Public-Private Partnership, Contracting Arrangements and Managerial Capacity to Strengthen RCH Programme Implementation

Lessons and Implications from Interventions in India

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Abstract

Strengthening management capacity and meeting the need for Reproductive and Child Health (RCH) services is a major challenge for the national RCH programme in India. Central and state governments are working through multiple options to meet this challenge, responding to the complexity of issues in RCH which cut across social, cultural and economic factors, as well as reflecting the immense geographical barriers to access for remote and rural populations. Other barriers are also being addressed, including lessening financial burdens and creating Public - Private Partnerships (PPP) to expand access. For example, the NRHM has been initiated with particular focus on rural population. However, there are a number constraints faced by departments of health in implementing these initiatives. In this paper we focus on one key area: the development of management capacity for working with the private sector. A synthesis of the learning from three case studies of public-private partnerships in the RCH area is discussed. Two case studies pertain to state level initiatives in Gujarat and Andhra Pradesh and third study focuses on the national level mother NGO scheme. The objective of these case studies was to investigate how management capacity was developed through the implementation of these three public-private partnerships initiatives and contracting out of RCH services. The case studies also focused on the partnership in service delivery setting by examining the structure and process of partnership experiences, understanding the management capacity and competency in make-up of various public-private partnership initiatives in RCH, and identify pathways towards developing management capacity of partners to address key challenges in implementation.

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List of Abbreviations

ANM	Auxiliary Nurse Midwife
APUSHCP	Andhra Pradesh Urban Slum Health Care Project
ARC	Apex Resource Cell
ARH	Adolescent Reproductive Health
BPL	Below Poverty Line
CBO	Community Based Organisation
CHC	Community Health Centre
CO	Community Organisers
DDO	District Development Officer
DEMO	District Extension Media Officer
DMHO	District Medical and Health Officer
DPC	District Project Coordinator
EOC	Emergency Obstetric Care
EDD	Expected Date of Delivery
FHW	Female Health Worker
FNGO	Field NGO
FRU	First Referral Unit
GOI	Government of India
ICPD	International Conference on Population and Development
IEC	Information, Education and Communication
IIMA	Indian Institute of Management, Ahmedabad
IMR	Infant Mortality Rate
IPP	Indian Population Programme
LHV	Lady Health Visitor
MAS	Mahila Aarogya Sanghams
MTP	Medical Termination of Pregnancy
MMR	Maternal Mortality Ratio
MNGO	Mother NGO
MOHFW	Ministry of Health and Family Welfare
MOU	Memorandum of Understanding
NGO	Non Government Organisation
NRHM	National Rural Health Mission
PHC	Primary Health Centre
PHE	Public Health Expenditure
PPP	Public Private Partnership
PRI	Panchayati Raj Institution
RCH	Reproductive and Child Health
RSH	Reproductive and Sexual Health
RRC	Regional Resource Centre
SCOVA	Standing Committee of Voluntary Agencies
SEWA	Self Employed Women's Association
SHG	Self Help Group
SNGO	Service NGO
STD	Sexually Transmitted Disease
TB	Tuberculosis
TFR	Total Fertility Rate
UHC	Urban Health Centre
WHO	World Health Organisation

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Lessons and Implications from Interventions in India

1 Introduction

The health system in India faces the daunting task of meeting numerous health challenges of a growing population. The public health sector has grown in size and scope to address this challenge. However, the increased managerial and financial complexities in health care systems pose problems in effectively meeting these challenges. In part these complexities are the result of shrinking budgetary support and fiscal constraints in the public sector, that lead to gaps in service delivery (particularly at the periphery). The ability of managers in the health system is also severely taxed by the rapidly changing environment, including an unrelenting need for increased coordination. One result has been a fundamental shift towards multiple health systems providing services to the public.

The Indian public health systems' huge infrastructure is not currently used to its full potential in part because of inadequate managerial capacity. In response, over the past several years the private sector has also grown and has gained considerable experience in addressing the needs of clients effectively. Notably today a majority of the out-patient, primary care services is not provided by the public sector but instead take place within private clinics and health centres in both rural and urban India[1]. The public sector is responding and contemporary health system policy emphasizes Public-Private Partnerships (PPP) as an important mechanism for both gaining from the experience of private sector managerial efficiencies and ensuring coordinated achievement of public health goals. The effective partnerships of two systems of providers through contracting out of services have the potential to compliment each others strength to promote accountability, improve performance of the system and achieve MDGs. PPP are also considered to be an important mechanism of tackling complexities of health delivery system where community participation and ownership are critical to success of the programme. Worldwide experience indicates that effective PPP lead to innovative service delivery strategies and positive consequences for national public health programmes. PPP can be effective mechanisms to address many of the complexities of the Indian health care delivery system by leveraging the ideas, resources, expertise of different partners and more so by ensuring community ownership of programme. Because of the tremendous interest and support for PPP there is a pressing need to understand how to develop management capacity to design and implement contracts.

This paper synthesises the learning from three case studies of PPP in RCH area that focused on managerial capacity to strengthen RCH programme through PPP. Two case studies examine state level initiatives in Gujarat and Andhra

Pradesh; a third case study focuses on the national level mother NGO scheme. Each of the case studies investigates the functioning of PPP at the service delivery level, including the following topics in the analysis:

- Description of the structure and process of developing the partnership arrangement
- Documenting the experiential learning that contributed to developing management capacity and specific competencies for PPP essential for each study
- Identify pathways towards developing management capacity of partners to address key challenges in implementation

2 Policy Context

Under the health sector reform process undertaken by several state governments in India, there is a substantial interest in developing effective and mutually beneficial partnerships between government, NGOs and private sector. At the policy level there is a wider recognition to the fact that these partnerships can contribute significantly to the programme performance. For example, the National Health Policy 2002 has clearly stressed the importance of government-NGO partnership in the formulation and implementation of health and family welfare policies and programs at both national and state governments. The mid-term appraisal of tenth Five-Year Plan marked a significant positive shift from the earlier perspectives on private sector participation. Prime Minster's opening remarks in Planning Commission meeting emphasised the following[2].

> *As Government's priorities and expenditure patterns shift towards social and rural infrastructure, such growth will not take place without a substantial increase in private investment. This will have to be not only in commercial activities but also in physical infrastructure, where its involvement has been limited in the past. To enable this to happen, the policy and procedural environment must be made considerably more welcoming towards private investment; and, the government will have to incentivise the private sector to enter unfamiliar areas through well designed public-private partnership models. The mid-term appraisal document brings out possibilities that exist for such involvement and the required policy changes.*

Many state governments has even shown its willingness to hand over, out-source and contract-out health services to NGOs or other forms of people's groups with the intention to improve equity, quality, access and efficiency of services. The involvement of self-help groups (SHGs) is increasingly considered important to facilitate both voluntary sector and PRIs initiatives through propagating preventive aspects of health and family welfare.

Developing public-private partnership in health sector has been consistently prominent in policy - level dialogue on health systems development strategies for several years now. Currently in India almost all-new projects developed with the State include a policy statement on involving the not-for-profit and private sector in implementing selected programme components -- most particularly reproductive and child health programmes. National health policy directions have stressed the need for PPP partnerships in health sector. Some of these pronouncements/intentions are as follows:

- National Health Policy of 1983 stressed that the state and central governments responsible for maintaining public health would design processes that encourage the establishment of practice by private medical professionals and investment by non-government agencies in promoting service delivery.
- National Health Policy 2002 clearly stressed the importance of government-NGO partnership in the formulation and implementation policies and programs at both national and state governments
- The new economic policy of the government at both centre and state level has paved the way for developing and implementing public-private partnerships in various sectors of the economy.
- Many state governments have shown willingness to hand over, out-source and contract-out health services to NGOs or other forms of people's groups with the intention to improve quality, access and efficiency of services during tenth Five-Year Plan.
- Increasingly the involvement of the self-help groups (SHGs) is considered important to facilitate both voluntary sector and Panchayat Raj Institutions (PRIs) initiatives through propagating preventive aspects of health.
- The National Rural Health Mission (NRHM) of Government of India has also laid down the framework for partnership and calls for public-private partnerships to meet the deficiencies in the public health delivery system. The approach suggests developing and implementing pilot projects in areas such as social franchising, contracting and involving private providers in service delivery in selected districts, and based on the outcome up-scale implementation in wider geographical area[3].
- The report of the task force on public private partnership for 11th Five-year plan stressed the need for PPP to overcome some of the deficiencies of the public health system[4].

Most of these policy pronouncements and intentions have stressed the need for partnerships to improve equity, quality, accessibility, availability, acceptability and efficiency of health systems. It is expected that through these partnerships there would be exchange of skills and expertise between the public and private sector and it would strengthen the existing health system by improving the management of health within the government infrastructure. As a result of this

the efficiency in resource allocation and resource generation is expected to improve, improving coverage and expanding services. Effectively implemented partnerships also promote community ownership. Improving managerial capacity to improve efficiency and address gaps in service provision and/or utilisation also figures prominently in the objective of these different policies and programmes.

One consequence of the sustained attention to developing effective PPP is a large body of experiences, as various approaches of partnership in health sector have evolved over time, producing a quite diverse range of results. Table 1 provides some illustrative list of approaches. As shown from this meta-review of recent programmes, contracting-out is the predominant model of public private partnership in health sector. Most of the earlier studies[5] in this area have argued the need to evolve a proper policy which should address the questions of public-private mix, scope of these partnerships, role of subsides and incentives in promoting these partnerships, having explicit, transparent and adequate mechanisms which would ensure involvement of all stakeholders in the process. In addition, appropriate monitoring and management of quality and performance have been focused as an important factor fostering these partnerships. However, the need for developing effective mechanisms to monitor largely remains.

Clearly the formation and management of PPP involves a complex set of factors and many locally contextual dynamics will have an influence on the gains and risks from such efforts. One cross-cutting issue is the formation of new roles for each of the key stakeholders involved in the PPP. Each stakeholder in partnership setting often must perform a role that is different from the one which they perform otherwise. These new roles at times also demand appropriate set of capacities and competencies to steer and develop these partnerships effectively. The realisation that what competencies are required may not be apparent in the beginning. Mechanisms and instruments to implement these arrangements also evolve over the period as the programme gets implemented. However, the success of these partnerships critically hinges on how effectively and fast these roles and capacities are identified and developed and competencies are nurtured. Unfortunately there is little information to assist in identifying these capacities and the pathways towards their development -- particularly at the district level. Understanding of this is expected to help the programme implementers and policy makers to delve on the critical linkages in developing, up-scaling and replicating partnerships to strengthen the service delivery.

3 Objectives and Rationale

The implementation of RCH programme involves considerable interaction with communities, non-government agencies and private organisations to meet the service delivery gaps. This is achieved through developing PPP and contracting out arrangements. During the first phase of the RCH-I programme of Government of India, the programme focused on involvement of the private

sector to overcome some of the implementation constraints in the area of emergency obstetric care (EOC), MTP, among others. The schemes for implementation included a number of other measures such as involving NGOs through state level registered societies (SCOVAs). The RCH-II progressively focuses on reaching those least served, and by earmarking a pool of resources for implementing innovative solutions. Proposed areas covered include monitoring systems, behavioral change communication, service delivery, demand-side financing such as insurance and voucher schemes, training and supervision of professional, auxiliary and administrative staff, research on tribal systems of medicine, planning capacities, disseminating good practice, etc[6].

Public sector engagement with the private sector is quite important given the significant dependence of communities on private providers. This is important for several reasons, including achieving health equity and promoting economic development. In a developing country like India high levels of private health expenditures can be a serious challenge to national economic development. Currently 76 per cent of the healthcare expenditure is out-of-pocket costs in India. These expenditures as proportion of per capita income have almost doubled since 1961. This was 2.71 per cent during 1961-70 and increased to 5.53 per cent during 2001-03[2]. The private health expenditures have grown at a much higher rate than the per capita income over the years. During the period 1991-2003 private out-of-pocket expenditures on health has grown at 10.88 per cent per annum in real terms whereas per capita income has grown at 3.76 per cent during the same period. The sheer size of these expenditures poses problems for families who have no ability to pay, forcing them to go into debt leading to poverty trap and suffer further. It is well documented that the poorest 20 per cent of population in India only utilise about 10 per cent of total net public subsidy while the richest quintile benefited three times more than the poorest[7]. Same study indicates that on an average, population in the poorest quintile are 2.6 times more likely than the richest to forego medical treatment when ill due to financial reasons. According to an estimate, one-quarter of all Indians fall into poverty as a direct result of medical expenses in the event of hospitalization. Even when government provides free or nearly free services, poor households spend a significant part of their income on transportation and paying informal charges.

The share of government in financing health care has not risen fast enough to take care of growing need for public health. For every 1 per cent increase in state per capita income, per capita public health expenditure has increased only by around 0.68 per cent; for every 1 per cent increase in real per capita income the real per capita private expenditure on health has gone up by 1.95 per cent[8]. This gap is significant. Appropriate public policy instruments and mechanisms are required to protect people from risky levels of health care expenditures and also ensure services are accessible. Ensuring that poor and vulnerable groups of population get services with less financial burden has been one important public policy goals of developing partnerships in health sector.

There is an increasing recognition among multi- and bi-lateral donor agencies about the role that public-private partnership arrangements can play in improving public health services, and alleviating poverty. Most donor agencies have altered their financing strategies to reflect this recognition. During last decade donor agencies have devoted time and resources to understand the various partnership issues, best practices and advocacy with state and central government to incorporate partnership as a measure to increase access of services to poor.

The objective of this study is to synthesise the learning from three case studies focusing on the partnership in service delivery setting. Specifically the cases focussed on studying the structure and process of public-private partnership experiences in India with a view to (a) understand the management capacity and competency in make-up of various public-private partnership initiatives in RCH; and (b) identify pathways towards developing management capacity of partners.

4 Case Studies

Three case studies were analysed using various partnership dimensions. The goals of each scheme that were investigated in the three case cases are presented in Table 2[9]. The case studies examined the following key aspects of each scheme:

- Key elements of partnership: This part of the study focused on partnership terms, structure, status, scope, diversity of funding and flexibility.

- Human resource and organisation structure: Involvement of people and organisation structure of the interventions of service delivery has the major challenge to manage people motivation and commitment. The case studies focused on examining the implications of contracting towards Human Resource issues and its impact on programme performance.

- Mechanics and characteristics of contracts: The contract defines the incentives and basic modalities of implementation and it is through these contracts these partnerships are initiated and implemented. In addition, contractual terms ensure effectiveness of benefits and efficiency that percolate to programmes and ensure adequacy of control over what services are to be provided and to whom. The cases studies therefore focused on studying these aspects of the contractual relationship between government and the three schemes.

- Capacities and competencies required: The partnerships assume new roles for which capacities and competencies are identified and developed. This in turn influences the ability of partners to develop, implement and monitor the process of partnership. The cases focused on studying these in detail with a aim of identifying pathways towards the development of managerial capacities among state and district level officials overseeing PPP.

Key features of each case are summarised in Table 3. Based on above dimensions we identified key attributes of each case and these are discussed below.

4.1 Chiranjeevi Scheme, Gujarat

Government of Gujarat announced a "Chiranjeevi Yojana" scheme in April 2005 to improve access to institutional delivery and improve financial protection from catastrophic health care costs to poor families in Gujarat. The scheme covers below poverty line (BPL) families who are generally under-represented in health service coverage as a result of have limited access to institutional facilities and who also may experience economic and social hardships due to complications during delivery. Given the increased availability of private providers throughout the state (and conversely, the limited availability of public sector providers in rural areas), it is imperative to include the private sector in schemes to improve access to maternal care services thereby improving the institutional delivery rate. This scheme covers the BPL families by making their utilisation of private facility a cash-less event and also covers other direct and indirect out-of-pocket costs such as travel and incentives to an accompanying person.

The scheme is implemented by creating a network of private medical practitioners to provide maternity health services in remote areas which record the highest infant and maternal mortality and thereby improve the institutional delivery rate in Gujarat. The scheme was launched as a one year pilot project in December 2005 in five districts viz., Banaskantha, Dahod, Kutch, Panchmahals, and Sabarkantha covering all BPL families. The networked private providers are reimbursed by the state government on capitation payment basis which reimburses them a fixed rate for each delivery they provide[10].

This scheme has made several positive contributions to improving the coverage of maternal health care services in the state, including the following:

- Identification and referral of delivery cases among BPL families to private providers
- Follow-up of delivery cases and their risk status, ensuring the service provision
- Protecting the most vulnerable (BPL) families from adverse financial burden

The mapping exercise carried out by the district health officials identified the private providers providing maternity services in five districts. A detailed survey of providers and their infrastructure facilities was carried out in one district to assess the service provision conditions. Meetings, interviews and consultations were held with these providers and professional bodies such as FOGSI and SEWA Rural to discuss the package of maternity services and cost of

providing these services. Based on this a package of institutional delivery was finalised at Rs. 179,500 for 100 deliveries including both normal and complications. Previously, the delay in payments had been a critical impediment in participation of private providers in various other schemes in India. This scheme put in place a unique mechanism governing the flow of payments that specifically addressed this concern. Each networked provider is given up-front advance of Rs. 20,000 to start providing services and funds are replenished on regular basis.

The Five districts covered by this scheme have population of about 10.5 million of which 43 per cent are below poverty line having about 110,000 deliveries per annum. The scheme during first year of its implementation covered 31,641 deliveries. Of the total 217 providers in the scheme's districts 133 (61 per cent) have been networked. The average number of deliveries carried out by these networked providers has been 238 deliveries per provided over one year period. During this period, institutional deliveries in the five districts have increased from 38 per cent to 59 per cent with no maternal deaths and 13 infant deaths reported in the pilot districts. The scheme has experienced 4.7 per cent of caesarean operations among the BPL expectant mothers which is much less than average of 15 per cent complications assumed in financial calculations. An overarching conclusion from the scheme's first year experience is that it contributed directly to substantial improvements in access to institutional facilities for maternity care, particularly among BPL families.

The experience of five districts suggests that developing partnerships with private sector depends directly on management and planning skills of government officials at various levels in the health department. Adhering to fundamental principles of decentralisation and providing enabling environment has played crucial role in the process. Taking into account the complexity of issues in maternal health which cut across social cultural and economic factors and given the geographical immensity of these five districts, the Government's role in developing capacity and providing enabling environment has been significant. For example, the government's role in providing up-front advance payments that are reimbursed at regular intervals and efforts to stimulate private sector providers to participate in the new scheme has provided significant impetus to the scheme. At the same time strengthening management capacity of district level personnel by providing them training to develop their skills in negotiation, consultation and networking has helped them to promote this scheme. This experience also suggests that there is huge potential for the non-state sector to play a greater role in provision of services and strengthening institutional processes in partnership with Government. Clearly identifying prospective partners and developing their capacities is a catalytic step in the process. The Chiranjeevi Yojana has also helped in nurturing the trust and demonstrated the credit-worthiness of partnerships that could assist in replicating the experience to other settings.

4.2 Urban Slum Health Care Project, Andhra Pradesh

The availability of basic primary health care services, including sexual and reproductive health services, is inadequate in most urban areas and is particularly limited for urban slum dwellers where the public health infrastructure is almost non-existent. In many urban slum settings the only health care provider is private, and the poor will experience financial barriers to SRH services. One consequence is the use of public sector tertiary care services by the poor, creating an overload of patients and driving up public health care costs.

In response to these pressures, the Government of Andhra Pradesh in 2000 initiated a scheme to provide basic primary healthcare and family welfare services to urban poor living in slums. The Urban Health Scheme in Andhra Pradesh was implemented with an objective to provide reproductive and sexual health services (RSH) services by building primary healthcare infrastructure for the urban slum population through public-private partnership and contracting out. The scheme has focused on issues to improve performance of the primary healthcare infrastructure and ensure that poor in urban slums have good access to quality care and referral system. The initial financial support for this project came from unspent funds of Indian Population Programme (IPP VIII). The scheme was implemented across the state in notified slums coming under 74 municipalities by establishing 192 Urban Health Centres (UHCs) each covering a population of about 3 million. The primary healthcare and family welfare component under RCH programme formed the basic service delivery package of the UHCs. The scheme has developed an effective mechanism to evaluate and monitor the performance of the agencies implementing the scheme. Evaluation studies of the scheme[11] have shown the benefit of the scheme on both output and process indicators.

The Department of Health and Family Welfare (DoHFW) provides support for building, infrastructure and equipments to run the UHCs. The medicines and drugs required are indented from the district health office. The state government contracted out the management of all 192 UHCs to local NGOs. The selection of the NGOs was done by a district level committee specifically constituted for this purpose. Mobilisation of communities is an important component of the programme. State government plays the role of supportive supervision with scheme monitoring and implementation decentralised to the district level. In order to ensure proper implementation and role clarity in the scheme, the state government has prepared a comprehensive reference manual defining the roles and responsibilities of the stakeholders in the scheme and expected outcome from the scheme.

The scheme covers around 3.05 million of the estimated 5.2 million slum population of the state and has contributed to state's attainment of several public health goals. For example, from March 2003 to March 2005 the institutional delivery rate increased from 88 percent to 94 percent, a 6 percent improvement in target population. An analysis of the annual validation exercise of UHCs for the

year 2005 shows that about 24 percent UHCs qualified for high performing centres whereas by 2006 that had increased to 42 percent registering a significant improvement in performance. During the same period the number of low performing centres decreased, from 13 per cent to 1 percent. The overall performance on key family welfare indicators of high performing UHCs on reported institutional delivery, reported infant mortality and maternal mortality rates were significantly better.

The experience of 192 UHCs suggests that developing partnerships with private not-for-profit sector depended on management and planning skills of functionaries in the health department at various levels. Taking into account the complexity of issues in family planning services in urban slums, which cut across social cultural and economic factors, the state government has played pivotal role in creating capacities to monitor and supervise the functioning of these UHCs. The grading system to evaluate performance of UHCs puts pressure on them to excel.

This project was started with the World Bank support. The state has effectively managed the transition from a donor-funded project to government programme. Adhering to fundamental principles of decentralisation and providing enabling environment has played crucial role in the process. This experience also suggests that there is huge potential for the non-state sector to play a greater role in provision of services.

The scheme ensures people's participation in management of the UHCs and placing the power for identifying the health priority in the hands of the community. Challenges remain, however, including the following:

- Development of effective strategies to involve NGOs as partners in service delivery, financing and financial management system
- Need to reposition the UHCs in view of changing epidemiological scenario so as to refine the service mix to better respond to the population's health needs
- Examining the incentive system for providers and managers, including developing management capacity and competencies of both partners.
- Strengthening institutional processes within the Government, and identifying prospective partners and developing their capacities to participate in public-private collaboration

The scheme has also helped in understanding the implication of nurturing the trust and credit-worthiness of partnerships based on performance measurement system. For example, a significant number (41 per cent) of UHCs qualified as high performing agencies in 2006 up from 24 per cent in the previous year. However, continuous efforts are required to improve the number of high performing agencies. In effect, the programme can gain by focusing on creating

social capital and working through an inclusive participatory management processes. This demands greater delegation of authority, financial autonomy, and faith in partners, accountability and capacity strengthening in the system. The programme can focus on creating resource support and by focusing on right environment and incentives to work to foster innovations and new thinking. Besides, monetary incentives, the scheme should recognise well performing NGOs and NGO representatives should be actively involved in consultation in policymaking and implementation of the programme.

4.3 Mother NGO Scheme, Government of India

Partnership with NGOs in delivering RCH services through mother NGO (MNGO) in the un-served and under-served regions is an important central sponsored scheme of the national RCH programme in India. The scheme involves large number of contracts between government and the NGOs. As of April 2006, 215 MNGOs were working in 324 districts of the country. In addition there are about 3 / 4 Field NGOs (FNGOs) attached with each MNGO in a district, indicating a significant corollary effect to investments in the MNGO scheme. . Expanding this scheme to 611 districts is a management challenge.

Under the MNGO scheme, the projects are sanctioned for a period of three years. Funds for the programme are transferred from the MoHFW to the State RCH Society. The State RCH Society disburses the money to the district RCH society for supporting the activities of NGOs. Funds are made available to NGO to implement specific interventions[12]. The salary component of the budget is not expected to exceed 35 per cent of the total budget. Based on the number of FNGOs and nature of proposed interventions, MNGOs get an annual support of approximately Rs. 0.5 to Rs. 1.5 million per district. MNGOs are allowed to retain 20 per cent of the total project cost for administrative and establishment purpose including for capacity building activities. Besides, the MNGOs are allowed a non-recurring grant of Rs. 150,000 towards purchase of assets and Rs. 100,000 for meeting exigencies such as drugs, vaccines and contraceptives. Depending on the nature of intervention, Service NGO (SNGO) get an annual allotment of approximately Rs. 1.0 to 1.5 million per CHC/block CHC area. MNGO enters into MoU with FNGO and provides fund to support their activities.

The observations presented here are based on a case study conducted in three states in India that investigated challenges to managing the MNGO scheme, including the following:

- Delay and uncertainty of funding and renewal of contracts
- Inadequacy of partnership mechanisms in the scheme
- Weak monitoring system
- Capacity constrain at the district and state health system

- Procedural delays due to complex structure and multiple points of authority and reporting relationships

It is also observed that the capacity of field NGOs to deliver in the programme is constrained due to the limited or non-availability of sufficient financial and human resources. The scheme demands a strong leadership at local levels and ownership from the state health system. This can be achieved through effective decentralisation, flexibility in decision-making and creating adequate accountability in the system. A lesson learned from the MNGO scheme is the important role played by the Regional Resource Centres (RRC) in coordination between state/district RCH society and the NGOs and particularly in strengthening their capacities. Developing the capacity of the RRC is essential for the scheme to work effectively.

The MNGO scheme was initiated as central sponsored scheme in RCH I with the provision to transfer funds directly from centre to implementing agencies. The selection of NGOs was centralised, which caused problems on several levels. Under RCH II some degree of decentralisation of the scheme has been done with larger involvement of states in the selection process and monitoring of the scheme. However, the transition of the scheme from RCH I to RCH II and discontinuities arising from this transition have not yet been addressed effectively at the time of the case study field work. As a consequence, the ownership of the scheme at the state level still remains a question and it is being seen as central sponsored scheme. There are at times conflicts between the state level policies to promote public-private partnerships and MNGO scheme. This is because of the lack of autonomy to the states in implementing the policies with regard to involving NGOs in this scheme. In many sites, the selection of NGOs and scheme implementation is based on national guidelines without considering the local level capacities and other specific issues at the state level.. Too often the scheme does not provide scope of innovations and flexibility to develop partnerships differently in a situation warrants so, particularly since the capacities of NGOs vary considerably across regions. Fostering the relationships across these aspects may require different intensity of resources. Implementing this scheme across all 611 districts needs huge capacity and resources.

It is also observed that the incentive structure across national and central sponsored health programmes such as HIV/AIDS and other state level incentives to promote public-private partnerships are significantly different from the MNGO scheme. For example, agencies such as states AIDS control societies or state level agencies have a strong mandate to promote involvement of NGOs in health programmes and offer more attractive packages than the MNGO scheme. Enrolment of the better performing agencies is sometimes competitive between state agencies. Also, conflicts may also arise as the state level agencies would be actively involved in evaluation of various programmes and reflecting on role of implementing agencies such as NGOs. The MNGO scheme does not address these conflicts and the best way to address them is to decentralise the programme

at the state level, and to create a state-wide policy on engagement with NGOs for all health programmes (i.e., PPP policy guidelines). The centre level agencies may focus on providing overall technical advice and state level agencies focusing on selection of NGOs and approval of budgets, but operational guidance needs to originate at the State level.

The case study repeatedly identified instances where local management felt that the centre micro-manages the scheme without having adequate capacity in place. For example, in most states the position of State NGO Coordinator (responsible for monitoring the scheme) is vacant. In states where the position is filled, it is managed by inadequately trained person affecting the decision-making and implementation process. There is significant gap in communication and coordination of activities between government and MNGOs. The central government tends not to focus on developing and strengthening state-level capacities to promote public-private partnerships and the implementation of the scheme should be decentralised to states. Instead it drifts towards operational management tasks, for which it is ill-equipped to handle. The scheme ownership and implementation should be with the state.

One positive step initiated during the RCH II is the role of regional resource centres (RRCs) which has been made more focused on capacity strengthening and advocacy. Earlier the RRCs were involved in selection of NGOs and monitoring of field level NGO activities. The centre should focus more on creating enabling environment and capacity of various stakeholders to foster and develop the public-private partnerships relationships. Lot of work is required to address various systemic issues such as development of accountable and performance oriented system, ensuring financial autonomy and decentralisation, delegation of authority, building trust and accountability in the system, effective integration, managing discontinuities and fostering true sense of partnership between the state and non-state sector. The centre should play catalytic role focusing on creating knowledge base in this areas and help the states to design and develop appropriate policies.

5 Discussion and Lessons Learned

We use the following dimensions to provide a discussion of the key learning that emerge from three case studies on PPP:

- Financing and provider payment systems
- Ownership and state level policies
- Capacity of different partners
- Financial management skills
- Incentive structure
- Leadership and supervision

5.1 Financing and provider payment systems

The way the partnership scheme is financed plays an important role in success of the scheme. Three different financing patterns have emerged from the case studies: State, Central and Foreign Assistance.

Chiranjeevi scheme in Gujarat was financed entirely from the state budget and the rationale for the scheme emerged from the felt need of the state to tackle its maternal mortality and promote institutional deliveries by involving private providers in the system. One important element of Gujarat scheme is that the state government assumed direct management responsibility of managing financing and paying the providers instead of working through intermediary agencies such as insurance company or specially created institutions to manage financing and payments to providers. In order to ensure that there are no funds flow delays in reimbursing the providers, the state government provided up-front advance for 11 deliveries (Rs. 20,000) to private providers and replenish this advance on month to month basis. The Chiranjeevi scheme uses capitation basis of paying the providers. This kind of payment system has been applied to services of general practitioners under health insurance plans and managed care systems. This has been a major departure from the existing provider payment system both in government and private. For example, private providers have been charging clients based on fee for service (each unit of service being separately priced) where as government doctors are paid based on salary. Capitation payment is based on per delivery rather than on service units used. Introduction of new payment method required time to understand and also work out financial implications. The state government involved professional bodies such as obstetrics and gynecology societies and local management institute in designing and implementing the provider payment system. The government had no capacity or competencies in place to address the implications of payment system. However, they learned and institutionalised the capacity as they progressed in implementation.

Managing the administrative load of new payment system was not significant as the government from the beginning decided to keep the implementation of scheme simple. For example, simple formats were used to keep information load minimum. The scheme did not ask for detailed information on various units of services provided to clients under the scheme. The policy context of the state already having several PPPs in place helped in getting adequate cooperation from departments such as finance and law needed in such interventions. It provided clarity to various issues and risks that are experienced in implementation of PPP.

The Mother NGO scheme was funded under RCH programme of Government of India. As stated earlier that there are 215 MNGOs and about 3 to 4 FNGOs attached with each MNGO. Most of these NGOs are not organised and may have inadequate capacities to handle and negotiate contracts. With limited capacity and not having a dedicated organisation it is difficult for implementing agencies

to handle such large number of contracts and financing and contracting mechanism. The MNGO scheme ensures that implementing agency does not get involved in handling a large number of contracts. Dependence on central funds creates its own risks. For example, there was no funding available for one full year during the programme transition from RCH I to RCH II..

AP Urban Healthcare Project was an initiative of the state government to improve the primary healthcare infrastructure in urban areas through utilising World Bank funded IPP VIII spill over money. Subsequently, the project activities were taken over by the state government and have demonstrated the commitment of the government to carry forward the activities which they believe are significant. The NGOs are contracted out and paid based on programme activity charges which are fixed. The programme has developed effective system to categorise the centres based on performance on selected key indicators and continue to support only high performing centres.

5.2 Ownership and state level policies

Ownership plays an important role in fostering partnerships and contributes to implementation of the scheme. The Chiranjeevi scheme in Gujarat and UHC scheme in Andhra Pradesh were initiated by the respective state government while Mother NGO scheme is a national programme initiated by Government of India. It comes out clearly from the studies that in the former two schemes, the sense of ownership and urge to ensure success of the scheme has been quite high. On the other hand, the MNGO scheme in India involves tripartite relationship between Government of India, State Governments and NGOs. In this complex network of relationships, state governments have a weakened sense of ownership that is directly related to having a less central role. State government and various implementing agencies view this programme as a centre driven programme. Although under RCH II, involvement of state government and delegation of power improved significantly, the mindset of state officials have remained more of a passive implementers.

There are at times conflicts between the state level policies to promote public-private partnerships and central level policies. This is because of the lack of autonomy to the states in implementing central schemes with regard to involving private providers. Implementation is based on national guidelines without considering the local level capacities and other specific issues at the state level. In addition, the state level polices to promote public-private partnerships are also at variance with the central schemes. For example, states endeavour to follow central MNGO guidelines but with varying degree of success and enthusiasm. The scheme does not provide scope of innovations and flexibility to develop partnerships differently if a situation warrants so.

The capacities of private sector vary considerably across regions. The central schemes do not take into account aspects of private providers' capacities such as

heterogeneity, versatility and malleability. Fostering the relationships across these aspects may require different intensity of resources. Implementing central schemes needs huge capacity and resources and this is difficult to arrange. The case studies suggest that ownership must be at the level of implementation responsibility, e.g., state and district. Schemes that are run from the Centre have experienced difficulties in generating local ownership.

5.3 Capacity of different partners

The three case studies provide a basis for understanding the dynamics of factors which can improve service delivery involving non-state sector. Clearly, different types of PPP require different sets of management skills. For example, managing a performance based payment contract (such as in Chiranjeevi scheme) is different than managing contracts based on programme activity fixed fees (such as the UHC scheme). The critical determinants in both cases are government's and non-state sector's capacity to design, implement and monitor the contracts. Table 4 summarises the key competency and skill mix capacities across the scheme and sectors for different types of contractual relations. The capacity of both the partners and the broader social, economic and political environment governs the success or failure of the contract implementation process.

Government capacity*:* Capacity of the government both at the central and state level to design, implement and monitor the contracts has strong implications on the success of the scheme. The central government depends on states for the implementation of central sponsored schemes. Government implementation requires strategic orientation and having a good idea of macro environment within which they were planning to develop the partnership. For example, Chiranjeevi scheme focused on involving private providers which required mapping of providers and consultation with large number of stakeholders to develop the scheme. Creativity and analytical skills emerge as common components to influence the scheme design and its development.

The management of the centrally sponsored MNGO scheme required a great deal of coordination across different agencies and different levels of the bureaucracy. This was particularly an issue when decision making processes required participation of officers from different levels. Managers needed strong consultative and negotiations skills to address various trade-off and coordination mechanisms that are required to avoid or resolve any conflicts. The case study found that the financial management, information collection and monitoring, analytical and contracting-out capacities were not adequate in MNGO scheme. In general the limited capacity of officials to contract-out negatively effected the operations of the MNGO scheme. In some cases management simply wasn't available, e.g., state NGO coordinator positions remained vacant in many states. In addition to initiating contracts, limited capacity was observed on the monitoring and reporting on the schemes.

Developing inter-sectoral linkages have been an integral part of the implementation for each scheme reviewed in the case studies. Receiving support from various stakeholders such as department of finance and in addressing various cross-cutting issues requiring involvement of Anganwadi workers in maternal health in Chiranjeevi scheme in Gujarat were identified as critical success factors in the programme. This support is also required in integrating it with other local and community initiatives. It is important that the political leadership is supportive and committed to the creation of a PPP while also avoiding an direct interference in operations. It was observed that wherever these linkages are weak, partnerships experience difficulties such as delays in decision making, higher risks and resultant higher contract-out prices and less than satisfactory performance.

Non-state sector capacity: Non-state sector capacity and competencies are also crucial to successful PPP, including an organizational structure that facilitates engagement with the state. The non-state sector, both for profit and not-for-profit have grown but remained largely disorganised and largely unregulated. There are an estimated 12 lakh NGOs[13] and a large number of for-profit private providers in India today. Implementing a performance based system sometimes creates conflicting situation and non-state sector needs competencies to effectively introduce these new forms of payments, in part to manage the initial financial pressures that can arise with the new schemes. Some types of provider payment systems are quite new and hence can create confusion. For example, providers in Chiranjeevi scheme still find difficulty to understand the implications of capitation payment system. The development of skills related to managing costs and human resources are quite important for the success of the different schemes analyzed in this study. For example, in the UHC scheme providers learned to focus on developing good budgeting plans and fiscal controls during operations.

At times there may be conflicts the way the government interprets the performance and the non-state sector needs analytical skills to negotiate effectively from an evidence-based position in such discussions. The lack of transparency and accountability in both government and the NGO sector is an important factor affecting the trust in the relationship. At times this also undermines the work of the credible providers. While the rationale for contracting has often been the failure of government to provide services effectively[14], transparency and accountability of NGOs and private sector partners are also critical. Monitoring and performance evaluation, therefore, become priority areas and non-state agencies requires capacity strengthening in these areas.

Another area for capacity development in the non-state sector involves competencies in preparing projects. For example, a review by the International

HIV/AIDS Alliance in August and September 2002, assessing the participation of HIV NGOs in 6 country level processes of the Global Fund for AIDS, TB and Malaria[15] observed that many proposals were necessarily prepared in haste, which has raised a number of issues about the extent of NGO involvement in the process and the quality of proposals. The same paper recommends that a number of issues need to be addressed in relation to NGO involvement, including lack of access to information, limited involvement in decision-making, weak NGO networks and the need to ensure effective funding disbursement to civil society.

A well-planned partnership initiative has to incorporate perspectives of both sectors while also developing appropriate incentive system that distinguishes between public interest and the profit motive. The partnership terms and selection process are important steps in ensuring that the non-state providers with adequate systems are empanelled in the implementation. The case studies found that this requires continuous maintenance and should not be a one-time effort. For example, Andhra Pradesh scheme has demonstrated that good evaluation system and monitoring on regular basis puts considerable pressure on private providers to excel and improve their performance. The screening system developed by Chiranjeevi scheme in Gujarat demonstrates that private providers having appropriate qualification and having physical infrastructure are empanelled in the scheme.

5.4 Financial management systems

The fiscal management of the different schemes involves several elements, including the review and approval of work plans, creation of funds flow mechanisms, clarification of financial powers and delegation, appropriate financial accounting system and internal controls to ensure funds are effectively used for programme objectives, and financial reporting which includes management reporting, auditing and accountability. Each element is important any lack of coordination among different agencies in meeting financial management requirements may produces delays in disbursing the funds.

Chiranjeevi scheme in Gujarat is a good example of how these procedures were effectively developed. The payment system in this scheme is based on capitation fees system. A financial flow mechanism was designed that paid an up-front advance to providers to start providing services. The scheme has developed appropriate monitoring system and involves public health workers in identifying the cases and ensuring referral. Based on the number of deliveries done, accounts are settled with the district health authority every month. The performance is reviewed periodically. Financial powers have been defined very clearly and have been decentralised. ANMs, AW and block level health officials are involved in monitoring the use of services and targeting of beneficiaries. Financial and performance reports are prepared by district level management unit and reviewed each month. Chiranjeevi scheme during its pilot

implementation phase has not experienced any noticeable delay in funds disbursement.

By contrast, the Mother NGO scheme is a case of weakened financial management procedures having a negative effect on the scheme's operations and impact. In this scheme all funds are transferred to the State RCH society by the Ministry of Health and Family Welfare, Government of India. The State RCH Society disburses the money to the district RCH society for supporting the activities of NGOs participating in the scheme. Delays in disbursement of funds were commonplace. The Mother NGO scheme suffered from delay in release of fund from the State RCH society and discontinuity of funding during 2004-05. Lack of ownership of the state health department in the scheme further compounded the funding delay in the scheme.

The Andhra Pradesh UHC scheme is an example of a different financial management system that has an uneven track record in operations. In this case, the state transfers the funds to the district in a joint account managed by the District Medical and Health Officer and the District Collector. Funds are released to the UHC quarterly through the participating NGO into a bank account jointly operated by the Project Coordinator of the NGO and another senior representative of the NGO. The accounts of the UHC are audited half-yearly. Some delays in the flow of funds have been observed, principally of slowness in government budget approval processes. At the district level, the fund is kept in a joint account of the project managed by the DMHO and the District Collector. There are instances of delay at the collectorate office due to their workload. De-linking the fund disbursement from the collectorate may result in removal of ownership from the district administration. The second reasons of delay are in submission of funds utilisation certificates from implementing agency. There were instances of delayed submission of fund utilisation certificates by the respective UHCs. In one instance, finalisation of accounts at State level was held up for want of required reports for three consecutive years. In this scheme, in spite of creating bank accounts, delay in disbursement of funds are observed due to three reasons: (a) delay in release of fund from state treasury, (b) complaints about delay from the district collector office in release of funds for the UHC, and (c) delay in submission of fund utilisation certificate by the participating NGOs.

5.5 Incentive

PPP initiatives require financial and other support from the government for which appropriate incentive structure needs to be developed. The design of delivery systems and incentive structure critically hinges on the understanding and assessment of how risks are shared and allocated among stakeholders.

A simulation study[16] of Chiranjeevi scheme suggested that using assumptions of prices charged by private providers in the absence of the scheme, the average revenue would be less than what the provider is being reimbursed by the government on capitation fee basis in Chiranjeevi scheme. The results further

suggest that revenue distribution in the absence of scheme is scattered asymmetrically indicating significant risk in revenues to the provider. By joining the Chiranjeevi scheme, the provider is able to reduce the overall risk in revenue. In addition to this, the increased volume of services from scheme spread the fixed cost of the provider and increase overall revenue position further. Since the provider is paid up-front advance for delivering services under the scheme, there is no transaction cost of bureaucratic delays in payments. The scheme is based on a capitation system that has disincentives to minimise unnecessary cesarian sections and which maximises the providers' revenue - producing larger indirect benefits from health systems. The incentive structure and payment package is based on cost assumptions which were arrived at after holding consultation with obstetrics and gynecology societies and has considered factors such as affordability both at the government and user level. The incentive structure, however, does not recognise the geographic diversity of the region and districts.

The financial package of the Andhra Pradesh UHC scheme was finalised during the schemes' during the conceptualisation phase. The staff salaries were fixed based on the prevailing market rates at that point of time. There has been no revision in the financial package over the years and even no adjustment to cope with the inflation factor. During this period, the demand for services has increased resulting in service load on NGOs going up. Given the contractual appointments of the staffs and annual validation of NGOs there is a constant pressure on the UHCs to perform. The scope of work of UHCs has also increased because of requests from DMHO to UHC staffs to participate in national health programmes and emergency health situations. The combined effect of increased responsibilities and frozen payment levels is a major challenge to retain motivated and qualified medical professionals in the UHCs, a major de-motivator for the UHC staffs. In addition, changes in the macro-economy of the state provide other, more lucrative opportunities, (Andhra Pradesh has emerged as an important IT hub in India). In addition, the current financial package and support received by the UHC does not provide for administrative expenses of the NGOs managing the particular UHC. Some of the key administrative positions such as project coordinator are not adequately budgeted and they are supposed to work on honorary basis. This has implications for working of NGOs that work in remote areas.

The incentive structures vary across schemes and there is no unified approach or policy on this at central or state levels. For example, agencies such as state AIDS control societies have strong mandate to promote involvement of NGOs in the programme. However, the comparably attractive financial packages across programmes may distract the NGOs to get actively involved in the other state level or national schemes. The attractive financial package however is no indication of its effectiveness. Table 5 shows the comparative experiences from the three schemes. Per capita government expenditure on health in India is about Rs. 721[4]. While in targeted interventions of HIV/AIDS per capita expense budget is about Rs. 1782, the same works out to Rs. 30 and Rs. 15 in Mother NGO scheme

and AP UHC scheme. This has implications on the involvement and motivation of NGOs to participate in the later two schemes. All NGOs contacted during the study observed that MNGO scheme and UHC in Andhra Pradesh were finding difficulties in sustaining their programme activities. While in MNGO scheme NGOs have some flexibility in use of funds disbursement, AP UHC scheme have strict guidelines and less flexibility thereby finding it difficult to innovate and take challenges in the implementation process. However, NGOs still participate in such programme to gain access to other government and other donor funded programmes.

The uneven funding of programmes in the health sector in general have significant implications for the NGO and private provider's preferences in implementing a programme in partnership. Each NGO or private provider has limited capacity to implement programme. However, their urge to have presence in multiple areas/projects fragments their efforts affecting the performance. This also results in hiring of inadequately skilled human resources with frequent staff turnover. The documentation of programme performance remains inadequate and these implementing agencies face problems of coordination across different activities within their organisations.

5.6 Leadership and supervision

Chiranjeevi scheme in Gujarat was implemented under direct supervision of the Commissioner, Health and Family Welfare. In Andhra Pradesh, an attempt was made to institutionalise the monitoring and leadership role among the district health authorities.

The MNGO scheme suffers from lack of strong leadership to steer the process, in part related to a lack of ownership at the state level for the centrally funded scheme. Given this is a national scheme, implementing it with equal effectiveness across all 611 districts in a major challenge. District health authorities lack the necessary skills in working with the NGOs implementing the scheme. The system lacks an enabling structure and communication process. Field level observations suggest that these roles can not be carried out effectively unless health officials are given adequate flexibility in decision making, autonomy and empowerment. While individual leadership can bring initial success in the scheme, institutional structure to foster leadership and supportive supervision has better chance to ensure sustainability of the effort. Studies also suggest that autonomy in decision-making is likely to have significant influence in ensuring commitment towards the scheme. For example, health officials at district level have very little autonomy and flexibility in decision-making. Their focus in implementing the programmes and schemes remains more as regulatory in nature since they follow mechanistic system of decision-making and observe strict hierarchies[17].

Supervision in scheme involving large number of stakeholders has to be strong to ensure better results. In Chiranjeevi scheme of Gujarat and UHC Scheme of Andhra Pradesh, supervision of the scheme was entrusted in the hands of district health authority. The MNGO scheme has devised a structure of supervision where MNGO supervise field level NGOs. Regional Resource Centres (RRCs) were also created for strengthening capacities and monitoring the activities of MNGO. These in turn were supervised by Apex Resource Cell at the central level. In case of RRCs it was difficult to combine the role of capacity strengthening and monitoring together and thus remained ineffective. As a result of this, the role of RRCs has been redefined to focus only on capacity strengthening in RCH II.

It was observed that where government agencies like district health authorities assume the role of facilitator and supervisor, the quality of monitoring and results of the scheme were much better. However, replicating such system has to be done to avoid extreme moral hazard of corruption and fraud. This can be done by constituting proper guidelines and quality control checks by competent health authority. A dedicated person made responsible for the scheme like "Regional Coordinator" in case of Andhra Pradesh UHC scheme could provide effective supervisory role in the scheme. In case of Andhra Pradesh, the six Regional Coordinators were chosen from person having adequate experience in working with government health system and having proper public health orientation.

In order to ensure sustainability of a scheme, adequate decentralisation to the district level authority needs to done. Adequate autonomy along with proper guidance for implementation plays the key role in implementation. It is inevitable that mistakes will be made while implementing schemes. For example, this may happen in selection of provider, improper implementation of guidelines in targeting the beneficiary etc. The central and state government has to play the role of supportive supervision which includes revising/refining guidelines, strengthening capacities and providing technical support as and when required during the scheme implementation. It is important to have the scope for learning from experiences towards strengthening future implementation. In order to ensure this, the system has to deal with structural rigidities, discontinuities and mechanistic system of decision-making.

6 Implications for Policy

The three case studies involving non-state sector in achieving public health objectives have some key implications for policy makers.

6.1 Sequencing of programme components

Implementing partnership involves dealing with a number of programme components. The case studies provide insights into how different implementing agencies have addressed implementing several components of the programme. Phased and step-wise approach to implement schemes in their scale and scope or

regional coverage may be more appropriate in partnership setting. Both Chiranjeevi scheme and Mother NGO schemes were initiated in phases. Although Andhra Pradesh UHC Project was initiated in all 74 municipalities at the same time, the scheme initially focussed on preventive and promotive aspect of family welfare. After the success of the initiative, the state government is planning to upgrade the UHCs to address comprehensive primary healthcare approach to address the changing epidemiological profile of urban population.

In Chiranjeevi scheme the basic quality standards were ensured through initial screening of applicants to verify accreditation / credentials and the quality of the physical infrastructure. However, the key challenge in the beginning was to attract and mobilise private providers in remote areas to join the networks and at the same time motivate beneficiaries to avail the services of private providers. Given this, it would not have been appropriate to address the quality (input, process and output) issues in totality during the initial phase of the scheme. This observation may challenge the view of health programme implementers /development partners who emphasise the need to address all the programme issues in one go. However, prioritising issues to be addressed and sequencing the action is critical determining factors in programme success in public private partnerships.

6.2 Creating sense of ownership

The success of any social sector programme in India depends upon the integration and strong ownership at the state level. Creating a sense of ownership among state and district health officials for a scheme initiated by the central government requires considerable involvement of state officials in implementation. Similarly, role clarity and delegation of authority are essential for instituting the ownership in a large scale programme. Communication has to be two way to ensure sense of ownership in the scheme. Apart from formal written communication there is a need to develop informal channels of communications and networking among various health officials. Understanding stakeholder perspectives through a variety of formal and informal forums is essential. Stakeholders' consultations without any follow-up action may affect the ownership as people involved lose confidence in such processes. This also indicates lack of autonomy and capacity in the system which makes such consultations a futile exercise.

6.3 Role of pilot

The Chiranjeevi scheme was launched as a one-year pilot in five districts followed by scaling-up of the scheme in the entire state. The MNGO was also launched in phases although not exactly in a pilot based approach. The AP Urban Healthcare Project was launched at one go in the entire state. Experiences suggest that where risks are high, the pilot approach is most appropriate strategy to test out initiative in a relatively risk-free way. The approach of "learning-by-doing" prior to attempting more widespread implementation is allowable under a pilot based approach. Pilots allow policy makers to test out alternative strategies, implementation challenge and scaling-up issues. Pilot approach

generates lessons regarding technical design and implementation that can feed into further implementation and refinement of the initiative. In scaling-up of the pilots, care has to be taken to account for the difficulty in replicating the intense support available during the pilot phase.

6.4 Role of information

Developing performance linked indicators and colleting information on these indicators is an integral part of the information management process that is so important for the success of any PPP scheme. The UHC case study suggests that using this information to categorise high perfuming centres made difference in improving performance of non-performing centres. The Chiranjeevi scheme based on capitation fee had fewer information requirements in the initial stages of its implementation, but these increased as the scheme focused more on quality of care. In many settings the existing mechanisms to analyse and process the data for effective decision making are not adequate. Significant efforts are required to put in this area to develop capacity.

The PPP uses public money and hence is subject to scrutiny all the time. There are constraints at times in developing an open and transparent sharing of information. For example, there is an anecdotal evidence of people not belonging to below poverty category using the Chiranjeevi scheme in Gujarat. Suggestions such as that each private facility should display names of persons who used scheme met with some resistance. Similarly, costing information of providers is not available. The implementing agencies also need to devise effective data management system for knowledge creation, information assimilation and dissemination. The academic institutions may be involved in the process of data collection and analysis.

6.5 Outcome monitoring

There is a need to introduce performance based reporting and evaluation where the financial allocations and expenditures are linked to activities and output indicators of the activities. Although the second phase of the MNGO scheme have developed specific output indicator for each of the interventions, proper implementation and follow-up of the same needed closer attention. The AP UHC Project has developed performance based monitoring system to report output of the project and NGOs are graded as per their performance. However, it may not be possible to use performance based system as all the activities can not be linked with the directly measurable outputs and outcomes, nor is this always feasible on an annual basis.

Chiranjeevi scheme in Gujarat has kept the output monitoring process simple and they use easy to report indicators in the first phase of scheme implementation. The timing and frequency of these reports is also realistic and is linked to replenishing the funds of provider.

Effective guidelines and regulations need to be developed to address the problem of predatory behaviour by some stakeholders. Monitoring mechanism has to be institutionalised to check for frauds and improper reporting. This can be done by linking the transfer of funds to performance indicators. There is a need to embrace a time bound mechanism along with defined responsibilities regarding selection, appraisal and release of funds to ensure proper implementation of the programme. With advancement of technology, the programme has to harness the benefit of electronic transfer of funds to ensure timely disbursement of funds. Accountability from NGOs has to be sought regarding fund utilisation and achieving the scheme objectives. In order to ensure achievement of deliverables, the programme implementation agency has to enter into relational contracting with the private parties. There is a need for involved planning and decision-making in the programme. Strengthening institutional mechanisms to disseminate information about good practices is a key priority.

7 Summary and conclusion

Strengthening the management capacities of both state and non-state actors in PPP is an effective and important priority for the RCH programme in India. . Given the complexity of issues in RCH which cut across social, cultural and economic factors and given the geographical immensity hindering access to services, central and state governments are exploring options of developing and implementing PPP to meet this challenge.

In this paper we provide synthesis of the learning from three case studies of PPP in RCH area. Two case studies pertain to state level initiatives in Gujarat and Andhra Pradesh and a third study focuses on the national level mother NGO scheme. The analysis of these case studies leads to the following conclusions.

> ***The policy context of the state has played a critical role in ensuring that PPP gets implemented.***

Developing these linkages help in addressing various cross-cutting issues requiring inter-sectoral collaborations, including the support of various stakeholders such as the Department of Finance. These linkages are identified as critical success factors in the programme and receiving this support is considered vital in initiating the schemes and integrating it with other local and community initiatives. Situations which have no earlier context of involving private providers in health programmes may need to address it by developing policy framework followed by starting the PPP initiative on pilot basis to gain experience and create context. Also, areas which have weak institutions such as mental health need strengthening the institutions first.

State governments need to focus on developing appropriate management capacity, both organizational procedures and individual health official skills.

In principle there should be a gap analysis conducted as part the start-up of any PPP initiative to identify capacity building needs related to the process of conceptualizing, developing, structuring, managing and monitoring of the scheme. The case studies have suggested that programme managers can identify these gaps as they gain some experience in implementation and as it progresses to interact with communities. In such situations the government must be in position to address these gaps as the capacities of specific functionaries such as district/block medical officers are critical in some respects. The catalytic role of government at the commissionerate, directorate or department level in creating opportunities for capacity strengthening is significant It is also important to recognize that private sector do have competency gaps and require support and facilitation to strengthen their capacities. Capacity strengthening issues need to be handled at different levels and not to club it together with micro level monitoring of programme implementation (as was happening in MNGO scheme).

Many of the PPP initiatives will not be sustainable on the basis of 100 per cent user fees to be paid by the user of services alone.

PPP require financial and other support from the government for which appropriate incentive structure needs to be developed. This hinges on the understanding and assessment of how risks are shared and allocated among stakeholders. The incentive structure should be based on reasonable costs assumptions and needs to consider factors such as affordability both at the government level and user level. The PPP in health sector, particularly in service delivery, creates added complexity of ensuring quality of care, health equity and sustainability. Most of the time an up-front clear specification of services and resources required is not possible. This specification problem creates additional risk factors about which policy makers need clear understanding and assessment. Managing partnerships in these situations is a challenge and the governments need to develop mechanisms to ensure continuity of services in case of any disruptions.

The capacities to develop and manage contracts in PPP are generally not adequate in the health department.

Technical support to meet this gap and to address other managerial challenges came from collaborating with academic institutions and other resource centres hired specifically for the project. It is possible to develop and strengthen institutions which can bring together the skills and competencies not available with the health departments, for example through mentoring arrangements and continuous training grants.

Initiating a scheme and managing any discontinuities arising during various phases of implementation is an integral part of PPP initiatives.

The AP scheme has demonstrated that managing the initiative from donor led scheme to government owned scheme is possible. At the same time MNGO could not manage the discontinuity arising from one phase of programme to another. The ownership of the scheme at the state level plays a critical role.

Conflicts can arise between the state level policies to promote public-private partnerships and central level policies.

This is because of the lack of autonomy to the states in implementing central schemes with regard to involving private providers or because of budget guidelines. Implementation in central schemes is based on national guidelines without considering the local level capacities and other specific issues at the state level. In addition, the state level polices to promote public-private partnerships are also at variance with the central schemes. This can be a problem if the scheme does not provide scope for innovations and flexibility to develop partnerships differently if a situation warrants so. The capacities of private sector vary considerably across regions.

The incentive structures across PPP schemes vary and there is a need for a unified approach/ policy guidance to harmonize approaches to working with the private sector at both central and state levels.

Agencies such as states AIDS control societies have strong mandate to promote involvement of non-state sector in their interventions and competitively offer attractive financial packages across programmes that can draw private sector actors away from other health programmes seeking to develop a PPP (e.g., the RCH Programme). However, the attractive financial package is no indication of its effectiveness. Given relatively better ownership and monitoring of state level programmes, the performance across state and central programmes vary. Conflicts may also arise as the state level agencies would be actively involved in evaluation of various programmes and reflecting on role of implementing agencies involving private providers.

There is a growing experience with PPP in the Indian health sector. The experiences and learning from these initiatives provide interesting insights in processes, outcomes and challenges. Policy makers, donor groups and other stakeholders need to think through innovative approaches to address the emerging challenges in area of capacity building needs, decentralisation and other issues. The varying performance of these PPPs should not be seen as failure but should be framed in a positive tone on how to move forward. Nurturing these initiatives involves time and effort as they are in very nascent stages. We need to learn from these experiences and develop appropriate frameworks which

can guide us in future. The detailing of capacities and competencies required in design, delivery and monitoring is important and needs to be incorporated in strategies. The capacity strengthening strategies should include designing and offering training programmes focusing on both state and non-state sectors, organizing study tours to expose stakeholders to have first hand experience of PPP initiatives, designing and developing toolkits and guidelines for policy makers and implementing agencies on various aspects of partnerships, and putting in place effective mentorship programme to help others interested in developing partnership programmes.

Table 1: Illustrative list of non-mutually exclusive partnership approaches	
Approaches	**Some selected descriptive attributes**
Contracting Out	Agreement between two or more parties that specifies provision of services by one party against receiving of payment by the other party in exchange of the services provided. In health sector services include both clinical and non-clinical. Agencies contacted out may include for-profit and not-for-profit agencies. For example, patterning with NGOs or CBOs to provide services in remote and rural areas. The payment to providers can be based on fee for services, salary or capitation basis. Vouchers may also be used to target the population for receiving services.
Contracting In	Government hires one or more agencies/individuals to provide services. This includes maintenance of buildings, utilities, housekeeping, meals, medicine stores, diagnostic facilities, transport, security, and communications etc. in major hospitals. Hiring of medical specialists for certain days in the week also forms a part of this arrangement.
Joint Ventures	Generally formed as legal entity either as society or joint stock company with equity participation of government and private sector. Equity participation from government may come in the form of land or other kind contributions. Proportion of equity of each partner may vary from one venture to another. The companies are usually formed for a specific purpose and for specific period of time.
Involvement of Professional Associations	Involving professional associations such as Indian Medical Association, gynaecologist's federation, nurses associations etc. in self-regulation function to ensure quality, accreditation/certification, working out payment structures in certain PPP schemes such Chiranjeevi scheme in Gujarat, and promoting new programmes such as Vande Mataram Scheme, Gaon Chalo project, immunization programme. Association of global partners can also form part of this mechanism.
Involvement of Corporate sector	As part of corporate social responsibility, corporate sector funding public health programme, generating advocacy campaign or opening up and running own hospitals and clinics for the community.
Social Marketing	Application of marketing techniques to achieve a social objective. Social marketing in India has been basically associated with expanding the access to contraceptives. The increasing trend now is to enlarge the basket of products by including ORS, IFA tablets, and other health products to make the marketing efforts more self-sustaining.
Franchising	A type of business model whereby a manufacturer or marketer of a product or service (the franchiser) grants exclusive rights to local independent agency (franchisees) to conduct business in a prescribed manner in a certain place over a specified period. Typically the franchiser has developed specialized skills, knowledge, and strategies. The franchisees contribute resources of their own to set up a clinic and pay membership to franchiser.
Capacity building of providers	Initiatives taken by the government to improve the technical and counselling skills of medical practitioners particularly rural medical practitioners by providing them training improved quality of services offered by them
Autonomous Institutions	Granting complete autonomy to public institutions by incorporating it a separate legal entity such as society or company and partnering with that newly formed entity to provide services with a view to improve equity, quality, accountability and efficiency. It also ensures greater involvement and ownership at the level of the institution, ensuring greater morale and encouragement to the work-force.
Management and Technical Support	Agencies acting on behalf of government as their management partner to undertake certain set of activities
Grant-in-aid	Schemes to provide direct financial support for recurring expenditures to non-state sector or transfers of public resources including subsidized or free commodities such as medicines, vaccines, contraceptives etc.
Campaigns with private partners	Special campaigns in partnership with the private sector to focus on demand generation for refurbished and revitalised public sector, generic promotion of health products (life saving ORS, menstrual hygiene with sanitary napkins etc).

Table 2: Goals of the three partnership cases	
Schemes	**Goals**
Chiranjeevi Scheme	Involving private providers using capitation fee payment system and targeting below poverty line households to prevent maternal mortality and increase institutional delivery through involvement of private gynaecologist and maternity homes. Improve access to institutional delivery and at the same time provide financial protection to poor families in Gujarat. The scheme was initiated with the objective to encourage private practitioners to provide maternity services in remote areas, which record the highest infant and maternal mortality rates in the state.
Mother NGO Scheme	Regional Resource Centres and Mother NGO scheme for provision of Reproductive and Child Health programme to the underserved region through NGO participation. The philosophy of the Mother NGO scheme has been one of nurturing and capacity building. Broadly the objectives of the programme are: (a) addressing the gaps in information or RCH services in the project area, (b) building strong institutional capacity at the state, district/field level, and (c) advocacy and awareness generation
Andhra Pradesh Urban Slum Healthcare Scheme	Contracting-out 192 urban health centres to NGOs for delivering RCH services and focus on community mobilisation. To provide basic primary healthcare and family welfare services to urban poor living in slums of 74 municipalities of Andhra Pradesh. The scheme is an initiative of public-private partnership through contracting-out management of the Urban Health Centres to NGOs in notified urban slums of Andhra Pradesh. The aim is to strengthen the managerial capacity of reproductive health programme implementation in urban setting.

Table 3: Three Partnership Schemes on Selected Attributes			
Attributes	**Chiranjeevi Scheme**	**Mother NGO Scheme**	**AP UHC Scheme**
Forms of Partnership	Voucher scheme to involve private providers in delivering maternity care	Contracting out NGOs to work in under served areas	Contracting out urban health centres to NGOs
Geographical scope	6 months pilot in 5 districts, followed by up scaling in entire state of Gujarat	324 districts of India	74 municipalities of the state of Andhra Pradesh
Reasons for contracting	High maternal mortality, low institutional delivery, involving large private practitioners to achieve the above	Limited capacity of government to deal with smaller NGOs, Leveraging on the capacity of NGOs to expand RCH services in community	Expanding primary healthcare services in urban areas through NGO involvement
Service Specification	Service provision for institutional deliveries	Wide range of preventive and promotive RCH services	Preventive and Promotive RCH services in urban areas
Information to private parties	MOU state the partnership clause. No implementation guidelines available	Detail guidelines issued by the MoHFW	Reference manual issued by state Commissionerate office
Financing	Financed entirely from state budget	Funded by Government of India under NRHM	Initially funded by IPP VIII spill over fund and then taken up by the state
Target Group	BPL women	Women in reproductive age group	Urban slum population
Evolution	Evolved as pilot by the state government	National programme	Evolved as pilot by the state government
Sanctions for poor	Strong	Weak	Strong
Implementation Problems	· Inadequate awareness among private providers about the scheme benefits · Shortage of specialists · Uniform service package impedes doctors to handle high risk cases · Monitoring quality of care	· Capacity of stakeholders a major constrain. · Procedural Delay in Selection and Disbursement of Funds · Credibility and trust among stakeholders · Contract clauses lack clarity and not comprehensive · Multiple points of authority · Inadequate monitoring	· No incentive for NGOs to participate · Inadequate incentive for UHC staffs · Delay in disbursement of funds · UHCs not equipped to handle changing epidemiological scenario. · Reference manual need updating
Management Responsibility	District Health Officials	Larger NGOs serve as MNGO and RRCs. Centre and State oversees the functioning	District Health Officials
Government Capacity	Strong	Weak	Strong
Private sector capacity	Strong	Medium	Weak
Social, Economic and Political Environment	Conducive	Not conducive uniformly, does not provide for innovation	Conducive
Ownership from implementing agencies	High	Low	High
Financial Management Skills	Medium-High	Low	Low-Medium
Leadership	High	Low	High
Supervision	High	Low-Medium	High
Sustainability	Medium-High	Low-Medium	High

Table 4: Key competencies and skill mix of different partners required for implementing partnerships

Sector	Scheme	Phases of partnership development		
		Design	**Implement**	**Monitor**
STATE SECTOR	Chiranjeevi	· Strategic planning and environment scanning · Creativity · Analytical · Consultative /Negotiations/ Motivating · Support from other departments	· Consultative/Negotiation · Contract management · Communication · Community orientation · Project management	· Supervision and Monitoring · Analytical · Reporting process with performance orientation · Conflict management
	UHC	· Transition management · Strategic planning · Analytical · Consultative	· Coordination · Networking and motivating · Performance management	· Indicators to capture performance · Conflict management and ability to solve problems · Analytical
	MNGO	· Strategic planning and identifying districts with high potential · Networking · Institutional and linkage management · Creativity	· Coordination · Managing large systems · Effective MIS · Analytical · Networking and linkage management · Capacity strengthening	· MIS and processing of reports · Performance management and governance
NON STATE SECTOR	Chiranjeevi	· Financial management and understanding provider payment implications · Negotiations · Ability to work through association · Partnership orientation	· Human resource planning and management · Cost and funds management · Supervision · Community orientation · Managing quality	· Analysis and understanding cost implications · Conflict management · Reporting and performance management
	UHC	· Project preparation · Community need and strategic planning · Creativity · Consultative /Negotiations/ Motivating	· Planning for activities with budget · Human resource planning and management · Performance management and taking corrective actions	· Managing performance as per agreed indicators · Conflict management · Reporting
	MNGO	· Project preparation · Networking · Creativity · Analytical · Consultative /Negotiations/ Motivating	· Managing networks and coordination · Managing multiple projects · Community linkages · Technical knowledge · Advocacy · Leadership and supervision	· Maintain and report MIS on large number of indicators · Identifying weak links in performance

Table 5: Comparison of financial package of PPP initiatives

Scheme aspects	PPP Interventions		
	Chiranjeevi Scheme	**Andhra Pradesh UHC**	**MNGO Scheme**
Target Group	Below poverty families	Urban Slum population Adolescent girls, Self Help Groups, ICDS Workers	Eligible couples, adolescent boys and girls, males involvement
Coverage	Five districts (now up scaled to entire state)	18,750 community members per UHC	10,000 person per FNGO
Services Provided	Maternal Delivery	Promotion of RCH services and BCC activities	Mother and Child Health Family Planning Services Adolescent Reproductive Health Prevention and Management of RTI
Average Annual Support	Depends on number of cases	Rs. 280,000	Rs. 300,000
Programme Cost	Included in financial package	Rs. 280,000	Rs. 240,000
Administrative Cost of provider	Included in the financial package	NIL	Rs. 60,000 (20%)
Cost per maternal delivery/Average Annual Cost (per person)	Rs. 1795	Rs. 15	Rs. 30

Note:

1 Costing and coverage for FNGO based on MNGO Guidebook by NGO Division, MOHFW, GOI
2 Costing and coverage for UHC based on Reference Manual for AP USHCP by Commissionerate of Family Welfare, AP
3 Per capita Health Expenditure in India: 3608[18] ($ 82)
4 Per cent of Government Expenditure from above (20%): 721

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