Public Private Partnerships for Urban Health: Experiences and Lessons from Urban Primary Healthcare

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Abstract

In India public healthcare services are inadequate to cater health needs of rapidly growing population and owing to unsuitable timings and compromised quality their usage is low. Though private sector providers are widely present, they also have limitations to be accessible to large population. However, both public and private sectors in collaboration using comparative advantage of their capacities can extend and improve utilization of health services among large population, especially rapidly growing urban poor. Various examples of collaborative initiatives of public sector and different private sector stakeholders are being practiced in the country to ensure health services to the urban marginalized populations. The paper, from these examples, identifies the mechanisms and feasible strategies for public and private sector involvement and draw lessons and good practices. These lessons need to be incorporated in policy provisions to guide public and private partnerships for ensuring access of poor in urban areas to health services and to achieve the goal of Universal Health Coverage.

Introduction

WHO (1999) defines partnership as a "means to bring together a set of actors for the common goal of improving the health of the population based on the mutually agreed roles and principles". The core elements of partnership include, Beneficence (public health gains), Non-malfeasance (must not lead to ill health), Autonomy (of each partner), and Equity (benefits to be distributed to those most in need). PPP does not necessarily mean collaborating with large corporate hospitals, nor do they mean direct contracts with clinicians, but find ways to join hands with a broad spectrum of non-governmental actors. Private health sector

comprises of all health care services providers who exist outside the public sector. They may be small or large, non-profitable charity organizations or commercial for profit oriented, may operate in remote areas or urban centres, treat illness or prevent diseases, involved in curative services or preventive services (Mills, et al. 2002). They could also be diagnostic centres, ambulance providers, blood banks, commercial contractors, religious institutions, industrial establishments, local or international development organization, and community groups. It is also important to distinguish PPP from privatisation. There is a danger that under pressure to economise, the governments may opt for partial or full privatisation, which is contradictory to the objectives of PPP, where larger number of non-profit organizations is required to be involved.

The health care system in India has been evolving steadily over the past six decades with the PHC concept introduced to cater to health needs of a largely rural country by Health Survey and Development Committee (Bhore Committee) in 1946. Over the IX, X and XI five year plans, the Government of India has been endeavoruing to augment the public health care system to provide preventive, promotive and curative health care services in pursuance of the Govt's commitment to provide affordable, acceptable and sustainable health care to all. While there has been improvement in some indicators, there are a few issues which indicate that we have a long road to travel. These issues include: a) several indicators such as childhood immunization, childhood under-nutrition have either remained stagnant or worsened; b) disparities between the urban poor and the remaining urban population have increased.

These disparities are expected to be further deepen with rapidly growing urban poor populations as India urbanises fast, if efforts are not taken to effectively address them. In the last decade the overall population has grown at a decadal population growth of 21%[1]. As per the population growth estimates the current 1144 million population of India is expected to grow by 1400 million by 2026[2]. Population growth among the poor population is further higher and their number is expected to increase at a much rapid pace. Along with this rapid population growth health needs of poor are also rapidly increasing.

There has been considerable effort to evolve partnerships or collaborative arrangement between the public and private sectors for health care. Many stakeholders including the Government see the synergistic approach combining the capabilities and comparative advantages of the public and private sectors as a potentially feasible approach to strengthen health care services. It is important to note that partnership or synergy or public-private mix as is discussed in this paper is in no way suggesting "privatization' of health care.

This paper is an attempt at: a) Anaslysing current access to public and private health care especially of the poorer segments; b) understanding complementarities of the public and private sector health providers; c) identifying lessons learnt and best practices from health policy interventions for rural and urban poor in India; d) identifying feasible mechanisms and strategies for engagement of the private healthcare sector to improve access and quality of care for underserved populations in rural and urban India

Access of Public and Private Health Services to the Urban Poor

Poor access of healthcare services to the urban poor

The access of health services among the poor population is restricted and due to many inherent constraints the use of public health services among them is low. According to the NFHS-3 (2005-2006) among poor households iron folic acid tablets which are recommended for good health of women and children are available to only 49 percent pregnant women. 83% pregnant women are forced for unsafe delivery of babies at home. Facilities of complete immunization are available to only one-fourth of children and nearly two third poor children are devoid of the services of complete immunization. Half of the children in poor households suffered with diarrhea, prior to last two weeks the NFHS 3 survey, could not be taken to health facility for treatment[3].

Government healthcare services at many places are inadequate and their quality is not appropriate as a result their usage is low. At many of the places timing of the health facilities is not suitable to the poor. Therefore, even among the poor the existing public healthcare services remains underutilized. This reach of health services is limited not only in rural areas but among urban poor settlements as well. Since hospitals and higher level health facilities are centered in urban areas, it may appear that health conditions among urban areas would be better. However,, a re-analysis of NFHS-3 data for urban areas by wealth quartiles reveals that among urban poor families a) only 56% pregnant women are not able to get recommended three ANC checkups, b) 44 % mothers deliver their babies at health facilities and 56% give birth to babies in unsafe conditions at home; c) 60% children among urban poor do not receive complete immunization; d) 45% urban poor children with diarrhea did not receive treatment[4]. Thus despite concentration of health facilities in urban areas the access of health care services is restricted.

Inadequate public health care services and their low reach to poor

Out of pocket expenditure for accessing healthcare services in India is 87% which is one of the highest in world[5]. This high medical out of pocket expenditure may annually push a large number of households (nearly 2.2 %) below poverty line[6] . This has severe implications on well being of 27.5% (301.7 million people) population staying below poverty line[7]. For their healthcare needs, the poor are mainly dependent on government health services. However, public spending on healthcare services has been very low, only around 1% of the GDP[8]. As a result government health services fall short of fulfilling the health needs of the poor.

Even the existing limited healthcare services, instead of benefitting poor serve the interests of non-poor. Studies indicate that subsidy on healthcare services largely reaches to middle and upper income groups and poor remain devoid of this government subsidy. People of poorest quintile get only 10% subsidy provided on curative services and 77% of it goes to richest three quintiles[9]. Due to this disproportionate utilization of subsidy despite more health problems a person form the lowest wealth quintile is six times less likely to access hospitalization than a person from richest quintile[10]. As a result government health services remain largely out of the reach of poor and marginalized who need them most.

Patient's Perception of quality of public healthcare services

Apart from the limited public health infrastructure, other problems also plague the public health care service delivery. These include inefficient management systems, weak referral linkages, duplication of services, lack of meaningful quality standards, lack of accountability, absenteeism, indiscipline and low morale among the staff, large number of vacancies, insufficient pay and incentives, and unsatisfactory working conditions.

A study conducted by IIPS11 reflects that even in urban areas the infrastructure is poor and quality of public healthcare services is compromised. It indicates that functioning of more than two third (68%) Urban Health Posts and Urban Family Welfare Centers is average or below average, their referral mechanism is weak. There is lack of sufficient manpower at public health facilities, nearly 30% sanctioned posts of medical officers at health posts and UFWCs are vacant and these are run my ANM or MPWs12. There is also lack of essential equipments, drugs and other supplies. In addition week and irregular outreach further restricts the reach of services to the poor. A study of eight Indian cities (Mumbai, Kolkata, Chennai, Hyderabad, Delhi, Indore, Nagpur, and Meerut) found that the most commonly reported

reasons for slum dwellers not using government facilities were poor quality of care, excessive waiting times, inconvenient opening times and the lack of nearby government facilities (Gupta et al., 2009). In addition, patients, including women, who perceive quality of facility-based care to be poor, choose to avoid facility-based deliveries, where life-saving interventions could be available[13]

Wide presence and usage of private healthcare personnel

An important option for improving health services in both rural and urban areas is partnership between public and private sectors or a "Publi-Private Mix"(PPM). It is estimated that 93% of all hospitals, 64% of all beds, 80% of doctors, 80% of outpatients and 57% of inpatients in India are accounted for in the private sector. The reliance on the private sector is higher in low performing states. For example the reliance on private sector is highest in UP and Bihar[14]. The private sector provides 79% of outpatient care for those below the poverty line, though much of which is of low quality and the payment is primarily out of pocket[15]. Despite these limitations of the private sector, it is perceived to be easily accessible, better managed, and more efficient and given the choice, as per micro level studies, 75.6 percent people prefer to visit private sector healthcare services[16].

Public and private sectors in partnership, despite their constraints, can extend reach of health services to poor and most needy sections by complementing each other through sharing resources, technology, skills and management techniques. Sharing of resources and techniques has the potential to improve equity, efficiency, accountability, quality and accessibility of the entire health system[17]. In the next section a brief review of different modes of public private partnership has been made and an attempt has been made to draw lessons from these partnerships to make PPP initiatives more effective.

Experiences and Lessons from different forms of public-private (Non-Govt) partnership/mix for healthcare provision

A public-private mix is considered desirable to address the needs or the rural and urban poor. This section discusses examples of a number of different types of partnerships/synergies, involving NGOs (private non-profit), charitable hospitals, individual private practitioners, and marketing/retail outlets.

This section is based on review of the literature on partnerships as well as the author's personal observations and association with some of the under-mentioned initiatives.

Partnering with NGOs for managing government Health Centers

When partnering with NGOs, different methods have been adopted for ensuring a synergetic effort and better impact. In some of the models, the private providers (NGOs) manage Government health facilities for providing health services. This model has been used in rural area as well as in big metropolitan cities in several states. For example State Government of Karnataka has established partnership with Karuna Trust for managing 24 primary health canters in rural areas to extend health services to tribal community[18]. It aims to develop and test a model of community health financing, increase access to and usage of public healthcare services to rural poor[19]. Similar partnerships have been taken up in cities for providing health services to urban poor population.

Under IPP-VIII, Arpana Trust in Delhi and Sumangali Sewa Ashram, Shri Sharana Seva Samaja, and Lions Club, Church of South India and Red Cross in Bangalore manage 13 Municipal Urban Health Centers in Bangalore. The municipal corporation of Delhi and Bangalore handed over all management function (hiring of and salary disbursement to staff, accounts, maintenance of infrastructure, mobility for outreach etc) to the NGOs (private partner). Vaccines, drugs, family planning materials, IEC materials are provided by the government via a monthly indent[20].

In Delhi, the Municipal Corporation of Delhi (MCD) partnered with Arpana (a private trust) to run a dysfunctional MCD urban health center in an urban poor community since July 2003. A five-year MoU was signed, whereby MCD provided the building, some medicines and vaccines; Arpana Trust was in-charge of staff salaries, running expenses and community volunteers. Arpana Trust also mobilised additional resources from nominal user fees, corporate, individual and other donations including the Prince of Wales Trust. Arpana Trust improved the quality of services by providing affordable diagnostic services, services of part-time, visiting specialist consultants, and outreach services. This partnership continued till 2012 when Municipal Corporation of Delhi was split into three Corporations.

In Andhra Pradesh, Urban Health Centres were managed by NGOs, Andhra Pradesh[21] Under the World Bank assisted Andhra Pradesh Urban Slum Health Care Project

(APUSHCP), 192 Urban Health Centres (UHCs) were established in 74 Municipalities of the State, starting in the middle of year 2000. While the UHCs were established by the State, their day-to-day management was contracted out to local NGOs and/or service providers. Every UHC was assigned a definite slum area, clearly demarcated in terms of the boundaries; average population of each UHC being 15-20,000. The UHC is located within the slum to ensure easy access for the target population.

Involvement of NGOs in the management of government health facilities reduced the management and supervision burden from the government. The private partners also supplement public sector resources with their own. For instance, in Bangalore, NGOs are sustaining the entire staff, outreach, mobility and operational cost (except vaccines and drugs) through their own funds[22]. They have prevented the health centers from shutting down as has happened in several instances after IPP VIII funding from the government ended in 2002. This mode of partnership liberates the health centers from traditional procedural delays of the government as NGOs are more efficient and take quick decisions and actions. The collaboration also provides opportunity to the government to get feedback from the private sector on various management issues of the health facilities.

How these partnerships operate in a city?: Every UHC is assigned a definite slum area, clearly demarcated in terms of the boundaries; population coverage of each UHC is up to 20,000. The UHC is located within/very close to the slum to ensure easy access for the target population. The premises for operating the UHC are provided by the Government but are managed by the NGO selected for the purpose. In UK the state health society has partnered with NGOs for running U-PHCs from rented premises including outreach services. In Delhi, the Municipal Corporation partnered with NGO whom they had provided constructed premises to run the Urban-PHC and outreach services.

Partnering for providing Primary OPD, outreach and referral services through private hospital or rented premises

In another arrangement, NGOs provide services from their own hospital under a government contract. The Government of Assam entered into an arrangement with Marwari Maternity Hospital (MMH), a private, non-profit maternity and child trust hospital in Guwahati, to provide RCH services in identified low-income wards of the city, having a total population of about 220,000[23]. The partnership was undertaken with support from the European

Commission funded Sector Investment Program in Assam. Under the agreement the State Government provided financial assistance to the hospital for adding to its facilities in return for outreach and referral services that the hospital organized in eight identified slum clusters of Guwahati. In addition, vaccines and contraceptives are provided free to the hospital. It is mainly providing RCH services but the outreach team includes a doctor and they also treat minor ailments and refer patients to the hospital. In the MMH hospital, sterilisation, spacing and abortion services are provided free of cost to patients, while deliveries, operations and diagnostic tests are charged at concessionary rates.
Similar partnerships have been done by Government of Tamilnadu with private hospitals for providing referral cases (neonates, obstetric, childhood illnesses) from governmental hospitals.

In the contracting out of outreach and other services model as in case of Guwahati, the Government benefits in being able to rapidly expand services to the un-served and underserved areas and migrant population with help of a local service provider while saving on infrastructure and staff expenses as well as supervision burden.

Uttarakhand Urban Health Program[24] - The program reaches reach communities in the under-served slums of the city through a Public Private Partnership approach with non government organizations (NGOs) working with a non-profit motive. The initiative was started in early 20010 and has been running successfully since. Full range of Maternal and Child care services is provided in the UHCs (except delivery). Immunization is also provided in door to door outreach to the community houses.
The urban health program in Uttarakhand focuses on: a) RCH services, b) including laboratory tests (including Hb, other blood and Urine examination), c) outreach in slums, d) referral to public sector hospitals/facilities using referral slips; treatment of minor/common illnesses. RCH services include maternal, neonatal, infant and child healthcare, including referral to public hospitals for delivery and, post natal care, immunization, Vitamin A supplement, family planning and spacing services. The UHC staff also promotes use of sanitary latrines, access to safe drinking water.

Collaboration with individual practitioners to provide part time services

In several cities partnerships with private doctors / specialists for providing health services through government health facilities on fee sharing/part time basis have been tried out under IPP VIII in Kolkata and with Arpana Trust in Delhi and also in Municipal Corporation of

Greater Mumbai and Thane in Maharashtra. In similar partnerships for providing emergency obstetric care at FRU due to non availability of anesthetists for surgical interventions, Ministry of Health and Family Welfare, GOI has allowed State governments to engage the anesthetist from the private sector on a payment of Rs. 1000 per case at the sub-district and CHC level[25]. This form of partnership helps preventing paralyzing services in case of vacant positions. This partnership could also help getting need based expert support especially in the remote areas where experts are not available.

Government - NGO partnership for regular outreach clinics

There is also collaboration with NGOs that facilitates providing outreach health services by Public Health System. Partnership of Department of Health and Family Welfare, District Indore, with Urban Health Resource Centre (UHRC) for providing health services through monthly outreach MCH clinics in about 200,000 population of underserved slums is such an example. Between 2008 and 2011, UHRC involved five NGOs, slum-level women's groups and private doctors for facilitating reach of health services in un-served slum communities.
In a similar partnership with private sector agencies The Government of Tamil Nadu has initiated an Emergency Ambulance Services Scheme in 10 districts of Tamil Nadu for providing maternal care and reducing maternal mortality rate in rural areas.

Partnering for increased utilization of government services through enhanced demand and linkage

In some of the areas, despite availability of health facilities, marginalized sections are not able to use them and the health facilities remain underutilized. For example in urban areas many of the health facilities remain underutilized as poor due to lack of awareness and low confidence hesitate to access their services. Recognizing this in Indore and Agra, Urban Health Resource Centre coordinates closely with the Health Departments of concerned state governments and periodically trains slum women's groups (Mahila Arogya Samiti's as mandated in the National Urban Health Mission of Government of India), to make the community aware and mobilize them for utilizing services of existing government health facilities. The empowered women's groups of slums and informal settlements are able to pull regular Outreach Health Services by

Government and Private Providers in Migrant, other Deprived clusters community based organizations motivate community to access healthcare services and promote healthy behaviors. These partnership approach help making the community aware of health services

and ensure optimal utilization of existing health services by motivating poor to access the healthcare services. Based on the sustained success of Urban Health Resource Centre

implementing these strategies in Indore and Agra, Ministry of Health and Family Welfare, Government of India mandated slum women's groups (as "Mahila Argya Samiti") in National Urban Health Mission (NUHM). Urban Social Health Activists identified from trained slum women, ANM mandated in NUHM to identify vulnerable pockets, improve service access, infection prevention, promote healthy behaviours.

Social Franchising for extending reach of family planning services

Franchisers in the health sector, who establish protocols, provide training for health workers, certify those who qualify, monitor the performance of franchisees, provide bulk procurement and do brand marketing. They have been successful in rapidly expanding reach of health services to population which have been traditionally difficult to reach. The best known franchising model in the health sector in India is the Janani model[26] which is operational in Bihar and Madhya Pradesh. The model has incorporated clinical services and using private sector channels such as network of shops that stock and sell contraceptives in un-served rural areas. The franchisee network provides counseling to village communities ("butterfly centers"), and a franchisee network of qualified doctors make available family planning services ("Surya clinics"), such as pregnancy tests, IUD insertion, sterilization, as well as medical termination of pregnancy.
Such franchisee networks can be easily expanded to improve access of RCH services in poor communities in the areas having a large pool of private providers.

Voucher Scheme for improved access of private sector health services

In the scheme vouchers are provided to the beneficiaries to purchase health services from a list of health providers who are generally close to target community. The clinics are

reimbursed for the number of clients treated (or the number of vouchers collected). An example of the use of vouchers to subsidize health services is the Local Initiatives Program (LIP) funded by the Bill and Melinda Gates Foundation and managed by Child in Need Institute (CINI) to make medical RCH services accessible in Kolkata's 12 most backward and underserved slums, covering approximately 240,000 people.

As part of the program, a referral network of 29 qualified private physicians who practice in the vicinity of slums was established. The referral network is based on a system of referral slips or vouchers which entitles beneficiaries to two visits (initial and a follow up) to any one of the private physicians. For maintaining quality of service, it is ensured that physician follow standard medical protocols for common illnesses and prescribe generic drugs from the essential drug list. The physicians received payment based for the number of coupons returned to CINI. In this system, the government benefits from a cost effective mechanism to increasing access of health services with limited subsidy leakages. The participant doctors also benefited from increased volume of patients, potential to cross sell other services and increased goodwill and foot hold in the community. The poor communities are benefited by increased access to services which were previously unavailable. Initiatives to increase access of urban poor to private facilities/providers with fees have been tried in many countries. For example a "voucher scheme" was implemented in Uttar Pradesh during 2007 to 2012 to improve access to maternal healthcare, associated diagnostic services and family planning services from empanelled private health facilities paid by a government agency[27]. Vouchers provided limited purchasing power to obtain a designated set of private health services.

Schemes for Private Sector Involvement in Government Health Programs

Recognizing that NGO's have a distinct advantage in the delivery of health services particularly to the disadvantaged sections, the Ministry of Health & Family Welfare have many schemes to involve private providers, especially NGOs, in various disease control programs and for improving health infrastructure in un-served and underserved areas including urban slums. Financial assistance is made available to voluntary organizations under various schemes for improvement of medical services, running hospitals, dispensaries in rural as well as urban areas, to provide family welfare, primary health care, promoting innovative and experimental concept in MCH, immunization, family planning and communication. NGOs have also been involved in the Government's effort of population stabilization by involving them in reproductive and child health program.

The National Urban Health Mission recommends partnership with NGOs and other private health agencies to expand healthcare to unreached urban vulnerable settlements as per the situation in the city concerned. NUHM lays emphasis on urban primary health care by mandating One Urban Primary Health Centre (U-PHC) for every fifty to sixty thousand population; b) One Urban Community Health Centre (U-CHC) for five to six U-PHCs in big

cities; c) One Auxiliary Nursing Midwives (ANM) for 10,000 population, d) One Accredited Social Health Activist ASHA (community link worker) for 200 to 500 households or 1000 to 2500 vulnerable population[28].

Complementarities of public and private Sector

Above PPP examples reflect that public and private sectors are not competitor rather they complement each other for extending reach of services to marginalized sections. Public sector has a constitutional mandate policy back up and wide network of health facilities to provide healthcare services to all. Private sector with a range of service providers and having 85 percent of medical professionals along with wide accessibility among poor, can support public sector of fulfilling its constitutional mandate of providing services to disadvantaged.

On account of weak planning and managerial rigidity in public sector their services have limited reach. However, private sector, especially NGOs owing to their commitment and passion to serve the poor and being flexible in adopting new techniques and management approaches can address health needs of poor effectively, if partnered with public sector.

Private sector due to their limited capacity has low breadth of interventions and many times their services are expansive to afford by the poor. Consequently their services are difficult to scale-up for catering health needs of poor in large geographical area. However, by collaborating with public sector the reach of health services could be widened to a large area, as public sector has provisions of subsidized and free healthcare for poor. Moreover, public sector having equal focus on preventive aspects can make a stable improvement in health conditions in poor settings.

Most of the government primary health centres on account of their relatively low quality of services and unsuitable timings to poor are sub-optimally used. Private sector having better physical presence in poor habitations, having advantage of their flexible timings and with skills of community mobilization can support public sector for extending reach and increasing use of their service among the poor.

Thus, public and private sector by partnering and complementing efforts of each other can ensure access of health services to all particularly poor and disadvantaged sections.

Suggested approaches and way forward for their effective operationalization

Analysis of the existing PPP approaches shows following lessons for effective operationalization of public private partnerships and extending reach of services to the poor and marginalized sections.

Selection of the appropriate partner based on management capacity and commitment to the cause holds the key to successful PPP and positive outcomes.

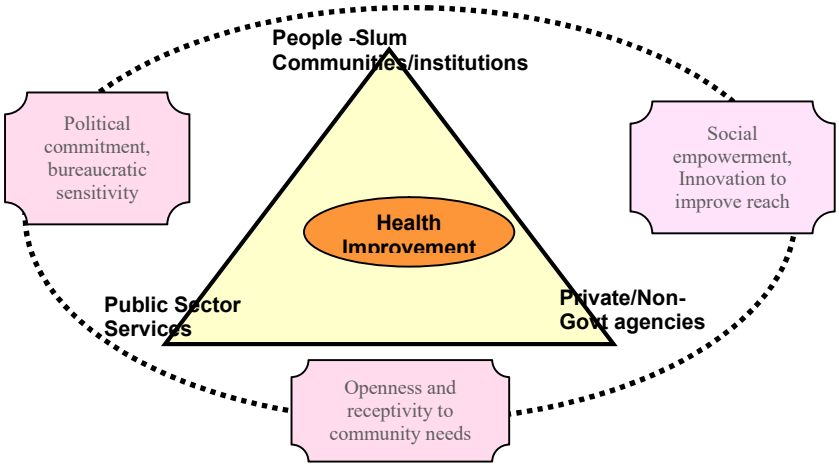
A key component of most successful public-private partnership (PPP) initiatives has been the emphasis on selecting capable and credible partners. The IPP-VIII project has witnessed greater success in those areas where NGOs working in that particular geographic area and with an agenda similar to that of IPP-VIII have been selected. Similarly, the success of partnership initiatives in Bangalore, Delhi, and Guwahati has been attributed to the selection of NGOs who have considerable experience of working with slum communities. In Orissa, the experiment of handing over the management of health facilities in a rural area met with failure as the NGOs did not have the required resources and skills to manage health facilities.

Thus in the areas where public sector facilities are not available NGOs with prior presence should be contracted to deliver health services rapidly.

Commitment of partners in non-health community development activities can lead to value addition. It has been observed that committed NGOs like Arpana Trust in Delhi, Saath in Ahmedabad and Sumangali Seva Ashram in Bangalore have added diagnostic and specialist services in their primary health centers. They have also been involved in community development efforts like vocational training, educational programmes and sanitation improvement which have improved their credibility among the community as well as being of significant benefit to them. In addition these activities help NGOs to deepen trust among communities for effectively mobilizing them. It is important that such endeavors get government support and do not get held up due to bureaucratic hurdles.

Need to evolve Public-Private-People Partnerships

It is critical to ensure that urban disadvantaged communities including migrants and informal settlements, which are the intended recipients of augmented health care through partnerships and synergies be included as integral partners. This will help in the approach/initiative reaching to the neediest and also serving them with sensitivity.



Vital to build in measures for accountability of health services:

Experiences Indore, Agra and other Districts have shown that empowered groups/organisaitons of slum women/men can effectively interface with public and private provider and have a VOICE: These serve as a mechanism for accountability of private providers. Empowered community groups are a potent approach to ensure that private providers continue to provide affordable services at agreed and optimal levels and that the poor are not left high and dry in an hour of need/medical exigency. A coordination forum at the level of a block, ward, health centre or larger area involving public sector departments and non-govt stakeholders has also served as a mechanism for facilitating accountability in terms of regularity, timing, responsiveness and affordability of services Such a coordination forum which can also be an adapted form of a Rogi Kalyan Samiti), should essentially provide space for the 'voice' of consumers/poor communities through the creation of a grievance redressal cum suggestion mechanism

It is important to focus on expanding reach of services rather than investing in creation of new infrastructure

It is observed that starting services early on even in makeshift facilities, and initiating demand generation activities minimizes loss of precious project time due to preoccupation with infrastructure development activities. In this regard, the Guwahati model in which health services to the urban poor were expanded rapidly using the private partners' infrastructure was far more cost-effective than IPP-VIII experience in Hyderabad and Delhi where significant resources and time were invested in infrastructure creation without commensurate returns[29.] Moreover, development of permanent infrastructure needs to be carefully assessed

in an urban slum setting where most residents are migratory, their reverse migration and event of slum resettlement could make a health facility redundant. In order to avoid time lag in expansion of services due to infrastructure building it is desirable that existing infrastructure of private partner is used and efforts be focused on early services provisioning.

Need for model instruments to expedite and expand partnerships

Lack of model documents is the most common and biggest bottleneck in initiating and implementing a public-private partnership. In view of the evolving nature of PPP in India, lack of experience among government as well as private sector providers in developing contracting clauses, identifying credible private partners, quality control norms, uniform rate lists and monitoring and evaluating performance is an important impediment. For instance, the partnership of Municipal Corporation of Delhi (MCD) with Arpana trust became functional only after a long gap of two years. This was partly due to lack of experience in formulating contracts and also due to lack of trust and a skeptical attitude among the government for partnership with private partners.

Making model Memorandum of Understanding, Terms of Agreement, Terms of Reference and other instruments available to government agencies and private providers would help initiating and operationalizing the partnerships with out delay. Further sharing of experiences and lessons learnt from existing partnerships may facilitate new initiatives that can be built upon these experiences.

Appropriate sustainability strategies have to be thought right from the initiation of project activities as project funding is limited and time bound.

The health centers established by the India Population Project - VIII (IPP-VIII) project faced an imminent threat of closure after the project funding ended. It has been observed that capable NGOs have been sustaining services even after project funding ended. For instance, in Bangalore, NGOs are sustaining the entire staff, outreach, mobility and operational cost (except vaccines and drugs) of health centers established by IPP-VIII through their own funds[30]. They have prevented the health centers from shutting down as has happened in Hyderabad after IPP VIII funding from the government ended in 2002.

Similarly, the health centers constructed with IPP-VIII funding had not been operationalized due to lack of resources by the MCD. Arpana Trust which has been assigned one of the health centers had been operating it successfully with limited support from MCD[31]. Arpana Trust in

Delhi had mobilized resources from donor agencies and other philanthropic contributions. The trust has also been successful in roping in a large pool of doctors who volunteer on a periodic basis. The specialist services offered by the health center are entirely operated by volunteer doctors.

However, such capacity is not found in all NGOs. It is thus essential that capacity of partners to mobilize resources is made an integral part of partnership strategies and should be initiated from the beginning of the project.

Private medical practitioners can be partnered for effective service delivery

In the areas where public sector facilities have limited effectiveness due to staff constraints, private medical practitioners and specialists can be roped in government health centers to provide RCH services on a part-time and fee sharing basis – as tried out in IPP-VIII in Kolkata. This not only resulted in relieving substantial government burden on salaries but also resulted in improved access and utilization of health services to the poor. The non-poor also availed the services at a higher cost than beneficiaries, which reflect on their quality of care. NGOs can also be involved in increasing demand of health services by training Urban Accredited Social Health Activists, other members of slum women's groups to promote preventive, promotive and timely care seeking behaviours as being implemented by UHRC in Agra and Indore.

Social marketing and franchising can help rapidly expanding services among remote and difficult areas particularly services such as family planning, ORS distribution. Establishing protocols, providing training, certification and logistical and marketing support to private practitioners (both qualified and informal) has shown improved access to quality RCH services which have been traditionally difficult to reach such as remote rural areas and urban slums. Both social marketing and franchising can be relatively more successful in areas where there is demand for products and services and a larger pool of private health providers to tap into. The government can promote and subsidize the franchisee networks and social marketing companies to provide health services and products in the areas where government services are difficult to reach.

Conclusion:

In a country of a billion and a quarter people with huge socio-economic diversities like India, it would be a grave challenge for any one sector alone to be responsible for provision of health care to the poor. Government partnerships with the private sector are necessary to ensure that a larger pool of stakeholders and providers with complementary capabilities working collaboratively to improve access, reach and quality of affordable health care for the rural and urban poor. In order to strengthen and expand such synergistic collaborations, learnings from existing initiatives need to be included in policy and program guidelines. It is vital to ensure that the focus of such partnerships remains pro-poor so that the under-privileged sections of our population can benefit for such partnerships as a matter of priority. What is important to note is that a collaborative and synergistic partnership of the private and public sector health care providers or a "public-private mix' as it is referred to in several circles is in no way suggested to imply in this paper privatization of health care or abdicating responsibility by the State. A strengthened public sector using resources and innovative, flexible and context specific strategies to synergise capabilities and strengths of different existing services providers can improve the reach and utilization of services and achieve the goal of health for all. Public Sector - NGO partnerships are vital for strengthening health services for underserved urban populations. Carried out with devotion, purpose and commitment, such partnerships will be able to actualize the aphorism: "The whole is greater than the sum of its parts" [32].

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