PPPs in Primary Health Care in Arunachal Pradesh

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Abstract: *This study of PPPS was conducted in six districts of Arunachal Pradesh which were selected on the basis of active implementation of the PPP programme in running PHCs. This report elaborates on some of the major findings of the study.*

In India, a large infrastructure exists for providing health care services. However, the facilities are not properly utilized because of lack of community participation and poor quality of services. Since the major thrust of the government is on providing quality health services through existing health care infrastructure, a good option is to explore the possibilities of working together with Non Governmental Organisations (NGOs) for improving the quality of services as well as making ways for easy access to services (Tekhre et al 2004).

In recent years important role of primary health care in helping to achieve these aims; providing cost-effective healthcare to the general population has been recognised. Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals in the community through their full participation and at a cost the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination (www.who.int/hpr/NPH/docs/declaration_almaata.pdf).

The Government of India is interested in exploring ways to partner with the private sector to improve health outcomes for the poor. Among the options available to improve the performance of the Primary Health Care system, one is to appoint the private sector to operate failing PHCs in partnership with government under Public Private Partnership (PPP).

The idea of PPP has increased in popularity over the past few years in India. An examination of this term is necessary to understand the actual partnerships being proposed. The private sector has had a growing share in various sub–markets such as medical technology, diagnostics, curative health care pharmaceuticals, hospital construction, ancillary services and curative health services. It is estimated to provide 81 per cent of outpatient care and 46 per cent of inpatient care in India. 68 per cent of India's 16,000 hospitals and 37 per cent of its 60,00,000 beds are in the private sector (Ghosh 2008).

History of PPP

Until the late 1970s, governments and development agencies contracted the private sector to execute large infrastructure projects, such as railroads, sewers, and road networks (Widdus 2001). The rise of neo-liberal ideologies, such as globalisation, free markets, privatisation, and competition, in the late 1970s and early 1980s coincided with the international debt crisis

of 1982. The poor performance of state-owned enterprises and governments' unsuccessful involvement in market processes in many countries became apparent. This was followed by a wave of deregulation, liberalisation, and privatisation across the globe in the 1980s and 1990s. The performance risk for all projects shifted from domestic taxpayers to private investors. Subsequently, influential international organizations began to champion a greater role and more responsibility for the private sector in providing efficient and cost-effective public services (Buse K and Walt G 2000).

The development can be summed up as contextual shift in PPPs. These are as follows:

- An ideological shift in the 1990s from "freeing" the market (i.e., liberating business from restrictive bureaucracy) to "modifying" the market (i.e., creating a facilitating environment);
- A growing disillusionment with the UN and its agencies and their overlapping mandates, parallel programmes, and interagency competition;
- An increasing recognition that the health agenda is so large that no single sector or organization can tackle it alone (Buse K and Walt G 2000);
- A realisation that the market alone cannot solve the problems of the world's poorest. Public involvement is needed if health services, drugs, and vaccines are to reach the poor (Widdus 2001).

The Indian polity and economy had envisaged development on socialist principles. However, with the economy in doldrums, the need for liberalisation became essential. The government infrastructure was crumbling. The need for public-private partnerships arose as a result of inadequacies on the part of the public sector to provide public good on their own, in an efficient and effective manner, owing to lack of resources and management issues. These considerations led to the evolution of a range of interface arrangements that brought together organisations with the mandate to offer public good on one hand, and those that could facilitate this goal though the provision of resources, technical expertise or outreach, on the other (Nishtar 2004).

Since 1992 Health Sector Reform, the importance of private sector involvement in the delivery of health services has been highlighted in successive plan documents, committee and commission reports of the central government and by bilateral and multilateral donor agencies. During the past decade, several state governments in India have experimented with encouraging private sector involvement in health care. The private sector have been involved in delivering health care services to the poor and underserved sections of society.

There can be a wide spectrum of arrangements between the public and private sector to provide public services. At one extreme, government plays the role of a provider. At the other extreme, services are fully privatized and the role of government is limited to that of a regulator. According to the United Nations Development Program (UNDP), the broadest definition of Public Private Partnerships includes agreement frameworks, traditional contracting, and joint ventures with shared ownership (Ref.). In this study, Public Private Partnerships included the spectrum of possible relationships between public and private players for the cooperative provision of infrastructure and/or services in health.

Overview Study Area

Arunachal Pradesh is a state with vast hilly area spread over 83743 sq. km in the north eastern part of India. In terms of area, it is the largest state in the north eastern region. The population of Arunachal Pradesh is a total of 1,091,117 persons with 573,951 males and 517,166 females and a density of 13 persons per sq.km.

The universe of the study comprised of the people living in and around the catchment area of the six districts of Arunachal Pradesh. These six areas are as follows:

1. Deed Neelam PHC, Lower Subansiri District.
2. Gensi PHC, West Siang District
3. Lumla PHC, Tawang District
4. Nacho PHC, Upper Subansiri District
5. Sille PHC, East Siang District
6. Thrizino PHC, West Kameng District

The sample was chosen by purposive sampling. It was adopted because the density of population was very low. The average size of the villages was between eight to ten households.

The model that is adopted in operating PHCs in Arunachal Pradesh is contracting out model under which the PHC is handed over to NGOs. This is a major initiative towards Health Reforms in Arunachal Pradesh. The project also hopes to link the tasks to be accomplished under the National Rural Health Mission with the resources available with the State Government, the civil society, local bodies and the community.

Since the study was empirical, the primary source of data was field level data supplemented by secondary data. The primary data source was information collected through interviews from the targeted beneficiaries who in this case were the community members in areas around the PHCs and the key stakeholders of the PPP programme such as PHC staff, members of the government health structure and related personnel. The sources of secondary data were contract documents/ Memorandum of Understanding (MoU) of the PPP, the health information system documents and others policy documents of the state government pertaining to the PPP.

The study was exploratory in nature as the PPP programme introduced in the state was in its nascent stage. Hence, interview schedules were used for people living in the catchments areas of the PHCs and semi structured interviews were used with key informants at the state, district, sub division and circle level.

Reality of Partnership in Arunachal Pradesh

On the basis of data that was collected from the six selected PHCs in the current study, the researcher has attempted to undertake a SWOT analysis of the umbrella partnership in running PHCs in Arunachal Pradesh.

The SWOT (Strengths, Weaknesses, Opportunities and Threat) analysis is an analytical tool widely used to identify both advantages and problems associated with the performance of an organization. It is also used to derive insight in management related problems. The SWOT analysis for these PHCs can be summed up as follows.

Strengths and Weaknesses

The strengths included the availability of at least one doctor in the six PHCs after the NGOs have taken over the PHCs where often no doctors were available previously, availability of enough stock of medicines in the PHCs presently being run by the NGOs and the indent of the medicine being made by the pharmacist in consultation with the Medical Officer (MO) of the PHC according to the need. There was an increase in the responsiveness of government health facilities to local needs through community involvement by formation of PHC Management Committee in each district which comprised of NGO staff, members of village panchayat and district health authority. Finally an increased competition was developed by effectively ending government's monopoly on the provision of public services and it was observed that the contracting out of PHCs cut down costs and provided an incentive for providers to explore innovative methods of service delivery.

The incentives are insufficient as the present remuneration given to the PHC staff was the same as that of government functionaries and no additional incentive was given to those posted in remote areas as a result a number of posts varying from Lady Health Visitor to Medical Officer were lying vacant in the PHCs where the study was conducted. In reality, the PPP is unequal as the Public sector is both the judge and the authority and the NGO's who have taken over the PHCs do not have much say in decision making. Further, the programme is often individually driven with over dependence on the Project Manager who often has a dynamic personality and commitment. One person has become the driving force behind the success of the programme till now in these experimented PHCs. Such personality dependence of the programme is a major weakness and it may turn into threat anytime if such person happens to leave the position. The successful performance of the NGOs in PPP has created some prejudice in the minds of government officials who are being blamed for the lack of results. This has led to resistance and non cooperation from these health officials. There is also lack of support from other departments of district administration in implementing the programme. Due to several reasons, the NGOs have not been able to recruit full staff and vacancies continue to exist.

Opportunities and Threats

The indigenous system of medicine including herbal, traditional practices should also be taken into consideration; indigenous health practitioners should be recognized and financially supported by the government (www.mohfw.nic.in/np2002.htm). The paramedical staff posted at distant and geographically difficult terrains can be provided additional increments or incentives in order to attract them to serve in the rural and remote areas. These paramedical staff can be recruited from the Paramedical Institute located in the East Siang district of Arunachal Pradesh. Also, currently the government budgets are

focused on inputs. Money flows to health services on the basis of organograms, seniority, size of establishment and previous expenditure patterns. Well designed PPP programmes can allocate government funding on the basis of population needs, demand for services, quality of service provided and health outcomes achieved. International funding for PPP projects are very high. This can be tapped and utilised to channelize more funds to the project.

Finally, some of the threats that emerged were that inadequate education and awareness on PPP among the community lead to inadequate support and acceptance from the community. The posting of medical and paramedical staff at the PHCs and SCs should be based on the established norms rather than any other influencing factors or political pressure or nepotism which is currently true in some cases. Accountability remains an issue as the present MOs appointed by the NGO are accountable to the Project Manager of the NGO and are not accountable to the state government. The PHC Management committee has been formed to review but it fails to address the issue of accountability. Risk sharing is an equally crucial issue as currently the state government is shouldering 90 per cent of the whole cost of this programme and the respective NGOs are pooling in 10 per cent which may encourage even some inefficient NGOs to undertake the programme. Lack of sustainability is an impending threat since the NGOs are running the show solely and the community is presently not in a position to take up the responsibility in case the NGOs decide to withdraw. This is a very serious issue which needs to be taken into account and worked upon.NGOs decide to withdraw. This is a very serious issue which needs to be taken into account and worked upon.

Rationale / Philosophy Prompting Initiative

The government of Arunachal Pradesh under the aegis of Health Sector Reform as a part of National Rural Health Mission has adopted Public Private Partnership model for running PHCs in the state. Recognizing that PHCs do not have adequate facilities to provide health services effectively; the low levels of utilization and lack of effective mechanisms to evaluate and monitor their performance, harnessing local support and private initiatives are emerging as an important option to improve the performance of the PHCs under a partnership programme. The government of Arunachal Pradesh has handed over one PHC each in all the sixteen districts to non governmental organisations on pilot basis for three years. The responsibility for managing all these sixteen PHCs has been entrusted to four different non governmental organisations. This project was initiated in the year 2005 and the NGOs started running the PHC from January 2006.

- The strategic objectives of the project are:
- Provide to the people residing in the PHC area with quality clinical and preventive health services.
- Effective implementation of the National Rural Health Mission (NRHM) and other national programmes.

- Information Education and Communication (IEC) activities related to health.
- Promotion of community based disaster preparedness.

Source: (http://arunachalpradesh.nic.in/nrhm/SHMS.html n.d.)

The project is aimed at exploring the potential of partnership between the public and private sectors in order to improve access, availability and efficiency of health care.

The key stakeholders are:

- District Medical Officer of the Six Districts
- District RCH officer of the Six Districts
- Medical Officer of the PHC
- Sub divisional Officer /Circle Officer/ Gram Panchayat member of the area where PHC is located.
- Members of the local community

Procedure for initiating the PPP project

The NGOs were selected in a transparent manner on an All India basis. The required advertisements calling for Expression of Interest (EOI) were published in the leading national dailies. EOI was invited till September 2005. The state government shortlisted the PHCs and a consultation meeting with the said shortlisted NGOs was held in the last week of September, 2005. Government of India representatives were also invited for the meeting. After discussions and consultations with the NGOs and other stakeholders, and after addressing the concerns of the NGOs, a Memorandum of Understanding (MoU) was signed with the NGOs. After that the interested NGOs were asked to give their offer/commitment letters for being considered to run the designated PHCs. Final selection of NGOs was done by the State Government along with the representative of the Government of India. This exercise was completed by 15th October 2005. After that the selected NGOs in the interim period were given an opportunity to visit the field area and make their own assessment of the ground level situation. Formal signing of the MoU was over by the end of October 2005, after which the NGOs started running the PHCs from January 2006 (http://arunachalpradesh.nic.in/nrhm/SHMS.html).

The number of PHCs that were handed over to different NGOs are as follows:

1. Karuna Trust, Karnataka : 9 PHCs
2. Voluntary Health Association of India : 5 PHCs
3. Prayaas, New Delhi : 1 PHC
4. Future Generation, Arunachal Pradesh : 1 PHC

Outcomes: PPP in operation

For operating the PHCs the government provides the building and all of its equipment, furniture and supplies. It also pays 90 per cent of the funds of medication and staff salaries.

Currently, it provides approximately Rs. 28,34,172 annually to keep each centre operational.

The PHCs are responsible for providing following services:

a) 24 hours Emergency/Casualty Services.

b) OPD service for six days per week as per the timings specified by the State Government.

c) 5 -10 bed inpatient facility.

d) 24 hrs labour room and emergency Obstetrics facility.

e) Minor Operation Theatre Facility

f) 24 hrs Ambulance Facility

g) Make available essential medicines as per the details in Schedule B of the MoU. The Agency would be encouraged to keep in stock such additional medicines as are found necessary after assessing the field situation.

h) Participation in and implementation of National Programs of Health & Family Welfare including the National Rural Health Mission. Outreach/IEC activities by conducting medical camps

Monitoring Structure

A PHC management committee was constituted at the PHC level comprising representatives of the Agency, District Medical Officer, District RCH Officer, Deputy Commissioner or their nominee (not below the level of Circle Officer) and not more than three representatives from the Anchal Samitis in the Area. It was also seen that at least one of the Anchal Samiti nominees was a female. The local MLA of the area was a permanent Special Invitee to the PHC Management Committee. Such other officers, as required and necessary (for example, Child Development Project Officer, Assistant/ Junior Engineer from Works Department) were also considered as special invitees to the said Committee (http://arunachalpradesh.nic.in/nrhm/SHMS.html).

The Committee is scheduled to meet at least once every two months and is responsible for guiding/monitoring the project. It is also responsible to address local issues and problems as are normally expected from such a Committee. At the State level, a Steering Committee chaired by the Commissioner & Secretary (Health) along with suitable representation from all stakeholders including the Agencies, Central Government and other State Government departments is formed. This State level steering committee is supposed to meet at least once every three months. It has been formed to review the work done at the PHCs, suggest suitable improvements and midcourse corrections, and resolve the difficulties faced by the Agency in running the PHCs.

The NGOs which take charge of PHCs are supposed to maintain records and furnish reports, in time, as are normally expected from any other PHC. The existing records available with the PHC were handed over to the NGO so as to maintain continuity. The respective NGO of each district has to maintain a record of proceedings of the meetings of the PHC Management Committee.

The Way Ahead

There is acute shortage of staff in the PHCs which was evident during the visit where all barring one PHC were understaffed. One of the main reasons behind this exception was that except one, the other five PHCs were located in remote areas which had poor infrastructure. Hence, the staff of the PHC were reluctant to stay in the station. The concerned MOs left the PHCs in the fate of the a few staff living there to look after the PHC. As a result most of the PHCs had a very pathetic look when the Government was running the PHC. The PHC surroundings were dirty and waste products like cotton and bandage strewn all over. Nothing much was done to keep the PHC clean and most of the PHCs were in very bad shape. Things became better when the NGOs took over PHCs with at least one MO was present in every PHC. Measures were taken at PHC level to repair and clean the PHC and even though there were some places where there was shortage of staff, thestaff present were efficient for the benefit of the people. This is one of the positive beginnings that have taken place after the NGOs have taken over the PHCs.

Only two of six PHCs maintained records like number of prenatal, infant and child deaths and other data like number of deliveries conducted by trained personnel in these PHCs,. When reasons were sought, it was cited that due to lack of staff and other constraints the concerned persons could not maintain records. This irregularity in maintaining records was also seen in case of outpatient and inpatient register. Nothing much was done in this case to solve the problem when the government was running the PHC. Now, after the NGOs have taken over the PHCs, proper records are maintained and it is seen that the present NGO staff are able to reach and cater to the health needs of all those areas which were previously left out by the government due to several reasons.

When the PHC was exclusively run by the government, drugs were rarely available. Sometimes important medicines like antibiotics and Tetanus Toxoid were not available in the PHC forcing the patients to buy those from outside. According to the local culture, men have a tradition of carrying local dau (sword) with them as a result of which they often get injured and due to unavailability of drugs the injured had to rely on private chemists.

When asked if the respondents were experiencing any difference in the previous and current management and service delivery and if they were satisfied with the present service delivery, most were of the opinion that they were satisfied with the service of the present PHC and rated it better than previous. One of the main factors that determined their satisfaction level was availability of doctor and medicine. It was found that most of the villages were located in far flung areas. When people from these areas walk to PHCs for 10 – 15 kms and when they get treatment and medicines from the doctor,they are satisfied. After the NGOs have taken over the PHCs, medicines are available in the PHCs. As a result more patients have started visiting the PHCs and they are satisfied with present service delivered by the PHC.

The successful performance of the NGOs in this PPP has created some prejudices in the minds of government officials, who are being blamed saying that, when NGOs can bring

such a result in this short span why can't government do the same. This leads to resistance and non cooperation from some health officials to support the programme.

Discussion and Conclusions

The PPP had started with much fanfare and enthusiasm from the government and the private parties. Once operational though, there are multiple challenges on the ground. These challenges have to be overcome in order to be an effective health delivery mechanism at the grassroots and also rejuvenate the primary health care system of the state. The challenges are both in the structure and in the day to day logistics of the programme. The model requires an NGO that has financial resources to complement the government's contributions. Government officials at the state, district and block levels as well as local leaders have to be educated about PPP. Many are distrustful of private organizations being involved in the delivery of primary health care services. It is also essential that the NGO has complete rights of hiring and discontinuing of staff. User fees are generally banned, but some nominal charges can be made for extra services. Most of the PHCs are located in the far flung areas and even telephone connections were unavailable in some of the PHCs. Hence, even in the case of unavailability of telephone connections efforts can be made to provide Wireless in Local Loop (WLL) phones which can help to overcome the communication problem. Unavailability of electricity supply is another issue. One of the PHCs has taken a novel step of setting up solar panels. Innovative methods such as these can be attempted at other PHCs to ensure a continuous supply of electricity. This will be very useful for operating ice lined refrigerator and other important gadgets.

In order to ensure that people make use of the PHCs, several initiatives need to be undertaken. If people are hesitant to approach the PHCs, as there are few villages which are not yet accessed by the present staff it will be a good idea to set up mobile clinics in places like weekly markets where these villagers from nearby areas come for marketing and can also avail health facilities. One of the NGO which had taken over the PHC in East Kameng district conducted a Health Mela in the district which is one of the few districts which lacked in good health facility. This Mela, which was organized in collaboration with the district health and family welfare society, was a grand success with a massive response from patients who thronged from all parts of the district. If such kind of Health Melas and other creative ways could be formulated in the areas where the health infrastructure is poor it will be a boon for people in these areas. Finally, sustainability is most crucial for projects as such. The NGOs maintaining the PHCs are the sole operators and if they decide to discontinue, then there is a high chance of the project collapsing since the community is currently not in a position to take up the responsibility of running the PHC. To prevent such a situation from arising, volunteers from the community should be identified and trained so that eventually when the NGO withdraws or hands over the project to the community, the PHC the volunteers and the community can take up the responsibility.

This paper looked and identified some of the issues related to Public Private Partnership in running Primary Health Centres in Arunachal Pradesh under the realm of health sector

reforms. The state is striving to address issues pertaining to better health care delivery systems. It has taken Public Private Partnership as one of the measures to enhance the performance of its health care services, improve the health status of the population and the quality of people's lives.

From the issues that emerged from the study and recognizing the paramount importance of health in the well-being of the people, it is crucial that policy action be taken to improve health services across the state through an effective Public Private Partnership. Assuming that the constraints mentioned in the study can be overcome, this model appears to be a viable Public Private Partnership. It is a legitimate Public Private Partnership that is both scalable and replicable.

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[I would like to Thank Ramila Bisht and Kanchan Mukherjee for their continuous guidance and encouragement.]