About this report

HANSHEP is a group of development agencies and countries seeking to improve the performance of the non-state sector in delivering better healthcare to the poor by working together, learning from each other, and sharing this learning with others.

On October 6-7, 2015, the HANSHEP group convened some of the leading stakeholders from the public and private sectors in Delhi to discuss mechanisms for developing and implementing a coherent Public Private Partnership (PPP) policy to support the achievement of Universal Health Coverage (UHC) in India. This report summarises the highlights from each session, reflecting on the opportunities, challenges and a way forward. The workshop benefited from the sustained inputs from a steering committee comprising the following agencies:

ACCESS Health International is a nonprofit think tank, advisory group, and implementation partner dedicated to improving access to high quality, affordable healthcare in low, middle, and high income countries. They advise national and regional governments and the private sector on the design and management of healthcare finance and delivery systems. They also identify and develop leaders in healthcare in the countries where they work.

The Health Systems Hub (the Hub) is a learning platform managed by Results for Development with stewardship from HANSHEP members. The platform supports knowledge exchange, networking and collaboration among global health practitioners, policymakers, researchers interested in mixed health systems.

The Faculty of Management Studies, University of Delhi focuses on management education across sectors. The approach to pedagogy combines fieldwork, case studies and instrumented feedback with a strong emphasis on concepts and theory.

The Public Health Foundation of India (PHFI) is a public private initiative that has collaboratively evolved through consultations with multiple constituencies including Indian and international academia, state and central governments, multi & bi-lateral agencies and civil society groups. PHFI is a response to redress the limited institutional capacity in India for strengthening training, research and policy development in the area of Public Health.

The World Bank group including the International Finance Corporation provides financing, state-of-the-art analysis, and policy advice to help countries achieve UHC. IFC’s roles include direct and indirect investment in health care and life sciences companies, sharing industry knowledge, raising management and clinical standards, informing government policy, and supporting public-private collaboration in health.
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DISCLAIMER

This report has been produced to disseminate the key messages and general discussion points of participants attending the workshop. It is not intended for use as a verbatim transcript, neither does its content necessarily represent the opinions or endorsement of the HANSHEP group, its individual member agencies or the organising bodies listed above.
Background

In India, nearly 80% of outpatients and 60% of inpatient care is provided by non-state actors (Draft National Health Policy 2015). As the country experiments with approaches to achieving UHC, policymakers are faced with the formidable task of understanding and working with a set of diverse non-state providers to enhance the scope, breadth and quality of healthcare services. Pockets of progressive innovation and public and private collaborations in health care are evident. However, scaling up these initiatives to benefit the poor and inducing discipline in the market has not always been easy. This has raised some strategic questions around opportunities and challenges of partnership, including:

- How to **develop coherent policy frameworks** for enabling, monitoring and regulating public-private collaboration in health;
- How to **promote alignment in federal and state** stewardship of the private sector;
- How to create **sustainable financing mechanisms** leveraging private actors for public objectives; and
- How to harness civil society and academic institutions to design **innovative delivery models** that reach the poor.

The workshop primarily demonstrated the experiences and challenges faced at the central and state levels in India, while complementing it with global examples where successful partnerships are now delivering positive results.
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Session One: Achieving Universal Health Coverage in India through Public-Private Collaboration: Targets, Challenges and Opportunities

Following a warm welcome from HANSHEP in-country representatives the workshop was inaugurated by a keynote speech and panel discussion consisting of high-level policy makers and thought leaders.

Mr. CK Mishra, Additional Secretary & Mission Director (NRHM), MoHFW

Mr. Mishra opened the event by raising a fundamental question often asked by policymakers on either side of the PPP debate – should the government be the ‘enabler’ or the ‘provider’ of health services. Urging participants to use the event as an opportunity to face this question head-on, he remarked that public-private engagement is unlikely to work without a more nuanced debate in which sustainability has to be one of the basic tenets of all UHC approaches.

On the whole, India has seen fewer examples of successful and sustained PPP in the health sector as neither the government nor the private sector has been able to articulate their needs and concerns effectively to each other. There are a few factors that have hindered this process.

Firstly, PPP discourse has been focused on hospital care rather than healthcare. Broadening the definition of PPP where the private partner shares the investment, risk and rewards and transcending the narrow contractual relationships often defined as PPP is necessary. Secondly, scaling up good examples of short-term partnerships has suffered due to the lack of a broader policy structure that can support these partnerships in the long-term. A clear articulation of where private sector investment is required to supplement public resources and compensate for government weaknesses is needed to help form a coherent whole across primary and secondary health care.

The speech concluded by emphasising the point that a partnership needs to be more than just a process of changing ownership of the same resources and underpin mutual responsibility and accountability.

What do YOU think? Join the discussion on the Health Systems Hub
Session Two: Developing a Coherent Policy Framework for Public-Private Collaboration: Perspectives from Home and Abroad

Chair: Professor A. Venkat Raman, University of Delhi
Prof K. Srinath Reddy, President, PHFI
Ms. Sheena Chhabra, Division Chief, Health Systems, USAID
Mr. Stefan Nachuk, Lead-Private sector Initiative, Global Health Group, UCSF

Following a brief overview about the forms of PPPs, the Chair highlighted the macro-level factors that had created an environment of mistrust between public and private sectors and had often led to the failure of PPPs. An absence of policy assurance to sustain private sector investment, unclear lines of authority at state or central levels to engage with the private sector beyond registration or transaction advice, weak government capacity to implement standards and accreditation, as well as inability to counter anti-PPP sentiments were some of them.

Panel discussions focused on the prerequisites needed to promote an enabling environment. Professor Reddy started by underscoring the need for increased public financing to make PPPs work for the poor- increasing it to at least 2.5% of GDP by 2017 and 3% by 2022. PPP, according to Dr Reddy, present several opportunities to harness the technological innovations of the private sector and address the acute shortfall in human resources for health (HRH). However improving the government’s capacity to monitor and induce discipline in the health market and forming PPPs with greater transparency would be essential to address the current trust deficit.

Ms. Chhabra articulated PPPs “as continuum of public-private engagement” ranging from regulation through to partnerships for service delivery. She added the need for policy makers to identify where the ‘sweet spot’ on this partnership continuum lies. She advocated the need for policy makers to start with a problem and to assess if private sector participation would be conducive to set the PPP discourse on the right trajectory. The implementation of PPPs has to address roadblocks such as poor communications, misaligned objectives and structural bottlenecks such as access to finance for lower-level providers.

“We should start with the problem we are trying to solve before we rush into partnering with the private sector, and then identify the key areas where it can make a difference and contribution.”
Ms Sheena Chhabra

When asked about the engagement and regulatory approaches for informal providers, she pointed out the great diversity in informal provision. A regulatory framework that enables engagement with informal provider associations may help to improve their knowledge and practice. However, some caution against piloting these projects with informal providers would be necessary to ensure a clear plan at the outset about long-term ownership of the programme.
Mr. Nachuk reflected on the significant demographic and economic shifts, as well as technological advances shaping the market-based thinking in health care in emerging economies. The private sector has been a driver for many of these changes and increased consumer power from the growing middle class has fed its growth. As a result, he conceded that health markets can appear confusing, as some decisions are by design, many are accidental and some of the consequences can be long-term. According to him “What constitutes good health services is not about public or private delivery – it is about the accountability, governance and regulation arrangements that are in place”.

In his view, private sector defragmentation is slowly underway as the providers organise themselves into associations and federations. This provides a ripe opportunity for a new interface for public – private engagement. Citing studies in 2009, he suggested that the ratio of public to private engagement in health across many countries doesn’t vary much over time, resulting in a ‘lock in’ effect. Countries have approached private sector engagement using a range of mechanisms including: a) strategic purchasing from the private sector, b) regulating quality, c) empowering consumers, d) shaping the markets to influence inputs and transactions and e) financial protection approaches – accreditation and purchasing under a scheme, and f) integrated PPPs for long term risk-sharing arrangements. He concluded by stating that PPPs are not a panacea and that they will only work if there is a buy-in from both parties.

Session Three: Promoting Federal and State Stewardship of the Private sector

Chair: Prof CAK Yesudian, Former Dean, School of Health System Studies, TISS  
Dr Ali Raza Rizvi, Joint Secretary, Medical Education, MoHFW  
Dr A Marthanda Pillai, National President, Indian Medical Association  
Mr Niraj Pawan, Additional Mission Director, NHM, MoHFW, Rajasthan  
Mr S. Soundararajan, AVP - Business Development, New Growth Engines & PPP and COO Manipal Ankur, Manipal Health Enterprises Pvt Ltd

The Chair remarked that the picture of the Indian health system has changed rapidly with the proliferation of the private sector. The government’s role has shifted from being a principal provider to one of a steward and the guarantor of health services. This evolution has now necessitated the government to negotiate and steer a system with non-state actors that are heterogeneous in their funding, legal structure, and objectives, etc.

Panel discussion in the session reflected on what is needed for the government to enhance its stewardship and structure a fragmented health system.
Dr Rizvi acknowledged the need for the government’s leadership to continuously evolve to set goals and make course corrections in a changing health market. But there are a number of hurdles to pursuing this approach owing to the lack of recognition by the government that the private sector is driven by profit and misconceptions about PPPs (often equating them to privatisation). He remarked that the states under the current structure are not adequately empowered to innovate and build systems that are suited to their context and are in need of support to attract private sector investment.

In his presentation, Dr Pillai advocated better targeting of government regulation and support to small and medium enterprises (SMEs) through loans that are contingent on delivering a defined package to the poor. Citing the example of private sector medical education to improve supply of HRH, his remarks underscored the importance of taxation policy to stimulate private sector growth in strategic areas of public health.

Mr. Niraj Pawan identified lessons on stewardship based on recent initiatives in Rajasthan while stressing the need to understand the characteristics of the private sector in a given context and the role of the government in relation to it. Through three specific examples of PPP for health services (PHC expansion, as well as the improved supply of diagnostic and tertiary facilities for the poor), he demonstrated the concurrent work needed by the states to improve policy and legal frameworks for private provider (for instance being very clear about where the liability lies in cases of death), while also implementing effective accountability structures such as “Rogi Mitras” (guardians) in all facilities to flag problems.

Mr Soundararajan called for HANSHEP to expand its canvass to include concern with better health for all and not just the poor. He added that there is a need to look at pro-poor models that reach the masses – with one of the solutions being in promoting preventative services to homes and thereby avoiding the need for hospital contact. Like preceding speakers he also called on policy makers for a long term perspective on PPP, adding that such contracts, which typically last for 7 years, do not cover the initial return on investment. As a result many players are currently underquoting in a bid to win contracts, making the partnership unsustainable in the long run.

Across all discussions there was acknowledgement that the private player will look at ensuring viability, if not profitability. Hence, defining the scope with utmost clarity is a key. Also choosing players based on deliverables rather than lowest bidders and choosing a longer time frame of at least 10 years are some of the critical considerations for policy makers.

“We are not handing over facilities. We are engaging private players to deliver services that were not available before”
– Niraj Pawan
Session Four: Financing health care –Lessons from Social Protection Schemes and Strategic Purchasing with the Private Sector

Chair: Dr Somil Nagpal, Senior Health Specialist, World Bank Group
Mr. Larry Rymbai, Rashtriya Swastha Bima Yojana, Meghalaya
Dr. Neeraj Kharwal, Mission Director, Uttarakhand
Mr. P. Boregowda, Exec Director, SAST- Head of Vajpayee Arogyasri
Nishant Jain, Deputy Programme Director, GIZ

The Chair’s overview highlighted that the new wave of Government Sponsored Health Insurance Schemes (GHIS) in India offer key lessons for strategic purchasing with and regulation of the private sector, as well as improved financial autonomy in the public sector.

The various central and state-based insurance schemes in India currently cover over 400 million people while representing only 0.4% of the GDP, yet they have become a crucial trailblazer for shaping the rest of health spending. 4 million of the 30 million hospitalisations are in the private sector, supported by the social protection schemes thereby indicating that GHIS have introduced an important framework for the concept of public financing for service provision through public and private channels. This presents an opportunity to regulate and incentivise the private sector to improve the quality of care options.

"4 million of the 30 million hospitalisations are in the private sector supported by the social protection schemes. This is far higher compared to less than a million hospitalisations supported by any other forms PPPs.”
Dr Somil Nagpal

The session’s discussion focused on three state-based schemes and a central health protection scheme as well as the lessons they have to offer on opportunities and challenges in PPPs.

Following a brief overview of the Vajpayee Aarogyasri, Rajiv Arogya Bhagya and the Jyoti Sanjivani schemes which cover 93% of the population in the state of Karnataka, Dr. Boregowda shared some of the key innovations and challenges. One key success across all schemes has been the ability to enhance the quality of services of the private sector through a strong phased accreditation process, split into three levels of accreditation. The phased approach put in place an acceptable benchmark for quality needed for the provider to enter the scheme and further incentivising them to move up the accreditation ladder. The scheme has also implemented an IT system to mitigate the risks of fraudulent claims, which has now fallen to 10% of all claims due to a strong pre-authorisation process.

Despite these gains, challenges with managing the performance and quality of providers persist. Overcharging patients and cherry picking lucrative procedures with higher reimbursement are some of them. Hence, now a robust monitoring system, whose inputs are constantly fed into a live information system, is necessary for course correction. In the earlier phases of the programme, the scheme initiated a strict blacklisting rule which radically brought down supply from 167 empanelled hospitals to 67 and proved counterproductive in expanding access. Hence the scheme continues to balance its incentive structure using a combination of ‘carrots and sticks’ to attain suitable outcomes.
Following a quick overview of Uttarakhand state-based insurance, Dr Neeraj Kharwal shared the experience of targeting beneficiaries in the scheme. He remarked that a focus on covering all non-tax paying beneficiaries (above and below the poverty line) distinguishes the scheme from those of other states, where eligibility is defined by ration cards or special below poverty line cards (which are harder to validate). The scheme is now set to expand the depth of coverage for all beneficiaries with a view that it would be a key mechanism for structuring and regulating the private market.

The state of Uttarakhand will also be launching a supply-side integrated PPP in collaboration with the World Bank Group. The scheme is designed to cover an entire district, including a district hospital (nodal center); two CHCs; and 3 mobile health vans, all of which will be managed by the private sector. The programme will also feature a ‘pay for performance’ mechanism, providing key learnings on PPP models encompassing primary and secondary care.

Mr. Larry Rymbai provided a brief overview of Meghalaya scheme before demonstrating its success in expanding coverage by incentivising the community health workers (ASHAs) that yielded impressive results for community engagement and empowerment. The positive spillover effect incorporating public and private sectors in the same scheme has resulted in noticeable quality improvement across hospitals through competition. Some of the major challenges however relate the lack of population-level data which had compromised the rate of enrolment in its initial phases.

Nishant Jain explained the implementation of the central RSBY scheme varied greatly by state, based on their levels of buy-in. With maturity RSBY has revealed a great potential in shaping the market for public and private provision. For instance, in 2008 when the scheme was first rolled out, only 5% of claims went to government hospitals. In 2013 this figure increased to 41% showing the noticeable impact it had on the public sector’s own provision through competition.

Despite the teething problems experienced in the beginning with issues involving poor coverage, poor registration of beneficiaries, fraudulent claims, etc. the impact of the scheme has been substantial, demonstrating the way RSBY can help link up a patient pathway from primary care to secondary care through effective tracking.
Session Five: Building an Evidence-Based Approach to Public-Private Collaboration- The Role of Academia

Chair: Professor A. Venkat Raman, University of Delhi  
Prof Dileep Mavalankar, Director, Indian Institute of Public Health Gandhinagar  
Prof V R Muraleedharan, Development Economist, Indian Institute of Technology, Madras  
Mr Siddhartha Bhattacharya, Country Director, Access Health International  
Prof CAK Yesudian, Former Dean, School of Health System Studies, TISS

The Chair opened the session by asking why the contribution of academia to facilitate dialogue between the private sector and government has often not worked. Questions posed to panel included a) Can the academia play a role in monitoring the characteristics of the private sector; b) can academia support training and capacity building and develop service delivery contracts which are agreeable to a larger group of people?; c) Can they advocate and create an ecosystem where academics have a more objective view on the public vs private debate?; d) How do academics build the evidence for the best model?

Prof. Muraleedharan cited a 2012 study undertaken by USAID, APAC-VHS, IITM and MSG on ‘Public Private Partnership in the Health Sector: Opportunities and Challenges’, analysing 22 states and over 110 projects, that highlighted the key challenges in PPP – mirroring many of the points raised in previous sessions, such as the lack of understanding of the private sector, problems with inadequate capacity and regulation etc. Challenges were then measured against six recommendations and sub recommendations which included – evidence based advocacy at central and state levels, strengthening processes for design, contracting, implementation and monitoring of PPPs; establishing PPP management structures; strengthening regulation of private sector, strengthening regulatory environment of PPPs and strengthening enabling environment. He added that “academia can play a major role in generating evidence for the impact but there is a need to think holistically, of which research is an important pillar”.

Prof Mavalankar citied problems inherent with PPP designs and the variability similar contracts can generate in different settings. He used the example of Cheeranjivi Yojana (CY) in Gujarat and a similar scheme in Madhya Pradesh, where a demand-side financing scheme has led to adverse incentives by either over-provision or under-provision of C-sections. He conceded that evaluations should not disregard loopholes, but it is necessary for research to focus on what worked, even in an imperfect scheme. Overall, the CY scheme’s successes were partly accountable to the government taking the concerns of the private sector into account in the scheme design.

“Evaluations should not disregard loopholes, but it is necessary for research to focus on what worked, even in an imperfect scheme.”  
Prof Dileep Mavalankar
Professor Yesudian remarked that the relevance of evidence is time bound or time specific, especially in a PPP context which is constantly evolving. So despite several studies on PPP there is no evidence to understand the characteristics of the private sector, in order to build an effective model of PPP. The major challenge to making this a reality was the limited research capacity in the country to compare schemes over time and deduce if they have been successful or what needs changing. Weak or inappropriate methodology and the lack of depth of research (which may for instance disproportionately focus on OOPs but less so on consumer experience), make it difficult for schemes to make course corrections. The lack of evidence in the public domain has also undermined their influence on practice.

Mr Siddhartha Bhattacharya cited the case of Emergency Management System (GVK EMRI), which covers more than 80% of India and over 850 million people, for emergency and non-emergency cases, through a single toll free number. The design of the program incorporated assessment for pre-hospital care, medical intervention and real time research to build an appropriate infrastructure. Research has been made an integral part of the project since inception helping to generate empirical evidence, impact evaluation, develop quantitative frameworks, disseminate knowledge and build capacity of providers.

The discussions gave rise to a number of questions a) should research on PPPs aim to support design or should it be independent and objective, b) what has prevented researchers from studying a given PPP model from multiple perspectives, and c) what support is there for such research? A discussion the panellists hope to continue with the wider community.

Session Six: From Dialogue to partnership: Practical steps for collaboration.

Chair: Dr Pranav Mohan, Investment Officer/ Health Specialist at IFC/ World Bank Group
Mr. Matthew Eliot, Principle Investment Officer, IFC/ World Bank Group
Mr Niraj Pawan, Additional Mission Director, NHM, MoHFW, Rajasthan
Dr Reena Nakra, Head, M&A at Dr Lal Path Labs
Mr. Sanjeev Vashishta, CEO, SRL Limited

The Chair opened the session by providing an introduction to PPPs—a long term contract for the government to buy a bundled package of services that are tied to performance. Despite their potential, he pointed out that global success rate for PPPs in health is only around 40-50% largely owing to a poor policy environment, lack of institutional capacity to manage them and political shocks. PPPs have also fallen prey to miscalculations about their long-term affordability and being developed in isolation from the wider health system.
Despite their capacity to mobilise capital where there are fiscal constraints, in the Indian context the use of PPPs in health have largely been limited for building efficiency and quality. There is a now a dire need to develop capacity to not just set up PPP but to continuously manage and monitor them. This is where the transaction advisors have come as brokers to support public and private stakeholders to design, tender, implement and monitor PPP agreements.

Matthew Eliot added to the above by remarking that the payment mechanisms set up within a PPP can be very complicated and a key contributor to failure, especially if they are not flexible enough to account for different levels of demand that may occur under the PPP. Added to this, payment security and timeliness can also pose problems to many providers.

Dr Reena Nakra concurred, noting the challenging environment for PPPs, although they can be flexible in achieving a variety of goals. She recommended legislation to enable PPPs, and urged public officials to ensure there is sufficient return on investment for the private sector to be incentivised to participate in PPPs.

Like previous participants, Sanjeev Vashishta also noted the importance of the regulatory environment at state-level to ensure the success of PPPs. Citing examples of two hospital PPPs that took a long to settle and mature, he added that states are often not enabled to enter into PPPs due to lack of expertise— as a result many of them lack clarity in their objectives. He also reflected on the tough environment in which PPP takes place with an innate suspicion about the private sector, often being viewed as unscrupulous and solely profit-oriented. This has grossly undermined PPP dialogues at the outset with many keen to see them fail.

While agreeing with the points made on payment mechanisms and clarity on PPP objectives of preceding panelists, Sunil Thakur observed that PPP in the Indian context had yielded more positive experience in GHIS contracting and accreditation than it has done for integrated PPPs. His comments also highlighted that there was a stark lack of PPP models in PHC where the private sector remains untapped and little has been done to attract private sector investment. This, accordingly to the speaker, is partly down to the expectation that such services should be free at the point of delivery. He also noted that PPPs have too often focused on demand and there is now a need to prioritise supply-side structures of any PPP model. For instance, the quality of data, especially to estimate demand, as well as flexibility at the PPP level to cope with mid-term corrections is often missing resulting in many PPPs being thrown into disarray.
The panel discussed the measures of PPP success and concluded that a range of indicators encompassing financial, clinical and social data was necessary to measure both performance and outcomes. Similarly knowing the unit cost of delivery in a PPP and whether government is charging more or less than the model proposed will help inform whether the PPP is appropriate or feasible. The panel suggested that pricing can be better managed by costing data being made available at the state and federal levels and payment security can be improved through contracts or tying the PPP to health insurance programs that are mature and reliable.

**Session Seven: The Role of Technology in Advancing Healthcare – Government stewardship for fostering growth and achieving scale.**

*Chair: Mr. Siddhartha Bhattacharya, Country Director, Access Health International*

*Mr. Srinivas Hundy, Health Care Lead, Reliance Foundation*

*Dr Kiran Rade, Nikshay, National Tuberculosis Control Programme*

*Mr. Partha Dey, Healthcare Lead at IBM*

In the opinion of Siddhartha Bhattacharya, “Technology has proven that it can unite to create one solution where you cannot separate what is public and what is private”. He opened the session by posing three questions to the panel:

1. How has health technology, especially ones in partnerships with government, worked around the world, and can these experiences inform us in India?

2. What are the lessons that we can share in the context of the regulatory framework, – where the role of government spans both a partner and regulator?

3. How can we take the discussion of PPPs into people, partnerships and performance?

According to Srinivas Hundy, ICT has a major role across the care continuum (awareness, diagnosis, treatment and follow-up); but it is a tool that needs to be used to address strategic gaps such as HRH, supply chain as well as help augment the role of PHC in a system dominated by secondary and tertiary care.

He described that Reliance Foundation is actively exploring 4G technology to help digitization from the primary care level upwards and optimizing the health care resources available. The Foundations project in Mumbai currently serves 400,000 people through a tertiary care center of excellence while widening primary health care (nutrition, oncology and MCH programs) in the community. The model is being used to gather evidence. Click [here](#) to find out more about he said.
Dr Kiran Rade noted that technology has been an integral part of the government’s TB eradication strategy that deals with the highest burden of TB in the world with an estimated 3 million cases reported annually. Launched by the Government of India the “Nikshay” PPP m-health programme uses a simple cloud based technology to identify, diagnose, treat and track treatment adherence as well as train, map and track referrals across public and private providers.

Dr Rade’s account of Nikshay, sharply contrasted with the more mixed feelings on PPPs from preceding speakers. He noted that the public and private facilities together treated 1.5 million cases of TB annually under the programme but the inclusion of the private sector has resulted in a doubling of TB cases being treated in regions. For instance an e-voucher programme (also developed as a PPP) in the state of Maharashtra noted a doubling of cases being treated by the private sector compared to the public and the data generated across both sectors have been integrated with Nikshay’s HMIS platform. Describing several similar innovations he concluded with a hope that many such schemes can be harmonised and scaled up for a far greater impact on outcomes.

Partha Dey described the contribution of IBM in controlling disease outbreaks through its collaborative work with the government. While concurring with preceding speakers on the role of technology, he spoke to the audience about the challenges that technological innovation can address with the growing ownership of mobile phones in India. This provides an opportunity to effectively target subsidy to the intended beneficiary and track outcomes. Using recent IBM examples, he described Digital tools – for example, tele health, Predictive tools –to forecast outbreaks of dengue (with recent models being tested in Singapore successfully) and smarter and connected healthcare – to ensure that health information is available to the provider when the patient reaches them. But his commentary also highlighted the need for the government to regulate this space by establish standards for interoperability and developing a platform for a national Electronic Health Record. The progress on this has been slow with the government only starting to reach out to private partners on options for their implementation.
Session Eight: Building Effective Systems for Monitoring Partnerships

Chair: Mr. Bathula Amith Nagaraj, Operations Officer, World Bank Group  
Professor A. Venkat Raman, University of Delhi  
Mr. Jorge Coarasa, Senior Economist, World Bank Group  
Mr Hemant Sahai, Managing Partner, HSA Advocates

The Chair and Professor Venkat Raman opened the session by stressing the importance of monitoring PPPs. The point was starkly made when Professor Venkat Raman outlined the findings of a recent research study that found that the best possible PPP contracts in India contained only 75 out of 194 minimum criteria required for the ideal contract. The evidence could be seen as a lack of maturity, leading to disputes arising from different interpretations and definitional dis-agreement, thereby making them difficult to implement. He also observed a lack of distinction between health infrastructure PPPs and service delivery PPPs among policy officials often leading to the exclusion of appropriate officials from PPP design and monitoring. Referring to the recent examples in the state of Bihar and in Delhi he noted that large service delivery PPPs often failed to adequately involve officials in MoHFW, making them largely simple transaction driven contracts that don’t adequately account for health market failures.

Mr Jorge Coarasa noted the lack of data has posed significant problem in monitoring and evaluation (M&E) of PPPs, not owing to the fact that there is limited appetite for M&E but because there remains a lack of effective systems to do so. Similarly, his observations also outlined limited information on the efficacy of PPP compared to direct public sector provision also due to the lack of data that enables meaningful comparison between the two sectors. All of these have led to global questions about whether monitoring is helping in improving PPPs and resolving dispute; which PPP model is of global relevance; and if there is any possibility of cross learning between countries etc.

Monitoring concerns were shared by Mr Alok Kumar, who believed that there should be a management information system for managing and monitoring the PPP. Learning from two experiences of PPP in Uttar Pradesh (UP) -RSBY and Biomedical Waste Management (BWM) was shared with the audience echoing the concerns about insufficient capacity and systems constraints, especially in the management of large contracts. Using the BWM example, Kumar explained that in the last decade the officials managing the contract had had developed little expertise in nuances of the contracting process or keeping a check on the partnership arrangements. The situation is only just started to be redressed with the recent adoption
of a draft PPP policy in the state and the creation of a health sector PPP cell mandated to plan, procure and contract health services.

According to Mr Kumar, the difficulty has been in managing such a platform with limited capacity at the district level; attracting quality service providers; poor patient feedback loop due to illiteracy; lack of performance indicators; and providers not fully geared up to make the system output-based. State authorities are learning the lessons and is now involving prospective bidders from the conception stage for new diagnostic PPPs in the pipeline, with inputs being taken from the field level functionaries. The systems are also being strengthened by central monitoring of performance by a web based software, as well as payment based on performance.

"Inherent incentive will attract provider and strong checks will reduce distortion.”
Mr Hemant Sahai

Hemant Sahai observed that PPPs in health are more complex than those in infrastructure due to subjectivity in its KPIs. According to him, the challenge is to reduce this subjectivity when formulating a contract and to strike a balance of incentives and penalties. He also added that it is important for the payment systems to account for fixed costs alongside performance incentives in the form incremental payment for achieving and outperforming KPIs. Mr Sahai concluded by offering insights to other emerging mechanisms for aligning commercial goals with public health objectives. This included cross subsidization models of PPP whereby a certain amount of capital is allowed to be used (at a considerably lower rate than the market value) by the private sector as well as an annuity models that changes the share between the government and private provider over time.

Session Nine: Priorities for Public-Private Collaboration

Ms. Kavita Narayan, PHFI
In her introduction, Ms Kavita Narayan remarked that there needs to be an urgent paradigm shift to move away from discussion about hospital beds to preventive and primary care that spans essential health care packages as well as non-communicable diseases. Hence, besides discussing PPP policy, there is now an equal need to understand how PPPs can help to improve gatekeeping and induce efficiency in the system. She asked the two subsequent panels to reflect on how the role of partnership may be augmented to take priority services to scale.

Chair: Professor Ramanan Laxminarayan, VP Research and Policy, PHFI
Mr. Girindre Beeharry, Country Director, Bill and Melinda Gates Foundation
Dr H Sudarshan, CEO, Karuna Trust
Mr. Gautam Sen, CEO and co-founder, Healthsprings
Dr Priyanka Saksena, Technical Officer, Primary Health Care, WHO
In the first panel discussion on **Primary Health Care (PHC)**, Prof Laxminarayan, noted that what is often missing from the PHC discourse is the emphasis on ‘process’ that translates inputs to outcomes. According to him, this often leads to crucial gaps in programme design and consequently impedes scale and measurability.

Building on the preceding speaker, Mr Sen stressed the importance of drawing out career paths for staff; having the right and transparent incentives structure for promoting good performance; and emphasising good management. But his account on processes in a clinical setting was contrasted by Dr Sudarshan who argued that PHC design processes have to lay equal weight on preventive programmes that can empower communities to make efficient choices. He proposed that PPP design in PHC needed to include community health worker and strengthen ties with the communities they intend serve through good governance.

Mr Beeharry while sharing views on good management with fellow panellists, highlighted the need to broaden focus to not just managing staff at the clinic but people who form the whole PHC architecture. Using the recent example of polio success, he observed that the nature of PHC delivery and outcomes are likely to depend on implementing and monitoring the correct architecture where the goals are well defined and individual incentives align with overall objectives.

"Pre-paid pooled financing is the way to finance care for agnostic delivery (public or private)."

**Dr Priyanka Saxena**

Finally, pro-poor PHC programming featured strongly in comments from Mr Beeharry and Dr Saxena, both of whom underscored the need to move away from out-of-pocket payments (OOP) to ensure equity. According to Dr Saxena, the divide between public and private sectors was irrelevant as long as the service delivery channels reaches the poor, delivers people-centric care and are financed through pre-paid risk pooling mechanisms. But to ensure quality control, besides standardisation, she cautioned against the current overreliance on ASHA(s) in light of their escalating workload.

Indicators proposed by the panel to measure PHC performance across public and private providers included: escalation rates to hospitals; chronic care management; re-use rate; adherence to protocol; patient to patient referrals (word of mouth); IMR/ MMR/ Communicable and non-communicable disease outcomes; community processes- how much is the community involvement; cost of providing the care; percentage increase/decrease in OOP spending.
The Chair opened the second panel discussion by reflecting on the preceding deliberations and stressing the centrality of PHC for tackling the rising burden of Non-communicable diseases (NCDs). He remarked that NCDs in India pose a major challenge to the already weakened public health system and risks impeding social and economic progress as more young people are affected by the rising epidemic of chronic illness.

According to Dr Ranjit Chaudhary, one of the biggest challenges with population level NCD intervention has been the lack of research in the area. With the majority of research focusing on disease specific intervention, little is known as to what works on the ground at scale. He proposed that PPPs could play a role to fill this gap as a formal mechanism to translate research to actionable programmes.

When asked about how best PPPs can support behavioral change, Dr Prabhakaran's account put equal emphasis on a) developing good policies such as a smoking ban or task shifting that engages different cadres of health worker on NCDs, and b) engendering good practice. For the latter, he urged behavioral change and communication to be contextualised so they can translate ‘awareness’ to ‘action’ and advocated the use of more traditional methods such as yoga that have more likelihood of uptake.

The panel concluded on a high note using examples of NCD interventions in states such as Kerala and Tamil Nadu. These southern states have successfully engaged with the Panchayat Raj Institution (Village-level governance) to provide NCD screening and treatment at village sub-centre while concurrently making improvements to medicine supply chains through the use of technology.
Where do we go from here? Suggestions from participants

**More research**
- Need for objective appraisal of the success factors and outcomes of PPPs.
- How to build up the capacity of the government?
- How to resource PPP research?
- Probing study into how other sectors apart from health influence PPP outcomes in health

**More exchange**
- More courses on involvement of the private sector in health.
- Organise workshop at the state-level where the action is, allowing for more in-depth discussion
- A thematic workshop on HRH and PPP
- Consolidate national-level forums for a harmonised PPP dialogue.

**More collaboration**
- Bring together fellow participants to establish joint learning on PPPs

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  [http://healthsystemshub.org/groups/47/posts](http://healthsystemshub.org/groups/47/posts)

Conference Participants

*This workshop included participants from:*

Abt Associates  
Access Health International  
Apollo Hospitals  
Bill and Melinda Gates Foundation  
Centre for Health Informatics, National Health Portal  
Children’s Investment Fund Foundation  
Department for International Development (UKAID)  
Faculty of Management Studies, University of Delhi  
Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ)  
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