

# **NATIONAL RURAL HEALTH MISSION**

## **DRAFT REPORT OF THE RECONSTITUTED TASK GROUP ON PUBLIC PRIVATE PARTNERSHIP UNDER NRHM**

**MINISTRY OF HEALTH & FAMILY WELFARE  
GOVERNMENT OF INDIA**



# **NATIONAL RURAL HEALTH MISSION**

## **RECONSTITUTED TASK GROUP ON PUBLIC PRIVATE PARTNERSHIP UNDER NRHM**

### **The Task Force and its membership**

A Reconstituted Task Force on Public Private Partnership was set up under the National Rural Health Mission. Dr. H. Sudarshan was the Chairman and Dr. Rama Baru the Co-Chairperson of the Task Force. The list of members may kindly be seen at Annex – I. The Terms of Reference of the Task Group were to:

- (i) suggest a framework for partnership to meet the public health goals of NRHM; and**
- (ii) examine the current systems of public private partnership and suggest modifications in systems of regulation and support for such partnerships.**

### **The process adopted**

The Reconstituted Task Force held three meetings. Minutes of the first two meetings of the Task Force that discussed substantive issues may kindly be seen at Annex – II and Annex – III. The PPP Task Force under NRHM had to be reconstituted as there was no consensus on the earlier draft. Realizing the nature of contested issues in such partnerships, the Task Group decided to focus on partnerships for meeting public health goals. It identified strengthening of the public sector health system and expanding the pool of health professionals for

public health goals as two key issues for consideration. It was of the view that partnerships with the non governmental sector (that includes profit and not for profit sectors) are required even to make the public system more credible. Issues of regulation and standards came up for deliberation. It was felt that there was a need to strengthen regulation and standards if partnerships with the non governmental sector had to be developed. The need for transparency and trust in the process of partnership formation with the private sector, was articulated by members of the group. It was also felt that a distinction should be made between the not for profit and for profit non governmental sector.

### **The context of NRHM – Crafting a credible public system**

The Group decided to lay down the context of NRHM very clearly as the foremost challenge was to establish a credible public system. Three sub groups looked at the issue of regulation, partnerships, and the broad framework for such partnerships, including the evidence. There was a lot of debate on defining the partnerships very clearly with well defined obligations on both sides. The Group felt that there was a need for partnerships with the non governmental sector but these need to be defined very clearly as there was an equally important need to strengthen the public system. In a way, the group saw partnerships as a way of strengthening the public system as also a means to widen the range of professionals available for meeting public health challenges. ***While not ruling out meaningful partnerships with non governmental providers for meeting public health goals, there is no getting away from a well funded, well functioning, effective and efficient public sector in health care at all levels – from the village, the sub centre, the PHC, the CHC to the district level.***

### **Perspective of the Task Group on the public sector in health**

The criticism of the public sector in health in India is often a misplaced one as conclusions are being reached on the basis of under funded, under staffed, over centralized, non-accountable and inflexible arrangement for public delivery in some regions. Of course, there are large scale inter State and inter Hospital variations in provisioning, administration and responsiveness of the public sector. In spite of its constraints, there are many examples of outstanding contribution of the public sector in meeting health needs of people at primary, secondary and tertiary levels. The gains in Tamil Nadu, Kerala, Himachal Pradesh have been on account of a large public sector in health. The public sector in health in India needs to be re-crafted with a thrust on community ownership for autonomous Hospitals, flexible financing for local decision making, innovation in human resource engagement for service guarantees, monitoring against public health standards, and building capacities at all levels for effective decentralization. The National Rural Health Mission is one such concerted effort at crafting a credible public system, in partnership with the states. The Task Force saw partnerships with the non-governmental sector as a means to improve the accountability and service guarantee framework of public systems while recognizing that their role is to supplement public services in contexts where it is weak.

### **Need for a credible public system**

There are many reasons for advocating a large public sector in health. Firstly, it is less expensive than private health care. Secondly, it is often much more equitable, both geographically and socially. Thirdly, it is an opportunity for rational drug use and use of standard treatment protocols. Fourthly, it helps to keep the balance right between preventive, promotive and curative care. Fifthly, it insulates the poor against market led promotion of drugs and diagnostics.

Sixthly, it allows the state an opportunity to face up to unfair markets for drugs, diagnostics and other health services. Seventhly, it allows a greater possibility for convergent action, given the wide diversity of determinants of health – water, sanitation, women’s empowerment, education, nutrition, social and gender inequalities, cultural practices, etc.

**The challenge of crafting a credible public system – Need for partnerships**

The crafting of a new public sector for quality health services has to ensure availability of well skilled resident health workers who have the resources to meet people’s health needs. The public sector needs a large scale expansion of Community Health Workers, Nurses and para medics at all levels to take care of primary health needs. More Medical Officers and Specialist doctors are also needed to provide appropriate referral links at all levels. There is scope for partnerships with non governmental providers for public health goals given the large private sector in India. However, the group recognized the plurality and diversity of the profit and not for profit sectors in terms of size and distribution across rural-urban areas and States. It also emphasized the importance of regulating the private sector at all levels of care and was encouraged by the initiative to build capacities of rural practitioners and also introduce the Licentiate Scheme.

Accreditation of private providers at the secondary level, through transparent criteria and engagement of private professionals on a case to case basis are some ways of taking the partnership forward. The fact that the number of doctors in the rural health care public system is less than the annual graduation of MBBS doctors in this country is reason enough to explore partnerships to provide service guarantees. **Partnerships with professionals outside the public system are needed, based on trust and transparency, even to make the public system deliver quality services.**

### **XI Plan Working Group on Partnerships with the Non Governmental sector**

As part of its preparation for the XI Plan, the Planning Commission also set up a Working Group on Public Private Partnership in Health. The Working Group has already submitted its report and the same can be seen on the website of the Ministry of Health and Family Welfare. All the key issues with regard to the approach and perspective of such partnerships have been discussed in the Working Group Report. This Report therefore will focus much more on the operational issues which require full clarity of purpose and objective. The National Rural Health Mission (NRHM) Framework for Implementation had clearly articulated the broad framework for partnerships with the Non-governmental sector.

Paragraphs 36, 37, 48, and 49 of the NRHM Framework for Implementation document, on the role of Non-governmental sector, sum up the basic thrust of these partnerships under the NRHM. The paragraphs are reproduced below:

#### **Role of Non Governmental Organizations**

*“The Non-governmental Organizations are critical for the success of NRHM. The Mission has already established partnerships with NGOs for establishing the rights of households to health care. With the mother NGO programme scheme, 215 MNGOs covering nearly 300 districts have already been appointed. Their services are being utilized under the RCH-II programme. The Disease Control programmes, the RCH-II, the immunization and pulse polio programme, the JSY make use of partnerships of variety of NGOs. Efforts are being made to involve NGOs at all levels of the health delivery system. Besides advocacy, NGOs would be involved in building capacity at all levels, monitoring and evaluation of the health sector, delivery of health services, developing innovative approaches to health care delivery for marginalized sections or in underserved areas and aspects, working together with community organizations and*

*Panchayati Raj institutions, and contributing to monitoring the right to health care and service guarantees from the public health institutions. The effort will be to support/facilitate action by NGO networks of NGOs in the country which would contribute to the sustainability of innovations and people's participation in the NRHM.*

*A Mentoring Group has already been set up at the national level for ASHAs to facilitate the role of NGOs. Grants-in-aid systems for NGOs will be established at the District, State and National levels to ensure their full participation in the Mission.*

### **Pro-people partnerships with the non-governmental sector**

*The Non-governmental sector accounts for nearly 4/5 of health expenditure in India. In the absence of an effective Public Health System, many households have to seek health care during distress from the Non-governmental sector. A variety of partnerships are being pursued under the existing programmes of the Ministry, especially the RCH-II and independently by the States with their own resources with non governmental partners. Under NRHM, Task Forces are set up with experts, institutional representatives and NGOs. The RCH-II has development partners, including UN agencies. Under this the States are trying contract in, contract out, out sourcing, management of hospital facilities by leading NGOs, hiring staff, service delivery, including family planning services, MTP, treatment of STI/RTI, etc. Franchising and social marketing of contraceptives are already built into the FW programmes. The Immunization and Polio Eradication Programmes effectively make use of partnerships with WHO, UNICEF, the Rotary International, NGOs etc. The Janani Suraksha Yojana (JSY) has also factored in accreditation of private facility for promotion of institutional delivery. The Disease Control programmes make use of NGO partnerships in a big way. The Ministry also has strong relations with FOGSI, IMA, IPHA etc. which are professional Associations for dissemination of information, advocacy, creating awareness, HRD etc.*



*The Non-governmental sector being unregulated, the rural households have to face financial distress in meeting the costs of health care. The NRHM attempts to provide people friendly regulation framework that promotes ethical practice in the non-governmental sector. It also encourages non-governmental health providers to provide quality services in rural areas to meet the shortage of health facilities there. Such efforts will involve systems of accreditation and treatment protocols so that ethical practice becomes the basis for health interventions. NRHM encourages training and up-gradation of skills for non-governmental providers wherever such efforts are likely to improve quality of services for the poor. Arrangements for demand side financing to meet health care needs of poor people in areas where the Public Health System is not effective will also be attempted under the NRHM. The NRHM recognizes that within the non-governmental service there is a large commercial private sector and a much smaller but significant not for profit sector. The not-for-profit centres which are identified as setting an example of pro-poor, dedicated community service would be encouraged used as role model, benchmark, site of community centered research and training to strengthen the public health system and improve the regulatory frameworks for the non governmental sector as a whole.”*

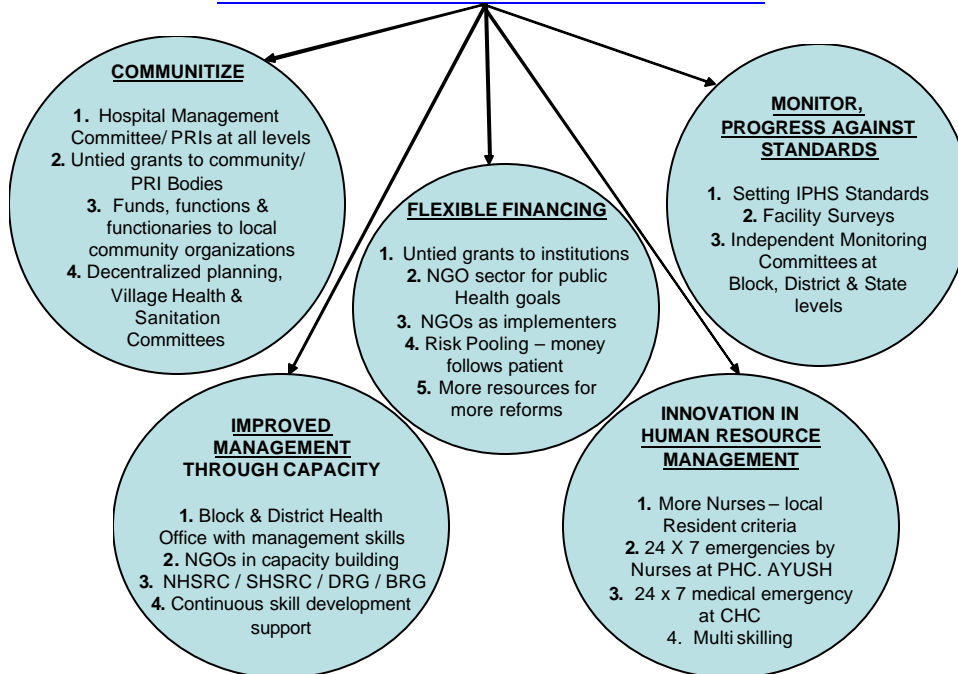
As has been clearly articulated in the Working Group Report, NRHM is about crafting an effective and efficient public system of health delivery. The thrust is on creating a fully functional platform for health care at all levels, from the village, the Sub-Centre, the PHC, the CHC, the District Hospital to the District and State levels. Meeting peoples’ health needs in rural areas through quality services that are affordable, accessible and accountable is its prime objective. The NRHM Mission document has also articulated the need for partnerships with the Non-Governmental Sector.

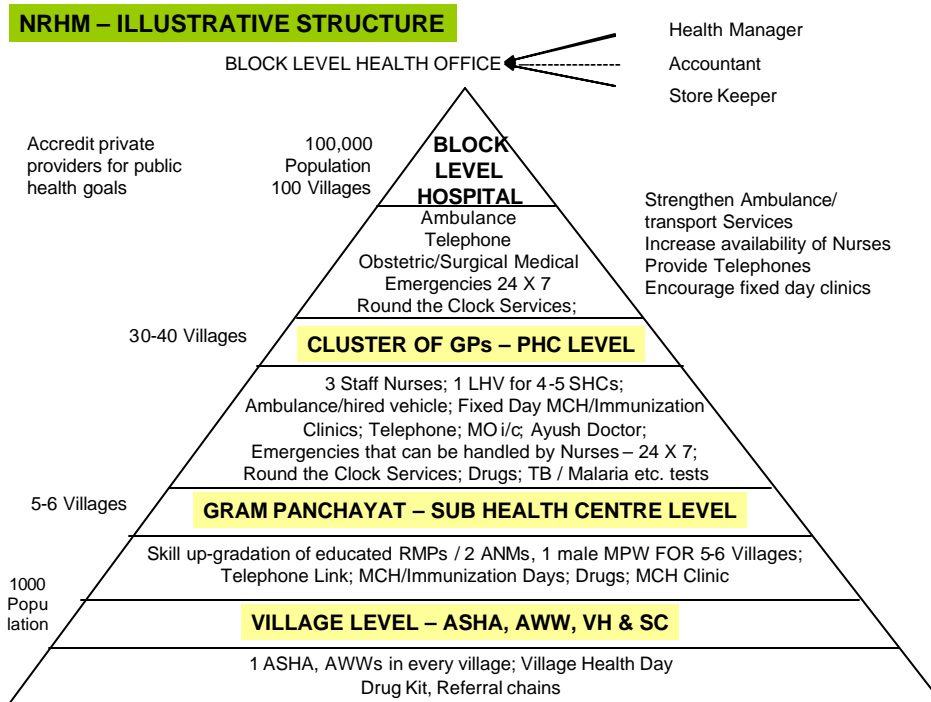
**Need for transparency and trust in partnerships**

NRHM welcomes partnerships with the Non-Governmental Sector in a fully transparent manner to ensure that quality services are available at

affordable costs to communities. Given the large scale presence of Specialist Doctors outside the Government system, the very act of re-crafting the public system, calls for innovations in human resource engagement. The Hospital Development Committees at District, Sub-District, CHC, PHC, Hospitals is an opportunity to move towards need based and health facility based engagement of Specialist services. The simultaneous effort under NRHM to add more than 300000 ANMs and Nurses to the system along side efforts at raising health facilities to well established Indian Public Health Standards are opportunities to make all our health facilities fully functional. Service guarantees and a focus on outcome is the key to success criteria for any organization. The re-crafting of the public system under the NRHM is based on 5 main approaches:

### NRHM – 5 MAIN APPROACHES





### **Distinction between for profit and not for profit**

The Task Force, while recognizing the presence of large Non-Governmental Sector in the health care provision in India, clearly differentiated between the not for profit Non-Governmental Organizations and the for profit private sector. The group was unanimous that improved service delivery and service provision require reaching out the remote regions which are often under provided. It is mostly the not for profit NGO that is willing to reach out in such areas. Therefore, in its recommendations, the Task Force was categorical in suggesting the creation of enabling mechanism of grants-in-aid committee at District, State and National levels which would facilitate the achievement of the NRHM norm of ensuring a minimum 5% expenditure of NRHM budgets through NGOs. Based on the experience of NGOs working in the remote Arunachal Pradesh to deliver health services at PHCs, it was felt that a special arrangement to encourage NGOs of repute to work in remote rural areas needs to be encouraged. It was also felt that such partnerships ought to be on a 100%

grant basis as there was no justification for the NGO contributing a certain percentage of resources to meet public health goals.

### **Need for Standards and Regulation**

The Group also deliberated on the need for standards and regulations that allow the private sector to follow ethical standards and standard treatment protocol. It was mentioned that a Clinical Establishment Act is under consideration and it can lead to formal self - registration of all health facilities in the private sector. It was also emphasized that Indian Public Health Standards for various categories of health facilities are as relevant for the Non-Governmental Sector as they are for Government. The Group felt that the process of accreditation of Non-Governmental providers undertaken as part of the Janani Suraksha Yojana (JSY) for institutional delivery following the Tamil Nadu Government's Criteria for Accreditation is a good beginning that will enable identification of Non Governmental providers. It was also felt that franchising as per agreed standards and costs as attempted by the Surya Clinics of Janani in Bihar or under the Yeshasvini Trust Health Insurance partnerships in Karnataka for standard surgeries at agreed costs are interesting examples that could be carefully looked at. There are many other examples of partnerships across the country and levels of care that need to be studied before replication.

Discussions were also held on the efforts made in Gujarat under the Chiranjeevi Scheme to involve private sector Gynecologists for institutional delivery of Below Poverty Line women. The Chiranjeevi scheme has been evaluated by the UNFPA and few issues have emerged as a consequence. One has to recognize the large scale contribution of this partnership in increasing institutional delivery and thereby reducing the maternal mortality. Some distortions like a tendency for some private Gynecologists to refer complicated cases to Government or to Government aided facilities needs to be resolved.

### **Need for Regulation in the health sector**

The non-governmental sector in India in health has grown rapidly in the last five decades. Neglect of the public system and its under funding has led to the private sector emerging as an important alternative for meeting health needs of people. It must be understood that the range of private providers is extensive and covers the best of hospitals to the worst of quacks. The cost of such care also varies from provider to provider and there are instances when over charging and unethical practices have been reported from the best of institutions. The very nature of health care makes it vulnerable to unethical practice. People seek hospitalized care during a period of distress and duress and are willing to spend any amount to ensure the survival and recovery of their family members. Health sector is fundamentally unfair and one reflection of it is the close proximity between medical research and its financing by drug companies. Close liaison of some doctors with representatives of drug companies is also an issue. While modern medicine has contributed significantly to improving well being, it has also led to a remarkable escalation in the costs of health care, the differences between cost of generic drugs and other combination drugs is also a reflection of how the pricing in the health sector is market driven. Given these vagaries of the private health care system there is no alternative but to balance it with an equally large and functional public system. Tamil Nadu is a very good example where the public system and the private sector in health care compete with each other to provide quality services. One cannot afford monopolies in health care and the under funding of health care by government has led to creation of such monopolies in many States. It is, therefore, imperative to increasing public expenditure on health and crafting a public credible system that draws on the skills of professionals.

Given its large pool of modern medicine professionals, India affords an opportunity to develop a credible functional system. However, there is also a

need for far better regulation of standards and costs of health care. For transparency and trust to develop it is important to visualize the creation of health regulator at State levels that could intervene effectively to ensure fair practice and treatment to patients both in government and private hospitals. The regulator needs to be an autonomous professional body that is able to enforce its directions effectively. **There is a need for a Public Health Act which could bring in the regulation and make adherence to basic standards a mandatory provision. It is only by moving towards a rights based perspective where obligations of providers are well articulated, will we be able to secure entitlements to health care for the poor.**

### **Experiences of Public Private Partnership in States**

A large number of partnerships with the non-governmental sector have been taken up under the various programmes funded by the Ministry of Health and Family Welfare and State Governments, in the health sector. There was already a large scale partnership with the non-governmental sector in programmes like Blindness and RNTCP. Various new forms of partnerships have been attempted in States. The Chiranjeevi Scheme in Gujarat for institutional delivery of BPL women in private nursing homes has been replicated in a few other States as well. Similarly, partnerships for outsourcing of basic services like provision of generator sets, ambulance, cleanliness in hospitals, diet for patients etc. has been attempted in Bihar and in many other States. Government of West Bengal has initiated partnerships with the non-governmental sector for its Mobile Health Clinics as also for expanding the capacity for ANM training. Non-governmental hospitals have come forward to share their case load for training of Auxiliary Nurse Midwives. Similarly the community worker programme of Mitans, ASHAs and link workers in States has involved non-governmental organizations on a very large scale in facilitation, training and resource support. Outsourcing of diagnostic tests has

been successfully attempted in Bihar and West Bengal. Diagnostics including x-ray is one example where the private sector has made investments in equipment and human resources in government hospitals to provide services at agreed costs and standards. In most cases of partnerships it is the agency of public expenditure on which the partnership is based. The successful management of PHCs in Arunachal Pradesh by Karuna Trust, Voluntary Health Association of India and other organizations is also an example of an emerging partnership that calls for trust and transparency. There are other examples in the field of Family Planning, Blindness Control, RNTCP where service provision at agreed costs and standards have been provided by the non-governmental sector. Success stories are also in areas of professional management as in the case of the Emergency Medical Relief Programme (EMRI) of Andhra Pradesh now being taken up in many other States. Provision of ambulances and human resources have been provided from public funds and Satyam Computers have provided the professional management needed for effective utilization of these services.

As the examples above indicate, partnerships with the non-governmental sector call for trust and transparency. The programme of handing over Additional PHCs to NGOs in Bihar had its limitations as District Administration was unwilling to certify and make payment to NGOs for services rendered. **The lesson from many of these partnerships is the need for defining obligations of the non-governmental provider as well as the government functionary very clearly. Without a detailed covenant of obligations and liabilities for not fulfilling obligations, it is likely that many such publicly funded partnerships will flounder in the absence of consistent support. We need to insulate such partnerships from the vagaries of administrative changes.**

Perusal of the Programme Implementation Plans of States indicates the thrust given to partnerships especially in difficult regions. Examples like the Janani Express in Madhya Pradesh whereby ambulances are available at the door

step on payment are good examples of how private funding has been brought into the sector. Examples of franchising like the Janani in Bihar and Yeshaswani Trust in Karnataka are also examples where private facilities provide a better opportunity to meet public health goals. Janani's experiment in providing professionals in government hospitals for regular fixed day services for Family Planning is another good example of improving efficiency and effectiveness of the public system through partnerships.

**An analysis of the proposals of the State Governments suggests the need for “letting a hundred flowers bloom”. The needs and situation of every State is unique and there is a need to allow for a diversity of approaches to partnerships. Thrust on transparency and trust will ensure that such partnerships are sustainable and in the interest of both the partners. More studies at national and at State levels to understand these partnerships will help in arriving at more effective models.**

### **Partnerships in Medical and Nursing Education**

The Group also recognized the emerging needs for partnerships in Medical and Nursing Education. The efforts of the Government of West Bengal to seek partnerships with the Non-Governmental Sector in training of ANMs was seen as innovative effort to improve the capacity building challenges in the short run. Some States have also issued advertisements asking for Expression of Interest from the private sector, to set up Medical Colleges with the Government providing District Hospitals for case load and mandatory requirements of 300 bedded hospital for Medical Colleges. While the private sector has evinced interest in some places, implications of this decision for cost of medical education needs to be examined to ensure that MBBS graduates of these PPP institutions are available for work in that State. Experience of States like Andhra Pradesh in large scale creation of MBBS seats in the private sector at high costs shows that



this has resulted in non availability of many medical graduates for Government Health services as the compensation available to them in Government is small compared to the cost of their Medical Education. While there is a case for improving compensation for doctors and creation of Class I Specialists' Cadres in States, very high out of pocket expenditure for medical and nursing education is likely to create a situation where the candidates so prepared would seek global markets and opportunities to recover investments made by them during their education. There is a case for Government subsidies for higher education both in medical and nursing from the point of view of availability of manpower in public systems.

**Hospital Committees – an opportunity for partnerships**

The Constitution of Hospital Development Committee in Government Hospitals and the mandate to them to ensure services guarantees is an opportunity for further development of partnerships for effective service delivery. Government hospitals through their Hospital Development Committees, with the appropriate hiring of Specialist doctors and diagnostic tests wherever required can actually facilitate improved service outcomes from different facilities. Every government health facility becoming a legal entity, allows partnerships for services at those levels. The Indian Public Health Standards for each such Hospital allows pursuit of basic service guarantees with the flexibility to hire locally. Human resource has been the greatest constraint in the past and these legal entities can help government hospitals to engage professionals on per case/per day basis. There is perhaps a space for HR agencies that can make available health professionals where they are needed. With a large number of private practitioners, it is actually possible to have a panel of private Specialist Doctors' panels in CHCs/District Hospitals, who can be called in provide services in public sector health facilities on a payment basis. The Human Resource partnership holds the key to service guarantees.

### **NGOs running PHCs**

Many Non-Governmental organizations have come forward to take responsibilities to run Primary Health Centres in many parts of the country. A very innovative experimentation is currently under progress in Arunachal Pradesh with the help of NGOs like the Voluntary Health Association of India and Karuna Trust. Such a window for partnerships with NGOs for service delivery, in remote regions or at public facilities where for some reason the Government delivery structure is not able to provide those service guarantees, would be an useful way to reach out services where they are needed. Such partnerships will require some high levels of innovation to ensure that NGOs provide the service guarantees that are kept out of public health facilities.

### **Outsourcing basic services**

The need for out sourcing simple arrangements like electricity provision, ambulance, cleanliness, laundry, diet, diagnostics, etc. in hospitals is well established. There are many experiments in the country where non-governmental provision improves the access to such facilities, if these are monitored effectively. While welcoming all forms of outsourcing based on transparency and trust, the task force would like to make the point that these work only in a framework of entitlements of health care seekers.

### **Need For PRI – Community Partnerships**

We have to remember that development entitlements have to be secured for those who are vulnerable, poor and often voiceless. Democracy has a way of crowding out the last quantile in development debates and public action. Even Panchayati Raj Institutions often fail to secure these entitlements for the poorest hamlets and habitations. The real challenge, therefore, is to craft delivery systems that can meet the diversity of needs and secure a voice to the people who ought to matter. It is for this reason that PRIs need local level partnerships with

community organizations at the habitation level, organizations of women, self-help groups, stakeholders, etc.

### **Flexibility in human resource engagement**

While hospitals and health facilities require more financial resources to perform better, they also require institutional autonomy and flexibility to deliver guaranteed service outcomes. It is difficult to seek better performance in a Government hospital or health facility without empowering the institution to exercise far greater discretion in decision making and in using financial resources. The role of the Head of the Institution has to be strengthened within a framework of decentralization that allows for accountability to local communities. Flexibility also demands that recruitment systems shift from non-accountable State Government recruitment to accountable local Government and local institution recruitment. The time has come when we require recruitment of nurses, para medics, doctors to institutions rather than to non accountable State systems. Local communities have to have a role in the assessment of satisfaction from a provider. When we start institution-specific recruitment we will also discover that in many parts of the country or in remote rural areas there is no substitute to a local resident. This would mean that we develop a Development Worker by providing support continuously for development rather than looking for an already developed professional, unwilling to work at the place where he/she is required. We need to adopt an incremental approach to developing local resident development workers. A system of developing local residents as development workers needs to be encouraged at a larger scale for accountability to triumph. There is no other way that problems of absenteeism can be handled. Non governmental organizations can facilitate this process of incremental development of resident health workers. They can also be a safeguard against misuse of discretion and flexibility.

### **System of incentives and partnerships**

Remote areas will require out of the box solutions. We will need to design a range of incentives that ensure service guarantees through availability of resident development workers. It may cost far more to keep a resident Gynecologist or a Surgeon in a remote rural area than in an easy urban location. This flexibility has to be exercised for a system to deliver and provide service guarantees. The incentives must be managed by institution specific societies whether it is a Hospital Development Committee or a committee under the umbrella of PRI. These specially crafted public institutions which are institution specific must have a mandate and the financial resources to provide incentives wherever required. The performance of these institutions can be monitored by independent research and evaluation institutions to see to the extent to which service guarantees are provided. Non governmental organizations can facilitate this process of innovations in human resource engagement.

### **Development Opportunities for professionals – NGOs in capacity building**

Building capacities and creating opportunities for growth and development are essential for retaining high quality and motivated manpower. Performance assessments and experience in the field must be important criteria for progression in the system. The State Governments can play a facilitation role in such processes. While regulation functions require direct State Government/ Local Government employment, development functions need to be employment opportunities with Societies, Trusts and Local Governments. State level facilitation systems will be required for appropriate guidance, counseling, and placement. The non governmental sector can provide useful third party platforms for continuing medical and nursing education and its assessment. It can also provide resource support to the Community Health Worker Movement.

There will be a focus on career progression and permanence but the permanence has to be linked with client satisfaction, judged by Third Party Assessments of performance. Public Service Commissions can have a role in Third Party Assessments of performance and in standard setting. The post will be permanent but the incumbent's employment will be subjected to client satisfaction. Performance benchmarks will have to be developed at each level for such systems to be effective. The proposal is not 'informalization' of the work force; it is much more for a community owned and accountable work force that is compensated on the basis of performance and need. It will be impossible to develop a cadre of resident development workers without greater flexibility in compensation and expected service outcomes.

### **Financing health care – need for partnerships**

The total expenditure on health in India is estimated to be anywhere between 4.5 to 5.5% of the GDP. Of this, the current level of public expenditure is less than 1% of GDP. The NRHM has made a commitment for increase in public expenditure to a level of 2-3% of GDP. Even if this were to happen, there would still be a substantial health care expenditure which is out of pocket and often made during distress and under severe duress. One also has to acknowledge that even though 30,000 MBBS Graduates pass out every year in our country, the entire rural health system up to the block level does not have more than 27,000 Doctors at any given point of time. The case of Specialists is worse with the vacancies in Government being extremely high. Specialists are largely available in the Non-Governmental sector and if we want people to have Specialist health services, we have to have mechanisms to enter into partnerships with them. The NSSO 60<sup>th</sup> Round 2004-05 has clearly brought out the fact that there is more than Rs.3,000/- expenditure in Government Hospitals in rural areas during every hospitalization, which is made out of pocket. The out of pocket expenditure in the urban areas and in private hospitals is 2 to 3 times more than

this. *Clearly, mechanisms have to be found to ensure cashless hospital treatment for poor households in Government hospitals.*

### **Making cashless hospitalization possible**

With this background and with the intention of the NRHM to strengthen the Public Health System, the efforts at developing a framework for Community Health Insurance/ Risk Pooling ought to include Government Hospitals as well. *Making cashless hospitalization in Government Hospitals through insurance/ demand side financing/Hospital Committee grants, for BPL families is a priority as far as design of Community Health Insurance/ risk pooling programmes go. This will also ensure higher utilization of Government facilities along with making money follow the patient in Government Hospitals. Additional incomes earned through Insurance in Government Hospitals could even be used for incentivizing the health workers of that Government Health institution.*

### **Need for more franchising models in the non governmental sector**

The other area where Insurance/ non governmental sector can play a role is in creating a franchisee system involving private hospitals for specialized surgeries. The Yeshaswini model of franchising where hospitalization for surgeries at fixed costs and as per defined treatment protocols and standards are provided, needs to be studied for possible emulation. This too will have to be resorted to in areas where hospitalized surgeries are available with the private sector. The Janani experiment in Bihar has also highlighted the potential of franchising. Closer scrutiny of such innovations will help in developing useful models of partnership.

### **Accreditation for quality services**

The other area of focus is through a process of Accreditation of Private Health Facilities in areas where the public system is deficient or likely to take

time in providing quality services. Already under the Janani Suraksha Yojana [JSY] for institutional deliveries, accreditation of Private Facilities is being attempted in every block of the country. This again could provide quality health services at agreed costs and standards. The system of franchising with standard treatment protocols and costs of specific services needs to be developed for this to move forward.

## Annex - I

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## **Annex - II**

### ***Record of discussion of the meeting of Reconstituted Task Force on Public Private Partnership held on 28<sup>th</sup> June, 2006 at 10.30 AM in the Committee Room, Nirman Bhavan under the Chairpersonship of Dr. H. Sudarshan, of the Karuna Trust.***

The list of the members who attended the meeting is at Annexure-I.

Opening the discussion, **Shri Amarjeet Sinha, JS (AS)** explained the Objectives of the meeting. He informed the Members that the Terms of Reference of the Task Group had been redefined to (i) suggest a framework for partnership to meet the public health goals of NRHM and (ii) examine the current systems of public private partnership and suggest modifications in systems of regulation and support for such partnerships. He also informed the members that for a proper mix of field based experience and academic learning it had been decided that Dr. H. Sudarshan, would Chair and Dr. Rama Baru would Co-Chair the Task Group. Shri Sinha also explained that the Task Group had been assigned three months for completion of its assignment.

Welcoming the members present, the Chairperson **Dr. H. Sudarshan** articulated the need for a clear definition of what constituted Public Private Partnership. According to him the word “Public” denoted Government, “Private” meant the Profit/Non-profit/Voluntary sector and “Partnership” did not mean contractors implementing government policy, but equal partnership in policy, planning, implementation, evaluation and research. He also reiterated that the public private partnership did not mean privatization of the health sector. However, there was no escaping from the reality that 80% of OPD cases and 50% of in-patient care was being serviced by the private sector. He

reaffirmed that there was a need for partnership at the district level for involving the community and for capacity building in the health system. However, the issue of **Accreditation** and **Quality** should remain the key determinants in partnership. He stated that in India, there was no Private Health Establishment Act to regulate the quality of the services being provided by the private sector. However, he cautioned that in the process of accreditation there should be no fallback to the License Raj.

**JS (AS)** thereafter made a detailed presentation on the Framework for Implementation of NRHM wherein he stated that the main objective of the National Rural Health Mission was to make the public health facilities fully functional. In the course of his presentation, he explained in detail the steps being taken by NRHM to strengthen the public system and the five main approaches for achieving its objectives. During the course of his presentation he highlighted the critical impediments in implementation of NRHM like shortage of 3 lakh nurses and the requirement of 12,000 Specialist doctors. Therefore, he reiterated that it was essential to explore a range of partnership options in terms of private sector support to nursing institutions and medical schools and colleges to make available the human resources required for NRHM. He also mentioned that partnership was not meant to be seen as a substitution for lesser provisioning of government resources.

**Dr. Sudarshan** and **Dr Baru** cautioned against Time Lines for NRHM as shown in the Framework. They stated that target settings had to be realistic as process building needed time and desire for numbers sometimes led to a bad quality product. They also highlighted the need for continued training for ASHA and others.

**Dr. C.N. Purandare, Secretary General, FOGSI** stated that there was an imperative need for a change of attitude from the British System of **“Can’t be**

**done**” to “**How to do it**” for any partnership to succeed. It was also important to give stature to the doctors and not just remuneration.

**Mr. Amar Jesani of CEHAT** expressed his concern about the issue of Regulation. He felt that there was an excessive concern for quality as the only objective of Regulation to the exclusion of other objectives like redistribution of services of doctors etc. He opined that if there could be a regulation on the number of schools which could be opened in an area, why the same procedure could not be applied for opening of Nursing Homes/Private Clinics for equitable distribution of health services. He was also of the view that there was a basic contradiction in the objective of strengthening of the public health system by the private sector in which the private sector would be the ultimate loser. Therefore, he stated that the partnership had to be long lasting otherwise the private sector would sabotage the whole process from within. He said pricing, transparency and accountability remained vexatious issues in the partnership process. He also stated that the quality and regulation should not only apply to the Private Sector but also to the Government Sector. He also emphasized that **equity** should underline the entire deliberation. He also stated that there was a need for documentation of the ongoing experiments in PPP and evaluation of their impact.

**Dr. Rama Baru, JNU** reiterated that private partnership did not mean abdication of Government responsibility but was meant for strengthening the public health system. She stressed the need for a framework of reference for the whole process of partnership which should not be ad hoc. She also emphasized the need for regulation for not only providers but also training educators and training facilities. She also felt that there was a need for a dialogue with the other task forces for e, g on Medical Education, Rural Medical Practitioners since there were many cross cutting issues involved. She stated that the power

relations in the partnership also needed to be understood. She also felt that there was a need to work on the costing of services.

**Shri Amarjit Singh, Commission and Secretary (Health) Gujarat,** highlighted the need for innovative methods for retention of human resource within the public health system. He informed that in Gujarat the payment mechanism for newly recruited staff nurses was partially based on the number of deliveries. He also stated that huge investments in capacity building and training was envisioned under NRHM but usually the capability of the person posted to man the training institutions left a lot to be desired. Therefore, partnerships in training and in running training institutes needed to be serious looked into. He stated that out sourcing the works of capacity building and communication had yielded commendable results.

**Shri T. Sundar Raman** stated that there existed wide difference between areas and regions. In States like Chhattisgarh the presence of the private sector was negligible. He also highlighted the need for differentiation between the private providers. He questioned whether partnership meant supplementing or passing on services to the private sector. He said that it was essential to build in monitoring structures when a policy of nesting of private practice within the public health system was being envisioned. He stated that the Indian experience in **Regulation** needed to be carefully looked into as very often regulation had insidious links with governance issues. He also stated that regulations had to be context specific and both public and private sector had to be accountable and open to transparent procedures.

**Dr Dharam Prakash, Hony Jt Secy, Indian Medical Association** stated that as the largest NGO in the medical field, the IMA had adopted 600 villages under the “Aao Gaon Chale” Programme. He stated that the problem of unemployment of medical professionals should be carefully looked into. The process of recruitment should be made simpler and incentives should be introduced and in doing so large number of people would be available for NRHM. He also cautioned against short course training in Anesthesia which produced “qualified quacks”. Instead he suggested that Diploma Courses in Anesthesia should be provided for in Universities.

**Shri G.J. Gyani Secretary General, QCI** stated that QCI had accredited 62 Clinical Labs. He stated that it was difficult to transport accreditation systems present in the U.K. and U.S.A. to India. Indian hospitals found it difficult to meet even the accreditation standards which the QCI had evolved. However, 12 Hospitals were under evaluation for hospital accreditation. He also emphasized that accreditation should have synergy with regulation.

**Shri Manoj of HLFPPPT** stated that a mechanism for sharing of the deliberations of the other Task Groups needed to be put in place. He also stated that the private players feel that there should be a formal contracting mechanism put in place. He also stated that the density of the private providers varied from place to place.

**Shri A.P. Singh, Director (DC)** argued for clarity on the definition of PPP. He argued that if the objective of the PPP was to enhance the quality of the public sector then what was the need for the private sector. He also expressed his reservation regarding lowering prices and enhancing quality which he felt was not in sync with the times. He also stated that the “For Profit” Sector was

not adequately represented. He also emphasized the need for differentiation between the Provider and the Regulator.

**Dr. Nita Jha, of Janani** expressed that regulations were very context specific and it was almost unenforceable in areas where there were single providers. Citing the example from the Janani experiment in Bihar, she stated that the clients were highly satisfied with the services even though it did not meet “standards” in the legal sense of the term. She also expressed the need for Anesthesia training for emergency operations.

**Shri Amarjeet Sinha, JS(AS)** reaffirmed the need for utilization of traditional knowledge in health system. He also stated that NRHM was a shift from ideology based to evidence based programme.

**Ms Archana Varma DS (NRHM-I)** made a presentation on three ongoing PPP initiatives in the States namely “Chiranjeevi” in Gujrat, “Vikalp” in Haryana and the “PHC” experiment in Arunachal Pradesh , highlighting in each, the programme design, funding pattern, management structures and the outcomes.

It was decided to constitute Sub-Groups to deliberate on the various issues highlighted in the discussion. The following Sub-Groups were constituted:

Sr. No.	Sub-Group	Members
1.	Regulation and Accreditation for the Public and the Private Sector.	a) Dr. Amar Jesani b) Sh. Sunil Nandraj c) Sh. J. Gyani – Member Convenor



2.	Evidence base for Public Private Initiatives	<ul style="list-style-type: none"> <li>a) Shri Amarjit Singh</li> <li>b) Dr. Amar Jesani</li> <li>c) Dr. Nita Jha</li> <li>d) Shri Manoj</li> <li>e) Shri Sunder Raman – Member Convenor</li> </ul>
3.	Framework for Partnership	<ul style="list-style-type: none"> <li>a) Dr. Rama Baru</li> <li>b) Dr. C.N. Purandare</li> <li>c) Dr. P.C. Bhatnagar</li> <li>d) Dr. Narayana – Member Convenor</li> </ul>

It was decided that the Sub-Groups would submit its preliminary findings in the next meeting on the 28<sup>th</sup> of July, 2006.

The meeting ended with vote of thanks from and to the Chair.

## **Annex - III**

***Record of discussion of the meeting of Reconstituted Task Force on Public Private Partnership held on 28<sup>th</sup> July, 2006 at 11.00 AM in the NUTIC Hall, NBO, Room No. 215, 2<sup>nd</sup> Floor, G Wing, Nirman Bhavan under the Chairpersonship of Dr. H. Sudarshan, of the Karuna Trust.***

The list of the members who attended the meeting is at Annexure-I.

Opening the discussion, **Shri Amarjeet Sinha, JS (AS)** apprised the Committee of developments that had taken place pursuant to the last meeting namely; approval of the Implementation Framework of NRHM by the Union Cabinet, constitution of another Task Group on Public Private Partnership (PPP) by the Planning Commission with Secretary as the Chairperson with a defined time line for completion by 31<sup>st</sup> August.

He also informed the Task Group that Prof. A. Venkat Raman of the Faculty of Management Studies, University of Delhi and a member of the other Task Group had shared a draft document analyzing 12 ongoing Public Private Partnership Projects in the States which would shortly be on the Website as a public document. He said that the document would provide good material for the evidence base group on PPP. In view of the defined time line for submission of the Task Group Report by the Planning Commission, he requested the members that if there was a broad agreement on key issues then a Preliminary Report could be submitted to the Planning Commission and the next meeting could be a joint meeting for the finalization of the Report.

Thereafter a presentation was made by **Shri Sunil Nandraj, WHO**, member of the Sub-Group on “Regulation and Accreditation for the Public and the Private Sector”.

He began by defining “Accreditation” as a voluntary process with set standards, provision for external review etc. Thereafter he detailed the initiatives on accreditation initiatives in India at the National level (QCI ,NABL) and at the State Level (AP, Karnataka, Tamilnadu, Kerala and Maharashtra). Thereafter he discussed the steps for development of Accreditation Systems ranging from compulsory accreditation, accreditation by independent agencies, facilitation of establishment of State Accreditation Councils to a blue print developed by the Ministry of Health & Family Welfare. In his end notes he also highlighted the significance of involvement of the stakeholders, capacity building, different bodies at different levels, and evidence base in the whole process.

**The Chairperson** thereafter invited the members for discussion on the issue of making compulsory or optional the process of Registration/Licensing/Accreditation.

**Mr. Amar Jesani of CEHAT** stressed that certain criterion which went beyond Quality was essential for setting up of health institutions. Therefore, registration and licensing were essential prerequisites. However, the basic components of the Rights based approach namely; availability, accessibility, acceptability and quality should be the broader framework for regulation within which registration, licensing and accreditation should fit in. Issues which went beyond quality like creating availability through redistribution of services should be made important determinants in setting up of health institutions. These parameters would help in the outflow of health institutions into peripheral areas. Accessibility may be created through financial access like Third Party

Administrators (TPAs) and voucher system. Acceptability of regulatory bodies like MCI may be through setting up of MCIs at District Level with emphasis on patient rights and medical ethics. He said that there should be some minimum standards for Registration, and Accreditation Systems can be used for anything above.

**Dr. C.N. Purandare, Secretary General, FOGSI**, however cautioned against over reliance on TPAs as many health institutions were facing difficulties in regular payments. He also agreed that medical ethics should emanate from all pockets and not from one nodal point. He requested for a mechanism to check frivolous complaints to the Consumer Forum. The Chairperson informed that this issue was beyond the scope of the Committee.

**Dr. Rama Baru, JNU**, endorsed the concept of registration with prescription and minimum standards. She said that accreditation also requires minimum standards and anything over and above that could continue to evolve at the District level.

The **Chairperson** was of the view that each State should fix accreditation standards and technical support for building registration system should be provided to them. **Dr. Purandare** stated that there should be a single window for registration of health institutions.

**Dr. Mahapatra** stated that the concept of accreditation was a “Mahasamundram” (vast ocean) and the focus on accreditation would make the Task Group loose sight of PPP, which had become a license for Governments to do whatever it liked. He said the defining criterion for any PPP initiatives should clearly entail value for public money and clearly identified risk sharing mechanism. He also advocated for AG Audit of PPP initiatives and said that in

the initial phase doables like running of PHCs under PPP may be explored subject to audit.

He also stated that the primary goal of any health system should be to guarantee “Professional Competency Assurance” to the public. For this all medical professionals including private practitioners should be registered under professional registration with the Medical Officer at the PHC, if he is functioning at that level or with the District Health Authority, respectively. These registers should be in the public domain available for public use and scrutiny. This would set up a national data base on professionals available under the system and also help in the judicial process.

**Shri Icchupujani, DDG (P)** endorsed the view that there should be maintenance of minimum standards. However, decentralization should be the key in setting up of standards and there should be an enabling environment to achieve the standards. He, however, cautioned that the recommendation of this group should not be in contravention of the proposed “Clinical Establishment Bill”.

**Shri Sunil Nandraj, WHO** stated that very few States have Clinical Establishment Acts as there were vested interests opposing the Act. Therefore, the Central Act should provide for registration at the district level.

**The Chairperson** endorsed the need for the Clinical Establishment Act as currently there was no redressal mechanism for health institutions (Example diagnostic Centres) owned by a non-medical person.

He also asked the members to respond on the issue of registration by an autonomous body to eliminate corruption. **Dr. Mahapatra** was of the view that since separation of public health and epidemic management from the

Government was not possible; therefore, registration should be in the Government domain as the Department responsible for epidemic management should be responsible for registration.

**Dr. Nita Jha, Janani** was of the view that maintaining standards and penalty clause for violation, was essential. However it was extremely important that the registrations were expeditiously given.

**Shri P.K. Hota, Secretary (H&FW)** who briefly participated in the deliberations was of the view that managerial issues and governance capacities within the public health system were key issues in determining the effectiveness of registration. He was of the view that in the initial phase self registration should be encouraged followed by an interim accreditation mechanism developed with the help of FOGSI/IMA before a fully e-governed registration system could be institutionalized.

He was also of the view that PPP had acquired significance under the 11<sup>th</sup> Plan as 50% of the primary health delivery was through the private sector. However, he cautioned against viewing the PPP as a tool for collaborating with the private nursing homes or for partnership with medical professionals only. He stated that it was equally important to have PPP with paramedics and nurses. Therefore, avenues for contracting out Para-medical services, alternate vaccinators may also be an important component of PPP.

**Shri Amarjeet Sinha, JS(AS)** said that the process of accreditation of Mother and Child Hospital specifying certain minimum standards had already begun in Tamilnadu for the Janani Suraksha Yojana (JSY) Scheme. He stated that under the NRHM the challenge was to operationalise structures to do accreditation at the local level and to evolve standards which was equally applicable for the public system. Since, NRHM would eventually move towards

a system of risk pooling, decentralized administrative mechanism be it in the form of TPAs or any other was needed to carry out the functions. He stated that the work of Health Insurance was being undertaken through the “Velugu” Project in Andhra Pradesh. Therefore, the challenge was to build the nitty-gritty of regulatory framework at the District Level. In this endeavour, though the lead could be taken by the Ministry at the National Level, the enabling mechanism had to be created at the district level which might challenge the monopolies of National and State bodies.

**Dr. C.N. Purandare, Secretary General, FOGSI** stated that the pregnancy and treatment for HIV should also be included in the package of reimbursement of insurance packages.

**Dr. Rama Baru**, Member of the Sub-Group on “Framework for Partnership” presented a brief outline of the framework which could be adopted by the Task Group. The draft outline for the framework highlighted the following:

- 1. Objectives of PPPs**
- 2. Potential areas of PPPs**
  - 2.1 Services, disease control and surveillance, diagnostics and medicines.
  - 2.2 Infrastructure
  - 2.3 Behaviour change communication
  - 2.4 Capacity building including training and systems development.
- 3. Experiences of implementing PPP models at primary, secondary and tertiary levels.**
- 4. Challenges faced in implementation of PPPs.**
- 5. Assessment of local needs and situation analysis for selection of PPP mechanism and potential areas for PPPs.**

- 6. Cost analysis of services.**
- 7. Defining contractual relationships.**
- 8. Process for implementation.**
- 9. Monitoring/evaluation/documentation**
- 10. Model contractual agreement(s).**
- 11. Technical support units at National and Regional and State levels for PPP design and implementation.**

She also stressed on contextualizing PPP in the NRHM context. Therefore, she reiterated that architecture should be available at the district level which is the cutting edge level under NRHM. Therefore, a regulatory frame work for the Rural Medical Practioners should be also defined.

**Dr. G. Narayana** suggested that it would be useful to call some stake holders for discussion before the work of drafting the document began.

**Shri Amar Jesani** stated that the evidence base for PPP needed careful examination. He was of the view that good evaluation of PPP initiatives had not been undertaken. The evaluation mechanism needed to highlight the issues of access, sustainability and audit systems. He also stated that initiatives which were less than six months old could not be evaluated appropriately.

**Dr. Rama Baru** endorsing Shri Jesani's view stated that the euphoria of PPP minus the evidence would be detrimental to NRHM. PPP should be for achieving common health goals and the work of the sub-group on Evidence base should develop sound parameters for judging the ongoing PPP initiatives.

**Shri Manoj, HLPPT**, Member of the Sub-Group on "Evidence base for Public Private Initiatives" made a brief presentation on the parameters for evaluating the ongoing PPP initiatives in the States. JS (AS) informed that Shri Sundar Raman was unable to attend the meeting. However, his suggestions for



the framework of Sub-Group which was being circulated to all the members could be perused. The format for PPP Rapid Appraisal Schedule suggested by Shri Sundar Raman inter alia focused on the programme objective, programme design, process of partner selection, management structure, process of monitoring, financing terms, outcomes, ensuring access to the poor etc. It was also decided that this Group would expeditiously make some State visits for first hand information on the ongoing initiatives.

It was decided that the Sub-Groups would prepare a preliminary report which could be finalized by the Sub-Groups on either the 11<sup>th</sup> or the 21<sup>st</sup> of August, 2006 in the forenoon session and a Joint Session with the Task Group set up by the Planning Commission under the Chairpersonship of Secretary, Health & Family Welfare, for appraisal of the preliminary report ,could be held in the afternoon session.

The meeting ended with vote of thanks from and to the Chair.