each sub-centre will have an Untied Fund for local action @ Rs. 10,000 per annum. This Fund will be deposited in a joint Bank

Account of the ANM & Sarpanch and operated by the ANM, in consultation with the Village Health Committee.

- PRI involvement in Rogi Kalyan Samitis for good hospital management.

- Provision of training to members of PRIs.
- Making available health related databases to all stakeholders, including Panchayats at all levels.

11. Role of Ngos in the Mission

- Included in institutional arrangement at National, State and District levels, including Standing Mentoring Group for ASHA

- Member of Task Groups

- Provision of Training, BCC and Technical Support for ASHAs/DHM

- Health Resource Organizations

- Service delivery for identified population groups on select themes

- For monitoring, evaluation and social audit

12. Mainstreaming Ayush

- The Mission seeks to revitalize local health traditions and mainstream AYUSH infrastructure, including manpower, and drugs, to strengthen the public health system at all levels.

- AYUSH medications shall be included in the Drug Kit provided at village levels to ASHA.

- The additional supply of generic drugs for common ailments at Subcentre/PHC/CHC levels under the Mission shall also include AYUSH formulations.

- At the CHC level, two rooms shall be provided for AYUSH practitioner and pharmacist under the Indian Public Health System (IPHS) model.

- Single doctor PHCs shall be upgraded to two doctor PHCs by mainstreaming AYUSH practitioner at that level.

13. Funding Arrangements

- The Mission is conceived as an umbrella programme subsuming the existing programmes of health and family welfare, including the RCHII, National Disease Control Programmes for Malaria, TB, Kala Azar, Filaria, Blindness & Iodine Deficiency and Integrated Disease Surveillance Programme.

- The Budget Head For NRHM shall be created in B.E. 2006-07 at National and State levels. Initially, the vertical health and family welfare programmes shall retain their Sub-Budget Head under the NRHM.

- The Outlay of the NRHM for 2005-06 is in the range of Rs.6700 crores.

- The Mission envisages an additionality of 30% over existing Annual Budgetary Outlays, every year, to fulfill the mandate of the National Common Minimum Programme to raise the Outlays for Public Health from 0.9% of GDP to 2-3% of GDP

- The Outlay for NRHM shall accordingly be determined in the Annual Budgetary exercise.

- The States are expected to raise their contributions to Public Health Budget by minimum 10% p.a. to support the Mission activities.

- Funds shall be released to States through SCOVA, largely in the form of Financial Envelopes, with weightage to 18 high focus States.

14. Timelines (for Major Components)

- Merger of Multiple Societies June 2005
- Constitution of District/State Mission
- Provision of additional generic drugs at SC/PHC/CHC level December 2005
- Operational Programme Management Units 2005-2006

- Preparation of Village Health Plans 2006
- ASHA at village level (with Drug Kit) 2005-2008

- Upgrading of Rural Hospitals 2005-2007
- Operationalizing District Planning 2005-2007
- Mobile Medical Unit at district level 2005-08

15. Outcomes

(a) National Level:

- Infant Mortality Rate reduced to 30/1000 live births
- Maternal Mortality Ratio reduced to 100/100,000
- Total Fertility Rate reduced to 2.1
- Malaria mortality reduction rate –50% upto 2010, additional 10% by 2012
- Kala Azar mortality reduction rate: 100% by 2010 and sustaining elimination until 2012
- Filaria/Microfilaria reduction rate: 70% by 2010, 80% by 2012 and elimination by 2015
- Dengue mortality reduction rate: 50% by 2010 and sustaining at that level until 2012
- Japanese Encephalitis mortality reduction rate: 50% by 2010 and sustaining at that level until 2012
- Cataract Operation: increasing to 46 lakhs per year until 2012.
- Leprosy prevalence rate: reduce from 1.8/10,000 in 2005 to less than 1/10,000 thereafter
- Tuberculosis DOTS services: Maintain 85% cure rate through entire Mission period.
- Upgrading Community Health Centers to Indian Public Health Standards
- Increase utilization of First Referral Units from less than 20% to 75%

- Engaging 250,000 female Accredited Social Health Activists (ASHAs) in 10 States.

(b) Community Level:

- Availability of trained community level worker at village level, with a drug kit for generic ailments

- Health Day at Anganwadi level on a fixed day/month for provision of immunization, ante/post natal checkups and services related to mother & child healthcare, including nutrition.

- Availability of generic drugs for common ailments at Sub-centre and hospital level

- Good hospital care through assured availability of doctors, drugs and quality services at PHC/CHC level

- Improved access to Universal Immunization through induction of Auto Disabled Syringes, alternate vaccine delivery and improved mobilization services under the programme

- Improved facilities for institutional delivery through provision of referral, transport, escort and improved hospital care subsidized under the Janani Suraksha Yojana (JSY) for the Below Poverty Line families

- Availability of assured healthcare at reduced financial risk through pilots of Community Health Insurance under the Mission

- Provision of household toilets

- Improved Outreach services through mobile medical unit at districtlevel

16. Monitoring and Evaluation

- Health MIS to be developed upto CHC level, and web-enabled for citizen scrutiny

- Sub-centres to report on performance to Panchayats, Hospitals to Rogi Kalyan Samitis and District Health Mission to Zila Parishad

- The District Health Mission to monitor compliance to Citizen's Charter at CHC level

- Annual District Reports on People's Health (to be prepared by Govt/NGO collaboration)

- State and National Reports on People's Health to be tabled in Assemblies, Parliament
- External evaluation/social audit through professional bodies/NGOs

- Mid Course reviews and appropriate correction

Strengthening of Public Institutions for Health Delivery

Introduction

The Rural Health Care System forms an integral part of the National Health Care System. Provision of Primary Health Care is the foundation of the rural health care system. For developing vast public health infrastructure and human resources of the country, accelerating the socio-economic development and attaining improved quality of life, the Primary health care is accepted as one of the main instrument of action. Primary health care is the essential health care made universally available and accessible to individuals and acceptable to them through their full participation and at a cost the community and the country can afford.

Review of existing Public health Infrastructure:

The primary Health Care structure in the country has been established as per the following norms:

Centre	Population Norms	
	Plain areas	Hilly/Tribal areas
Sub-centre	5000	3000
Primary Health Centre	30,000	20,000
Community Health Centre	1, 20,000	80,000

Sub-Centre

Sub Centre is the first peripheral contact point between community and health care delivery system. A Sub Centre is Manned by one Female Health Worker (ANM) and one Male Health Worker (MPW). One Lady Health Visitor (LHV) for six sub-centres is provided for supervision at the PHC level. Department of Family Welfare is providing 100% central assistance to all the sub-centres in the country since April 2002 in the form of :

- Salary of ANMs and LHVs
- Rent@ Rs.3000 per annum
- Contingency @ Rs.3200 per annum
- Drugs and equipment kits.

Currently there are 142655 sub-centres in the country.

Primary Health Centre (PHC)

PHC is the first contact point between village community and the Medical Officer. Manned by a Medical Officer and 14 other staff, it acts as a referral unit for 6 Sub-Centres and has 4-6 beds for patients. It performs curative, preventive, promotive and family welfare services. These are established and maintained by the State Governments. Cur rently there are 23109 Primary Health Centres in the country.

Community Health Centres (CHCs)

CHCs are established and maintained by the State Governments. Manned by **four specialists** i.e. Surgeon, Physician, Gynaecologist and pediatrician and supported by 21 paramedical and other staff, a CHC has **30 indoor beds** with one OT, X ray facility, a labour room and laboratory facility. It serves as a referral centre for 4 PHCs. Currently there are 3222 Community Health Centres in the country.

Situational Analysis and Recommendations:

Adequacy of Coverage:

All public health services depend on the presence of adequate basic infrastructure. The Primary Health care services in rural areas in the country are provided through a network of health facilities. Although vast network of this infrastructure looks impressive, accessibility, availability of manpower and quality of services, and their utilization have been major issues in the Public health care delivery system. Adequacy of coverage is an important issue. The number of facilities is not adequate when we consider the current population. New centers need to be established in order to cover the entire population of the country.

These requirements have been estimated based on the population as per the 2001 census ignoring the excess in some of the States.

	Requirement (Numbers)	Existing (Numbers)	Shortfall (Numbers)
Sub Centre	158792	142655	21983
PHC	26022	23109	4436
CHC*	6491	3222	3332

Physical Infrastructure:

I. Strengthening of the Physical Infrastructure of the existing facilities:

(a) Buildings:

- Only 50% of the sub-centres, 84 % PHCs and 86% CHCs are in Government buildings. The rest are either in rented buildings or in rent free Panchayat / Voluntary society buildings. It has been observed that the quality of work suffers if the facility in rural areas is located in the rented building as the space is inadequate.
- Adequate residential facility for the essential staff at these centres is also a problem.
- Electricity, water supply system and telephone facilities, referral transport, furniture etc. are also not optimal.

Nearly 60,000 Subcentres, 1700 PHCs and 320 CHCs currently functioning in rented buildings need buildings of their own. Applying the above yard sticks, the cost of construction of the buildings for these existing Sub-Centres, PHCs,and CHCs will be approximately Rs.3000 crores , 612 crores and 320 crores respectively (a total of Rs.3932 crores).

(b) Repair and Maintenance:

Repair and maintenance of the centres having their own buildings and ensuring 24 hours water supply and electricity will require a lumpsum amount of approximately Rs.2333 crores.

Financial Implications for strengthening the existing Rural Health Care Infrastructure				
	Existing (Numbers)	Per Unit Fund proposed for strengthening a centre (under RCH-II) (in Rs.)	Untied Fund proposedunder NRHM(in Rs.)(Recurring)	Total Financial Implication for strengthening (figures in Rs. Crores)
Sub Centre	142655	50000	10000	855.93
PHC	23109	500000		1155.45
CHC	3222	1000000		322.20
Grand Total				**2333.58**

c) **New Facilities**: New centres need to be established in order to cover the entire population of the country as has been discussed before.

Financial Implications for establishing new centres:

The financial implications of setting up of a new Sub-centre along with the ANM's residence is approximately Rs.5 Lakhs (Floor area of 73.5 sq. meter @ 7000/sq.m). The recurring cost is about Rs.1.5 lakhs (Without the salary of the Male worker).The allocation for funds for Sub-Centres during 10th Plan is 9663 crores. Salary of Male Health Worker is borne by the State Government. Capital cost of one PHC is about Rs.36 lakhs and recurring cost of Rs.19 lakhs. Capital cost of one CHC is about Rs.1 Crore with a recurring cost of about 40 lakhs. (The estimated cost is only indicative.)

Capital Cost:

Health Facility	**Financial Implications for new centres**
Subcentre	Rs.1099.15 crore
Primary Health Centre	Rs.1596.96 crore
Community Health Centre	Rs.3332.00 crore

Recurring expenditure per annum

	Requirement (Numbers)	Existing (Numbers)	Shortfall (Numbers)	Per Unit Recurring Cost (in Rs.)	Total Recurring Cost per annum (in Rs. Crores)
Sub Centre	158792	142655	21983	150000	329.75
PHC	26022	23109	4436	1900000	842.84
CHC*	6491	3222	3332	4000000	1332.80
Grand Total					**2505.39**

Note:Recurring cost for a Sub Centre is without the salary of Health Worker Male

* The number of CHCs shown above has been calculated on the basis of existing population norm of 120000 for plain areas and 80000 for tribal and hilly areas. If a norm of one CHC per 100000 population is taken, the number of CHCs required will be 7417 and the shortfall is 4195.

(The funding for the construction of new PHCs and CHCs is the responsibility of the State Governments).

Thus a total capital cost of about Rs.12,000 crores will be required for establishing new Centres in order to improve the coverage as per 2001 census population and strengthening of the physical infrastructure of already existing Centres.

I. Manpower

At the Sub-Centre and PHC level, the vacancy position of ANMs is approximately 5 %. Taking in to consideration the new and the existing Sub-Centres and PHCs, there is a need of 1, 65,764 ANMs. Presently 1,38,906 are in position.

Nearly 50% of the existing Sub-centres do not have a Male Health Worker. This is because the State Governments do not sanction the post of the Male Health Worker as the State bears the cost of the salary of the Male Health Worker. There has been a demand that like ANM and LHV, the salary of the Male health worker also should be paid by the Government of India. The National Advisory Council (NAC) has recommended for funding of the 50% of male health workers. However, the states demand funding of salary of all the male health workers (100%). If, so the additional cost to Government of India will be Rs. 2000 Crores annually.

Recommendations:

Subcentre:

- The Government of India may consider funding of all the male health workers.
- Under NRHM, the ANM will have the support of the 4 -5 ASHA and the AWWs. Hence, instead of a male worker, flexibility may be given to the states to either opt for male health worker or additional ANMs.
- Strengthening of management and supervisory assistance at the CHC/FRU level is recommended as this is needed for efficient functioning of National Health Programmes and ASHA .

Primary Health Centre:

Although the numbers of doctors sanctioned are more than requirement, currently about 700 PHCs are without a doctor because of mal-distribution, improper transfer policy of the State Government, political interference, lack of basic amenities and incentives for working in rural/difficult areas. At the PHC level-ensuring availability of services of doctors in the PHCs especially in difficult areas is a major problem.

The Ministry of Health and Family Welfare is having a plan to make all the PHCs a "24 hour functioning PHCs" in a phased manner. In view of this there would be a need for 2 doctors at the PHCs (Guidelines for Operationalizing a 24 hours functioning PHC for service delivery is in final stage) The number of doctors required, therefore would be 52,044. Currently there are 21974 Doctors available at PHCs. With the existing number of Medical Colleges and the annual turnover of MBBS Doctors,

mainstreaming of AYUSH physicians, and with appropriate recruitment, posting and transfer policy, this requirement can be met.

(To improve availability of doctors at the PHC level, various options have been explored which have been discussed in a separate paper.)

Community Health Centre:

- At the CHC level non availability of specialists at these centres, lack of anesthetists, improper manpower and transfer policy, non-existence of a specialist cadre in many states, lack of basic amenities, quality control, lack of referral policy/ support, involvement of Private sectors and professional associations, contractual appointments etc are the major issues. Indoor facilities provided are not used to the desired level. There is a shortfall of 1074 O&G specialists, 1121 Surgeons, 1607 Pediatricians and 1457 Physicians even in the currently functioning CHCs. This requirement will increase if new centres are established as per the estimate. Service of anaesthetists is not available at present in CHCs, which seriously hamper the functioning of the surgical and OBG specialists. Provision of the services of Anesthetists is a daunting task. Various suggestions have been put forth for strengthening of CHCs which are discussed in a separate paper.

- To strengthen the management and supervision at the CHC level, it is recommended to have a Programme Manager with public health back ground, who can supervise and coordinate all Public Health activities including the National Health Programmes and ASHAs. A Public health Nurse (PHN), one Nurse-Midwife are also recommended for round the clock supportive services and supervision of ASHA.. Therefore, 6491 Programme Managers, 6491 PHN and 6491 Nurse will be required.

The major task is to make these centres fully functional and grade them as per set standards (Indian Public Health standards are being worked out and dealt with, in another paper).

III. Equipments, Drugs and other supplies:

A list of essential drugs, equipments and other supplies have been prepared. However, the states/ districts may be given the flexibility to have their own list of essential drugs. The list of the Ayurvedic drugs currently supplied through the Department of Family Welfare is given in another document. (Mainstreaming of AYUSH). The logistics aspect of these supplies needs consideration**.**

Recommendations:

- Currently the drugs and equipment kits are centrally procured and supplied. Decentralization of the procurement process and supplies should be given priority**.**
- Some of the States have established effective functional systems to take care of the logistic aspects such as Tamilnadu Medical supplies Corporation. These may be adopted by the states after appropriate modifications to suit their needs.
- Procurement process and supplies will be decided in consultation with the State Governments. The District Rural Health Mission should be given the choice of taking a decision on this.
- A flexi-fund of Rs.10 lakhs per annum for meeting the cost of drugs and other supplies during epidemics/ natural disasters may be provided at the district level.

IV. Training

NRHM envisages an accountable system for delivery of quality services. For quality services, the skill of the health personnel needs to be improved. The attitudinal changes in the health personnel to be responsive to the health needs of the community will require orientation of health personnel. In this context, the induction training, in-service skill development training, and management training of the health personnel are being planned in RCH-Phase-II. The training load of various categories for personnel is as follows:

I. Training of ASHA – Minimum 2.5 Lakhs

Orientation and Skill Development Training for ANMs -158792

II. Orientation and Skill Development Training for Male Health Worker–158792 (in case states opt for additional ANMs then the number will change)
III. Orientation and Skill Development Training for LHVs / Female Health Supervisor – 26022
IV. Orientation and Skill Development Training for Health Assistant (Male) – 26022
V. Orientation and Skill Development Training for Medical Officers at PHCs – 52044 (for the proposed two doctor PHCs) to make them 24 hours functional.

Recommendations:

- Currently the admission capacity in the existing ANM training schools is about 13000 every year. Every year about 7000 ANMs

come out of the training schools (the training course being for a duration of 1 and half years). There are 336 ANM Training Schools with an admission capacity of approximately 13000 and 42 promotional Schools.

- To meet the requirement of about 22000 more ANMs for the proposed new Sub Centres, it may be considered to open new ANM Training Schools particularly in the underserved areas.

Other Recommendations:

- Public Health should receive greater attention. In order to achieve this, a separate Public Health Cadre is being recommended.
- Primary Health care, which is currently being funded predominantly by the State government (85%) should be funded fully by the Central Government after ensuring that the funds are utilized by the States for the purpose intended.
- Support facilities like transport, electricity, telephone, potable water, etc. will have to be ensured in all the centres if utilization is to be improved. Computerisation should be encouraged in CHCs.
- Intersectoral coordination at all levels is to be strengthened like water supply and sanitation, nutrition and other health determinants.

Draft Policy for Public Private Partnerships in the Health Sector

Contents

Abbreviations

AP	Andhra Pradesh
BOO	Build Own Operate
BOOT	Build Own Operate Transfer
BOT	Build Own Transfer
BPHC	Block Primary Health Center
CII	Confederation of Indian Industries
DoHFW	Department of Health and Family Welfare
GDP	Gross Domestic Product
GoWB	Government of West Bengal
MRI	Magnetic Resonance Imaging
NGO	Non Government Oreganisation
PHC	Primary Health Centre
PPP	Public Private Partnerships
SOP	Standard Operating Procedures
SPV	Special Purpose Vehicle
UP	Uttar Pradesh

Draft Policy for Public Private Partnerships in the Health Sector

Government of West Bengal (GoWB) ins committed to the concept that health of the people is safest in the hands of community itself. With this policy commitment and in the background of severe resource constraints of public sector health systems and simultaneous growth of private sector coupled with very low coverage of health insurance and almost no-existent social health insurance systems, the Department of Health and Family Welfare (DoHFW), GoWB have been encouraging establishment of public private partnerships during last three years. This would involve collaboration with not only private sector but also with NGOs/ CBOs and other interested persons of civil society.

The National Health Policy 2002 also states that "In principle, this Policy welcomes the participation of the private sector in all areas of health activities – primary, secondary or tertiary".

This Public Private Partnership Policy document outlines various ways in which the diverse segments of the private sector can be engaged with the government for achievement of desired health outcomes.

A. Background

Trends of the last 10-11 years' demonstrate decline in government spending in the health sector in terms of percentage of the total budget allocations as well as a percentage of the GDP. The public health investment in the country over the years has been comparatively low and as a percentage of GDP has declined from 1.3 percent in 1990 to 0.9 percent in 1999 among the lowest in the world. In contrast India records a high private health spending, which is amongst the highest in the world. Between 75-90 percent of public health spending is made by India's states.

The bulk of public spending on primary health care is thinly spread and thus not fully effective. Referral linkages to secondary care are deficient. State governments do not have the necessary funds to invest in infrastructure development of secondary or tertiary level hospitals. Even if states have made investments in health infrastructure through externally aided projects, such improved facilities also tend to run down rapidly in the absence of adequately funded maintenance systems and problems relating to management systems.

Public awareness of and expectations from health services provided by the government are rising rapidly making the management of public health

systems and programmes more challenging that it was earlier. The private sector is expanding but issues like quality assurance and pricing mechanisms are yet to be adequately addressed.

There is now substantial evidence that despite massive investment by the state governments on health care the users of services are still spending huge amount either directly or indirectly to avail the services. A study on the basis of National Sample Survey (NSS – 52nd Round) Data showed that estimated private per capita spending on health services at private and public facilities in West Bengal was Rs. 90/- in 1995-1996, which was slightly lower than that of the national average of Rs. 30/-. The same study also revealed that about 80% of out of pocket expenditure went to private facilities.

The private sector accounts for most ambulatory curative care services in India, and this is true in the case of West Bengal as well. Although the poor still largely depend on the public sector for the majority of their hospital care needs, the private sector provides a bulk of outpatient care for those below the poverty line, much of which is of low quality and provided by the untrained practitioners.

The National Health Policy 2002 states "since 1983 the country has been seeing increase in mortality through 'life-style' diseases – diabetes, cancer and cardiovascular diseases. The increase in the expectancy has increased the requirement for geriatric care. Similarly, the increasing burden of trauma cases is also a significant public health problem". There are little or no sources with the government to invest in facilities to take care of the increasing burden of these emerging diseases. It is estimated that in the next ten years the cost of caring diabetic patients alone would be crippling for health sector financing.

State governments would be hard pressed to maintain allocations/spending on healthcare while dealing with increasing pressure to enhance public investment in this sector. Most multi/bi-lateral donor organizations do not wish to invest in tertiary medical care services provided by the Government of India.

In the next 10 years it is envisaged that average spending on health care delivery will almost double – from Rs. 86,000 crore in 2000-2001 to over Rs. 200,000 crore in real terms by 2012. Largest component of health care spending is from the private sector and by 2012 it is expected to rise from the current level of Rs. 69,000 crore to Rs. 156,000 crore. In addition public spending could double from current Rs. 17,000 crore if the government reaches its target spending level of 2% of GD, up from 0.9%

today. [Data source *Healthcare in India* : *The Road Ahead*, A Report by CII – Mckinsey & Company]

India has 1.5 beds per 1000 people, while middle income countries such as China, Brazil, Thailand and Korea have an average of 4.3 beds. As compared to middle and high-income countries where registered physicians are 1.8 per 1000 people, in India we have 1.2 (of which only 0.5 are registered allopath). This necessitates significant improvement of infrastructure. Across the country approximately 750,000 additional beds will need to be added to the exiting base of 1.5 million beds. Additional 520,000 physicians will be required over and above the numbers that will be added through existing medical colleges, to reach a ration of one allopathic practitioner per 1000 people. It is estimated that creating this capacity will require Rs. 100,000 crore to Rs. 140,000 crore of investment over the next 10 years. After factoring in the expected capital investment by government and multilateral agencies during this period, it is estimated that almost 80% of this amount will need to come from the private sector. [Data source: *Healthcare in India: The Road Ahead.* A Report by CII – Mckinsey & Company]

In this background the role and importance of other stakeholders in health sector, apart from Government can be easily appreciated.

Public-Private partnerships in health sector can supplement the government's efforts in several ways enumerated below:

- By ensuring access to services in regions or for groups that the government cannot adequately cover
- Increased number of people receiving health service
- Conservation of scarce public resources and their targeting for the poor
- Source of revenue for the private and public sector partners
- Ensuring regular supply of medicines, etc.
- Improved infrastructure and facilities
- Easing the pressure on the public sector

B. Scope of Public-Private Partnerships in West Bengal

The Government has a very open mind in so far as selection of partners and design of partnerships are concerned. However, the information given below in this paragraph will give some idea about the range and scope of such collaborations.

B1. Public-Private Partnerships already in place

a. Diagnostics
   i. CT Scan established in 7 medical college hospitals.
   ii. MRI installed in one medical college hospital.
   iii. Agreements signed for diagnostic facilities in 19 Rural Hospitals for X-ray, USG and selected pathological examinations.

b. NGO Partnerships in AIDS Prevention & Control Programme undertaken by West Bengal State AIDS Prevention & Control Society.
   i. Partnership with NGOs for implementation of 43 Targeted Interventions for highly vulnerable groups such as Female Sex Workers, Males having sex with Males, Injecting Drug Users and Bridge Population Groups such as truckers, migrant labours, street uncovered zones of service delivery.
   ii. Partnerships with NGOs for running 23 voluntary and Confidential Counseling and Testing Centres.
   iii. Partnerships with NGOs and CBOs for running 10 different centres in various hospitals under the prevention of parent to child transmission Project.
   iv. Partnerships with 3 NGOs for providing care and support services for people living with HIV/AIDS.

B2 Public-Private Partnerships Proposals under Examination

a. Establishment of a private medical college
b. Establishment of a dental college
c. Dialysis units in tertiary level hospitals
d. Three mechanized laundry units for hospitals in Kolkata
e. Establishment of a chamber hospital
f. Sale of fair priced quality drugs, contraceptives, consumables, etc. through socially franchised private shops to be set up in BPHCs/Rural Hospitals. For cost effective procurement and managing supply chain, a special purpose vehicle in form of a Joint Venture Company is proposed to be set up.
g. Outsourcing the management of selected non functioning primary health centres.
h. Emergency transport network: Management of vehicles for emergency transport in BPHCs and PHCs through NGOs/CBOs/Trusts, etc.

B3 Public-Private Partnership initiatives envisaged under Reproductive and Child Health Programme II

i. The current social marketing scheme as envisioned by GOI is to be expanded and diversified and new social franchising initiatives will be developed.
ii. Current contracting in approaches of both Health and Non-health professionals will be developed and expanded.
iii. Current contracting out approaches (for clinical services, non clinical services and BCC management and ancillary functions) will further be developed and expanded.

C. The New Paradigm

In recent years there has been a paradigm shift in the policy planning of the department and in view of this the following issues that have been adopted as a policy by the department shall guide the overall approach in priority of development of PPP.

1. To achieve the ambitious targets set by the DHFW there is a need to introduce courageous and quite radical reforms, which represent a challenging agenda of re-orientation of the public sector. It has been recognized that government has a stewardship role to play in order to ensure both the public and the private health systems operate and interact in such a way that all parts of society and particularly the most vulnerable parts have access to affordable good-quality essential services.
2. Under the new strategy, the GoWB has decided to replicate and scale up successful service delivery experiences such as those initiated during the IPP-VIII project in the poor areas of Kolkata, characterized by community participation and ownership, flexible delivery systems, and focus on results (outputs and outcomes).
3. It has been decided that it is important to distinguish more clearly between problems which have efficacious interventions exclusively as part of ambulatory care service – such as the life-threatening illnesses and communicable diseases and those which do not, such as reducing maternal and neonatal mortality. The former can be addressed exclusively by actions to affect services at or near community level. The latter typically also require higher-level services, usually beyond those that can be adequately financed or provided at the primary health center level.
4. To improve post neonatal and child mortality indicators, control communicable diseases, and prevent non-communicable diseases, the focus shall be on ambulatory care, nutrition, and on diseases prevention and health promotion activities. The targets shall include interventions which will: increase coverage of immunization; prevent those diseases for which there are already good preventive interventions; recognize at an early stage and promptly and effectively treat life threatening illnesses (especially ARI, diarrhea and malaria); and improve child feeding practices to prevent malnutrition; improve child nutrition; and increase age marriage. How to do this at a time of severe fiscal constraints is the challenge that can be partly met by involving private partners in service delivery, community outreach and social mobilization.

5. For maternal and neonatal mortality reduction, improved antenatal care, increased coverage supervised deliveries, and improved postnatal care are essential. First referral units need to play a critical role by providing 24-hour access to emergency obstetric care services.
6. The challenge shall be attempted to be addressed from several points of view; in secondary care, further improving performance of public facilities, and making a better use of the growing capacity of private facilities, in primary care, strengthening the coverage/quality of public providers (mainly ANMs and PHC staff, but also including nutritional programs such as ICDS), engaging formal and informal non-government providers (which account for more than 80 percent of first-contact services), experimenting innovative delivery systems characterized by outreach activities, team-work, greater community participation and new accountability mechanisms based on resutlts.
7. The Government appreciates and realizes the fact that attainment of many of the goals adopted by the DoHFW cannot be done without involvement of the private sector and that shall certainly lead to improved health services, building on the experience being accumulated in the national TB and other programs (such as IPP-VIII), and on the other initiatives more recently initiated by the Department.
8. The market share of the private sector in both and urban areas and for both inpatients and even more outpatients is large and increasing. For ambulatory care, the first healthcare provider consulted, especially by the poor, is most frequently a Rural Medical Practitioner / traditional healers / quacks, etc. Qualified private providers are also important, especially for those with higher incomes but also for the poor in some more developed areas. In some locations and for specific services NGOs are the most important providers.
9. However, quality of treatment and care in the private sector and process of over-medicalization of treatment are serious issues, which shall be addressed by the Government, particularly quality of care provided by not-fully qualified providers. There care several types of not-fully qualified providers, including practitioners of traditional forms of medicine who also administer allopathic treatment, faith healers, assistant pharmacists and drug sellers, etc. The anecdotal evidence available suggests that informal providers continue to practice irrational medicine, and can endanger their patients health by unnecessary and often unsanitary treatments, such as harmful injections, and over-prescription or under-prescription of antibiotics. For qualified providers, anecdotal evidence indicates

that; a) their services are too costly and not accessible to be well beyond poor people's ability to pay; b) they tend to over-prescribe and provide unnecessary treatment, particularly to better-off patients (supply-induced demand)

10. The private sector has enormous unexploited potential to help deliver information and services that would address the priority health goals, but in order to exploit such potential a completely new approach of engagement shall be adopted by the Government.

11. Some priority areas for PPP have already been identified which are either under implementation of examination. These have already been indicated in Section C under the heading ''Scope of PPP''. However, the list given there is only illustrative and not exhaustive.

12. Another area where the private sector could play a potentially important role is in improving maternal health; both by providing antenatal and postnatal care services, as well by contributing to step up coverage of emergency obstetric care services. For the latter, Secondary care facilities both in the public and private sector shall play a critical role.

13. Although it is common to see the provision of supervised deliveries as the responsibility of the state, this need not be the case. West Bengal shall look at all the options for supervised delivery including deliveries performed in private sector.

14. Finally, for other secondary care and tertiary services, whose impact on priority health outcomes is more limited, a much increased emphasis on private sector investment in hospitals will be given to help the Government to create fiscal space for reallocation of funds to activities in support essential services. This will also help create bed space for the poor in public hospitals. It shall be ensured that agreements between government and private sector in tertiary care result in net savings for government, and not additional expenditure, so that more resources can be devoted to essential public health and primary care services.

15. A gradual and planned increase in involvement of the private sector in provision of hospital beds by setting up more private nursing homers and hospitals, together with greater autonomy and strengthening of the current system of user fees at public hospitals shall be attempted. In order to achieve the above, the GoWB shall develop an institutional framework for enhancing the quality of care in the private sector, which would include licensing, an accreditation system, and a continuous programme of quality monitoring and evaluation. The may require setting up of an Independent Board / Authority in place in due course.

D. Some Partnership Models

The Department of Health and family Welfare (DoHFW), GoWB would adopt measures to translate the policy framework into operational strategies. It has been the international experience that following types of public private partnership models can be established for different areas, objectives and situations. DoHFW, GoWB would also adopt suitable models on case to case basis.

Model 1: Build, Operate and Transfer

Build, Operate and Transfer Model is usually preferred for projects involving large size and long duration lease (usually 25 to 30 years). In this option the private sector will bring in the required capital investment, build and operate the facility as per the specified outputs of DoHFW, GoWB. At the end of the lease period, the facility will be handed over to the DoHFW, GoWB.

Salient Features :

a. Contractor (usually a consortium of private partners) provides a running facility.
b. DoHFW, GoWB will specify clear outputs
c. Payments by DoHFW, GoWB will be linked to and will be proportionate to achievement of outputs tye the private sector parter
d. Balance of risk will get transferred to the private partner – optimal risk sharing
e. Usually of a long term duration (25 – 30 years)
f. Needs good and efficient monitoring system, which is not easy to setup.
g. Control over the facility will be retained by the DoHFW, GoWB.
h. A Special Purpose Vehicle (SPV) will be created by the private sector partner for implementation of the particular project. The SPV could be a separate company or a legal entity, which comes into existence exclusively for the purpose of that particular initiative and the life of such entity will be co-terminus with the life of the project under consideration.

Critical Success Factors	Features ‘c’, ‘d’ and ‘g’
Advantages	Features ‘c’, ‘d’ and ‘g’
Limitations	Features ‘e’ and ‘f’

Model 2 Joint Venture Company

Joint Venture, as a model for private sector participation, entails both the DoHFW, GoWB and the private sector partner bringing in equity capital, which need not necessary be in monetary terms for the DoHFW, GoWB. DoHFW, GoWB will enjoy a proportionate share in the equity in the company for the opportunity, space, market, authorization, goodwill, etc. that it will provide to the private sector for operating a particular service or a set of services.

Salient Features:

a. Both DoHFW, GoWB and private sector partner will bring in some value, which is tangible in nature and could be quantified for determining allocation of percentage shares in the company.

b. Risks will be shared by both the partners, but here the stake as compared to Model1 is limited because there is no long term commitment as in the BOT (Model 1).

c. Returns, in form of cash or services/ goods (non cash), are shared between both the partners proportionate to the equity allocation

d. Simple to set up

e. Government's involvement in the governing board slows down the progress

f. Usually it is difficult to monitor "benefits in kind"

g. Government may not have expertise in the relevant area

Critical Success Factors	Clarity of roles of the partners Good monitoring system Clearly laid out exit policy
Advantages	Features 'a'
Limitations	Features 'f' and 'g'

Model 3 Buying a Product/ Service

Buying of a product or service will be usually preferred by the DoHFW, GoWB to meet gaps/ demands in services for a short period of time. This option might not always be a cost effective solution and therefore will be a short-term solution to the need. Usually products purchased are in form of specialized services, like conduction of lithotripsy, dialysis etc.

Salient Features :

a. Simplest of all forms

b. Outputs are easy to measure

c. Prices are determined in advance
d. Better clarity of transactions
e. Easy to control
f. No long term commitment
g. No long term risk involved
h. Low risk for both the partners

Critical Success Factors	Clear definition of outputs Good contracting experience with legal know how
Advantages	No legal entity required to deliver Can help in managing short term sudden increase in demand of a particular service
Limitations	Could in certain circumstances be costly

Model 4 Outsourcing

Outsourcing, as a model, is similar to "Buying a Product" except that unlike the later the former covers the entire service package for a particular area, like the complete diagnostic set up could be outsourced by the DoHFW, GoWB to a private partner to provide all diagnostic tests that the DoHFW, GoWB wants.

a. Simplest of all forms
b. Outputs are easy to measure
c. Prices are determined in advance
d. Better clarity of transactions
e. Easy to control
f. Commitment depends on the type and length of the contract
g. No long term risk involved
h. Low risk for both the partners

Critical Success Factors	Clear definition of outputs Good contracting experience with legal know how
Advantages	No legal entity required to deliver Can help in managing short term sudden increase in demand of a particular service
Limitations	

Model 5 Social Marketing and Franchising

The DoHFW, GoWB will work closely with the private sector/ NGOs to use their extensive marketing and distribution capability to promote social services/ products to meet community needs through a combination of social marketing and social franchising approaches.

Salient Features :

a. Inbuilt strategies for financial sustainability
b. Improved access to health care
c. Increased efficiency, coverage and utilization of services
d. Standardized quality and uniformity of delivery
e. Objectives and performance criteria are carefully defined and monitored
f. Effective decentralized implementation systems are institutionalized
g. Encourages healthy competition in delivery of services
h. Standard Operation Procedures (SOP) are put in place and implementation team is well trained on the SOP.

Critical Success Factors	Features 'a', 'e', 'f' and 'h'
Advantages	Features 'b', 'c', 'd', 'g'
Challenges	Setting up of effective service delivery management systems and procedures. Setting up mechanisms of total quality management and continuous quality improvement

Model 6 Working with Civil Society

The Government is committed to the concept that health of the community is safest in the hands of the community. The Government's role is to empower the communities and work with them for service delivery in some identified areas.

Salient Features :

a. Clear identification and documentation of areas/ schemes where Civil Society could be involved
b. Schemes to be easily available and accessible
c. Clear guidelines for pre-grant appraisal to be developed and guidelines to form a part of the scheme

d. Strategies to be developed for institutional strengthening of NGOs including developing governance and management systems

The Department of Health and Family selfare, GoWB will invite NGOs to partner in the following areas :

i. Behavioural change communication initiatives focusing on improved household practices especially child bearing and rearing, small family norm, increasing age at marriage of girls, improving health seeking behaviour, promoting higher utilization of government healthcare facilities.

ii. Advocacy support initiatives aimed at promoting partnerships with the community and community based organizations such as self help groups, youth clubs, mahila mandals, village panchayats, village health committees etc.

iii. Responsibility for provision of specific support services such as emergency transportation, sanitation and maintenance of public hospitals as well as the running of diagnostic facilities.

iv. NGOs would also be considered for taking responsibility of managing operations of selected PHCs and Sub Centres with the involvement of local doctor/ nurses.

v. NGOs would be invited to set-up and operate medical and para-medical educational institutions in the State.

Some illustrations of the areas in which PPPs can be implemented are:

- Outsourcing no-clinical (cleaning, catering, building maintenance including asset management) support services
- Buying in/ outsourcing clinical support services (such as diagnostic services)
- Buying in/ outsourcing specialized clinical services (such as dialysis) or routine procedures
- Private management of a public hospital
- Private financing, construction and leaseback of a new public hospital (BOO)
- Private financing, construction and operation of a new public hospital (BOOT)
- Authorizing patients from the OPD of a government hospital to a private facility at a fixed predetermined price.

E Specific Areas for PPP in West Bengal

Within the overall framework of different models indicated in Section E above the following specific areas can be considered both by the Government as well as private partners for PPPs.

i. **Tertiary & Secondary Level**

E.1.1 Outsourcing support services such as diagnostic and pharmacy services in government hospitals of West Bengal to specialized private partners meeting prescribed quality standards.

E.1.2 Government hospitals in West Bengal partnering with private hospitals for provision of specialized medical services to patients referred by the government hospitals.

E.1.3 PPPs to upgrade/ establish and operate specialized treatment services/ wards and facilities (including diagnostic services) within government hospitals in West Bengal on profit sharing basis.

E.1.4 GoWB may invest in land and building of a new or an existing hospital. For example, the private partners could bring in the equipment be given executive management roles with Department of Health and Family Welfare, Government of West Bengal participating in the governing board. In this case the partnership can be in the form of a joint venture or a management consortium with voting rights of both partners protected.

E.1.5 The DoHFW, GoWB may hand over the management of an existing public hospital to a well-established private partner under a partnership agreement with the responsibility of investing in the hospital for its up-gradation/ expansion and management.

E.1.6 The DoHFW, GoWB would invite private partners to invest in setting-up and operating fair price pharmacies in government hospitals.

E.1.7 Operational management of catering, laundry, sanitation/ cleaning and waste management, gardening, security, parking are some of the support services that would be priority areas for PPP.

E.1.8 Partnerships for using the larger government hospitals for GoI approved medical research including drug trials will be explored on revenue generating basis.

E.1.9 Shelter and sheds for the attendants of the patients and other civic amenities like public toilets.

E.1.10 Medical Waste disposal systems

E2 Primary Healthcare Level

E2.1 The Department of Health, GoWB may handover management of health sub centres, Primary Health Centres, BPHCs/Rural hospitals to private/NGO partners under lease agreements (with or without government staff).

E2.2 The Department of Health, GoWB would partner with private players to set up and operate a network of diagnostic centres in the State covering their PHCs/Rural hospitals with appropriate range of diagnostic services on a fee for service basis and profit sharing agreements.

E2.3 The DoHFW, GoWB would invite private partners to provide emergency transportation and trauma care services.

E2.4 Private pharmaceutical manufacturers/distributors could partner with the Department of Health, GoWB to set up & operate a network of fair price pharmacies for genetic drugs (essential drugs lists) operated from within/outside the government hospital facilities.

E2.5 Private distribution and rural marketing companies could partner with the DoHFW, GoWB to market contraceptives and maternal and child health related drugs and supplies at agreed prices.

This is to again clarify that the above mentioned examples are only illustrative and a lot of other innovative schemes and approaches can be implemented.

F Guiding Principles

1. The PPP model will only be used where it is appropriate and where it can deliver value for money. Enhanced competition, innovation, optimal risk transfer, the use of whole life costing, improved asset maintenance are some of the expected benefits of the PPP approach. But these potential benefits shall not be taken for granted and must be demonstrated on the basis of evisence in each case. A robust and transparent process for assessing the value for moneyof each project would therefore be essentially adopted.
2. The PPP approach will be used where the private sector can offer innovative design, management skills and expertise, which can facilitate risk reduction and can bring substantial benefits.
3. The PPP model will not be used where the transaction costs of pursuing PPP are disproportionately high as compared to the overall value of the project.

4. Under the PPP model, private partners will enter into long-term partnerships and take responsibility for the quality of service they provide through the particular project. To ensure the success of a project, optimal share of risk between the Department of Health and Family Welfare, Government of West Bengal and private sector would be promoted, with each partner retaining the risk, which they are best placed to manage.

5. The success of PPP arrangements shall depend in large measure on the sustained participation of the Department of Health and Family Welfare, Government of West Bengal and the private partners in real partnerships to deliver quality health services to the people.

6. Innovative cost recovery and financially self-sustaining strategies will receive preference in all areas of PPP.

7. Pro poor strategies to ensure and equitable access to health services will be given preference.

8. Approaches suggesting innovative strategies entailing no additional financial burden on DoHFW, GoWB will be given preference.

9. The Department will generally frame the models/schemes for different areas of PPP and publish them as government policy documents as and when they are ready. Usually the partners will be selected through the process of press tendering.

10. The processing of the individual proposals which is very special in nature shall be started only with the approval of the Minister-in-Charge of the Department.

11. No proposal for allotment of land or assistance in giving land for establishment of any hospital or other health facility shall be processed by the Public Private Partnerships Branch of the Department, except the cases where the land belongs to the Department of Health and Family Welfare.