Public Private Partnerships for Improving Health of Urban Poor

National Planning Workshop on Public private Partnerships in Health Sector in India

November 28th , 2005,
National Institute of Health and Family Welfare

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URBAN HEALTH RESOURCE CENTRE

Outline of the presentation

- Need for focusing on Urban Health
- Various approaches to PPP
- Experiences and lessons from Agra PPP
- Challenges in operationalizing PPP and suggested steps

Unabated Growth of the Urban Poor

2-3-4-5 phenomenon of population growth

Urban population - 285 million[1]

Urban poor estimated at 70[2] -90[3] million

Estimated annual births among urban poor – 2 million[4]

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[1] 2001 Census of India.

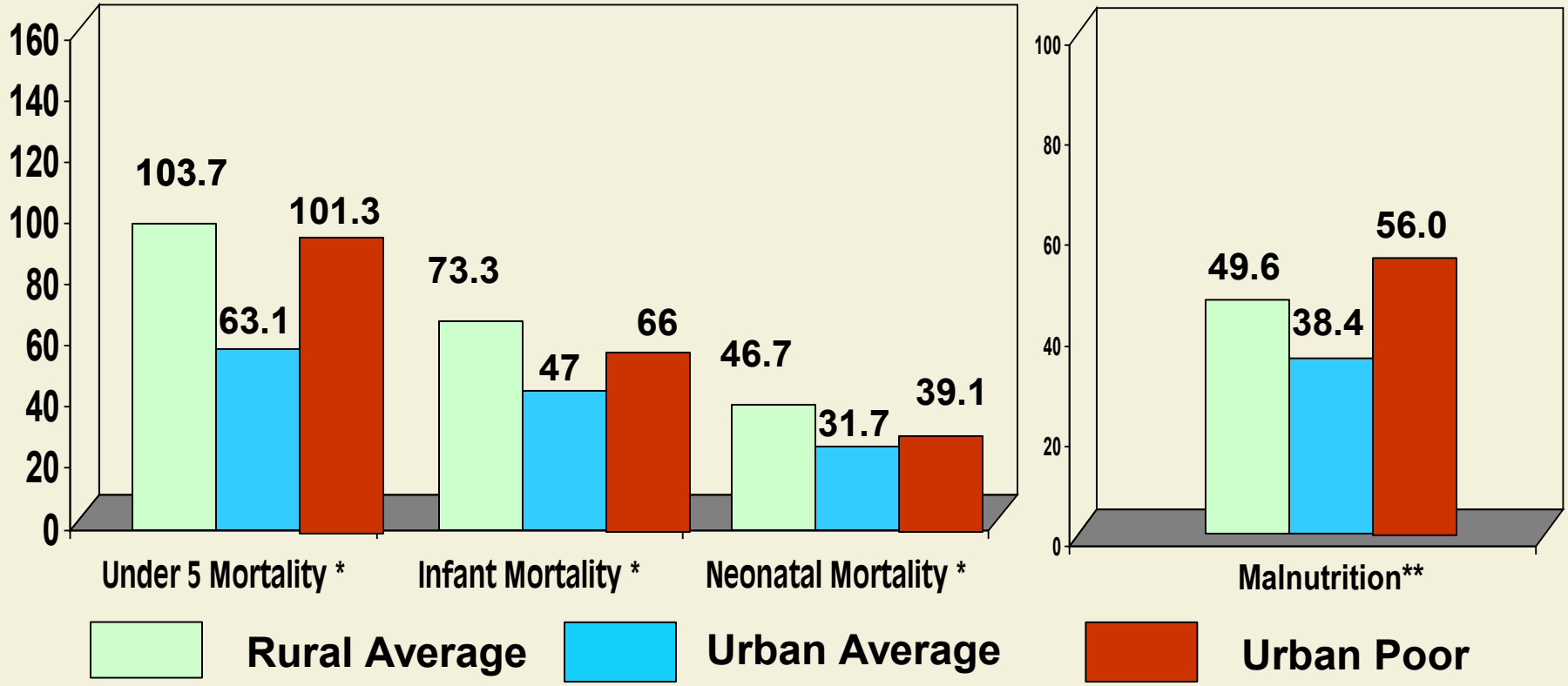
[2] 1999-2000 NSSO (55th round) using 30 day recall of consumer expenditure.

[3] Lawrence Haddad, Marie T. Ruel, and James L. Garrett, 1999. Are Urban Poverty And Under-nutrition Growing? Some Newly Assembled Evidence.

[4] Calculated based on Total Fertility Rate of 3.0 for urban poorest quintile from Laveesh Bhandari and Shruti Shresth, Health of the poor and their subgroups in Urban areas, June 2003.

Poor Child Health and Survival among Urban Poor in India

Health conditions of urban poor are similar to or worse than rural population and far worse than urban averages



* Mortality per 1000 live births

** Weight for age <-2 SD

[Re-analysis of NFHS 2 (1998-99) by Standard of Living Index, EHP: 2003]

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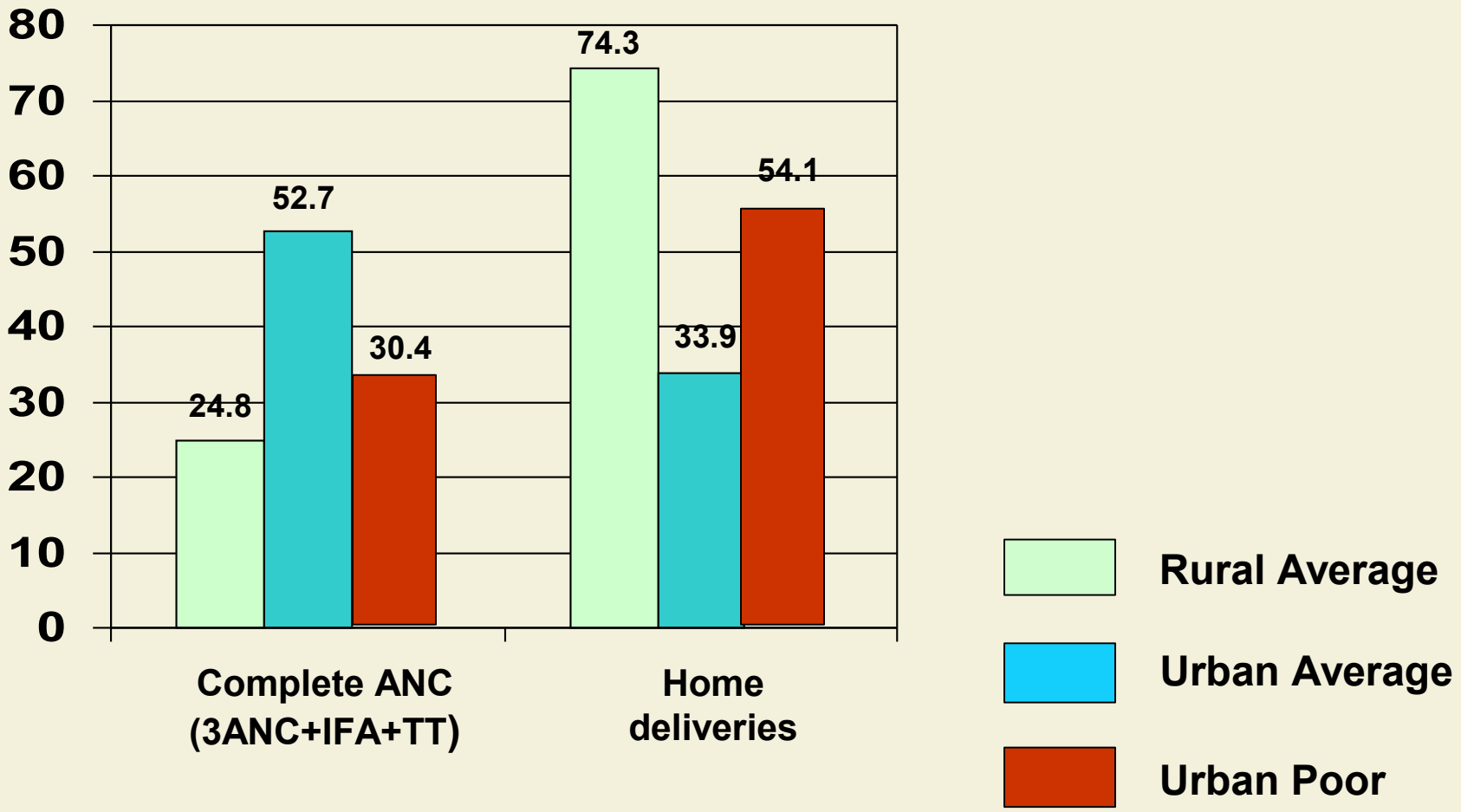
Poor Access to Health Services



> 1million babies are born every year in slum homes

Re-analysis of NFHS 2 (1998-99) by Standard of Living Index, EHP: 2003

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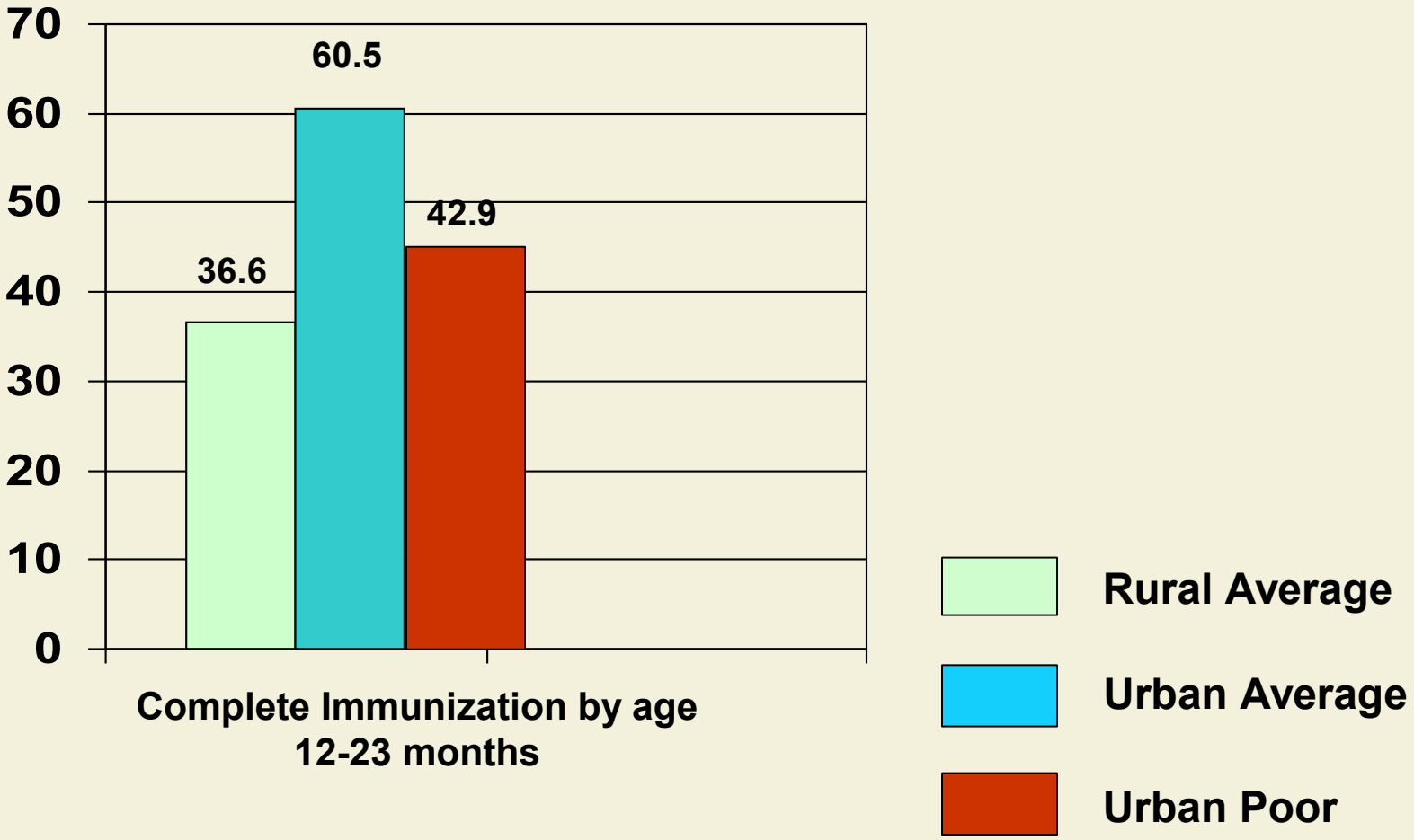
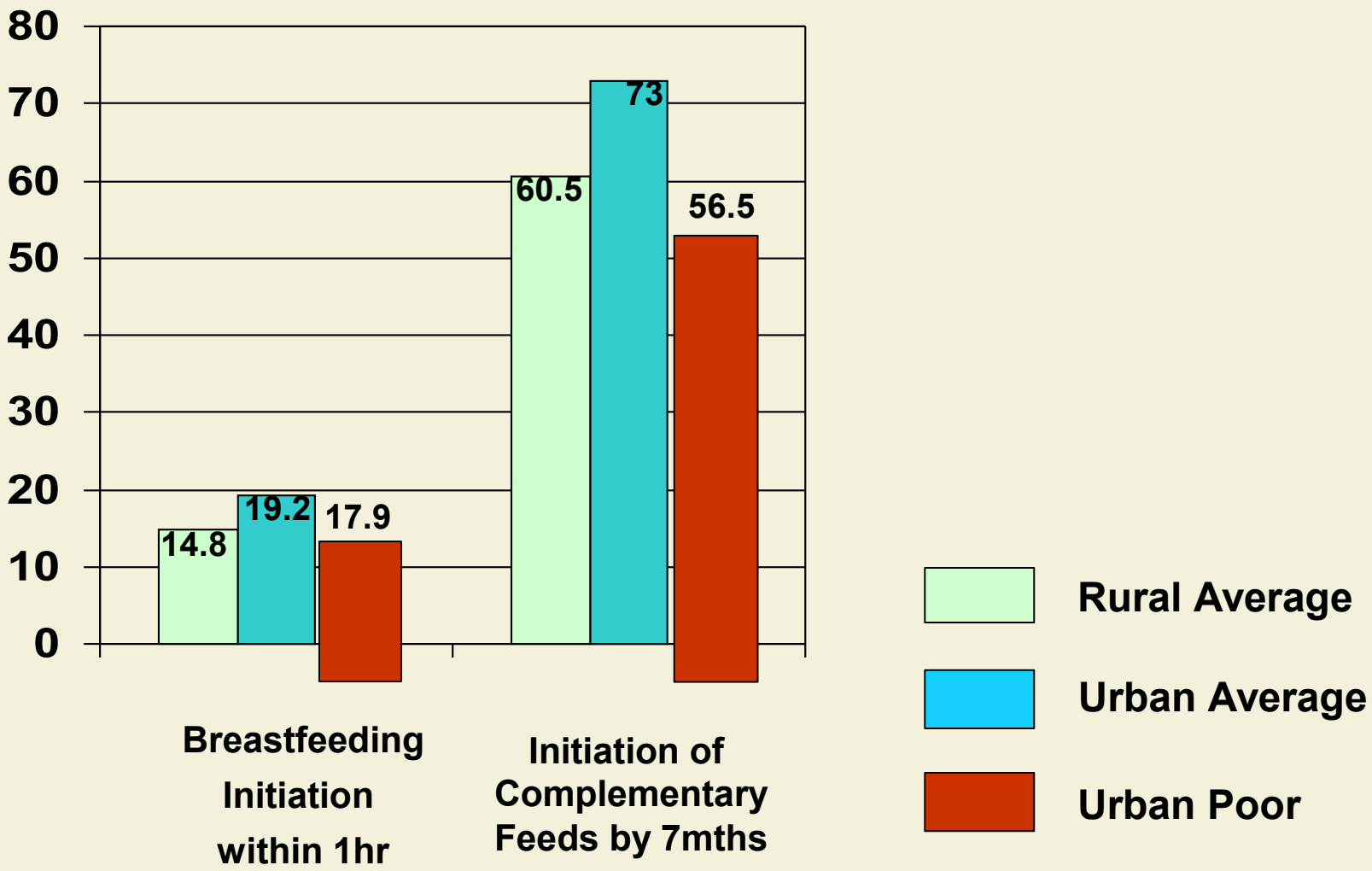


[Re-analysis of NFHS 2 (1998-99) by Standard of Living Index, EHP: 2003]

Sub-optimal Health Behaviors



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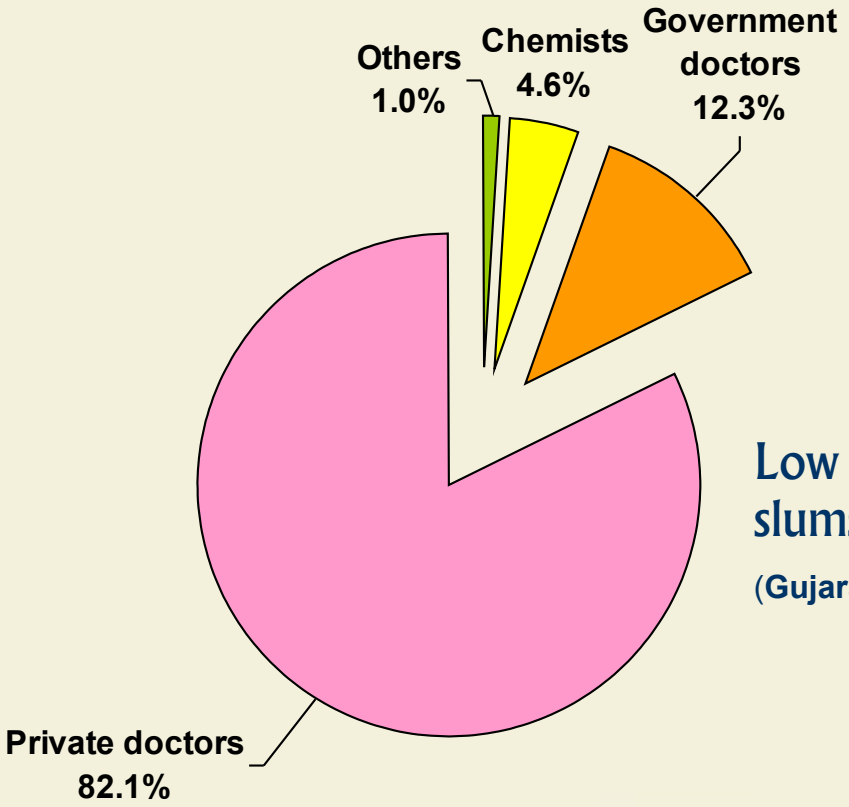
Inadequate Public Sector RCH Services

There is one UFWC/HP for about 1.5 lakh urban population



Low utilization of public health services in urban slums; private sector predominantly accessed

(Gujarat State-wide Multi-Indicator Cluster Surveys (MICSs), 1996)

1083 UFWCs, 871Health Posts, and 531 facilities in IPP V and VIII

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Private and Public Sectors Complement each other

	Public Sector	Private Sector
1	Constitutional mandate, Policy backup & wide network	Many types of providers – 85% medical professionals private, non qualified providers widely accessed
2	Weak planning and management systems – rigidity	Availability of modern technology – flexibility and openness in approach
3	Provision of subsidized and free health care for the poor, equal focus on preventive measures	Limited willingness to serve the low profit sections; weak emphasis on preventive care. High commitment to the poor among non-profit sector
4	Poor quality of services at most Primary Care centres and low social access	High physical and social access to the poor esp. of non qualified providers; no mechanism to monitor quality

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NRHM lays strong emphasis on PPP

- Partnership with the private sector to meet national public-health goals is one of the key strategies of NRHM

- Forms of partnership mentioned in NRHM relevant for increasing access to health services for the urban poor include
  - Contracting the management of UHCs to NGOs
  - Contracting in private practitioners / specialists to public sector facilities / provide out reach services
  - Contracting delivery of health services to unserved areas to NGOs
  - Social franchising / marketing
  - Partnership with corporate sector
  - Partnership with Community based organizations
  - MNGO / SNGO scheme

PPP Approaches in Urban Health

- Non-governmental Organizations
- Private Practitioners
- Corporate Sector

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PPP Approach # 1

Partnership with NGOs

- NGOs manage government health facilities for urban slum health in several states e.g. Delhi, Bangalore.
- Service delivery by NGOs using their infrastructure under a government contract (Guwahati)
- Collaboration in government health programmes (DOTS, Mother NGO scheme)
- Informal partnerships – NGOs facilitate public sector health services. E.g. Mumbai, Delhi, Bangalore, Indore

Value Addition as noted in above examples:

- Quickly expand access to child health services in slums without delays due to creating new infrastructure
- Have provided better quality and expanded range of services
- Better able to Identify and target vulnerable population
- Better able to forge ties with community and build community capacity
- Ability to coordinate with other stakeholders and garner resources/support

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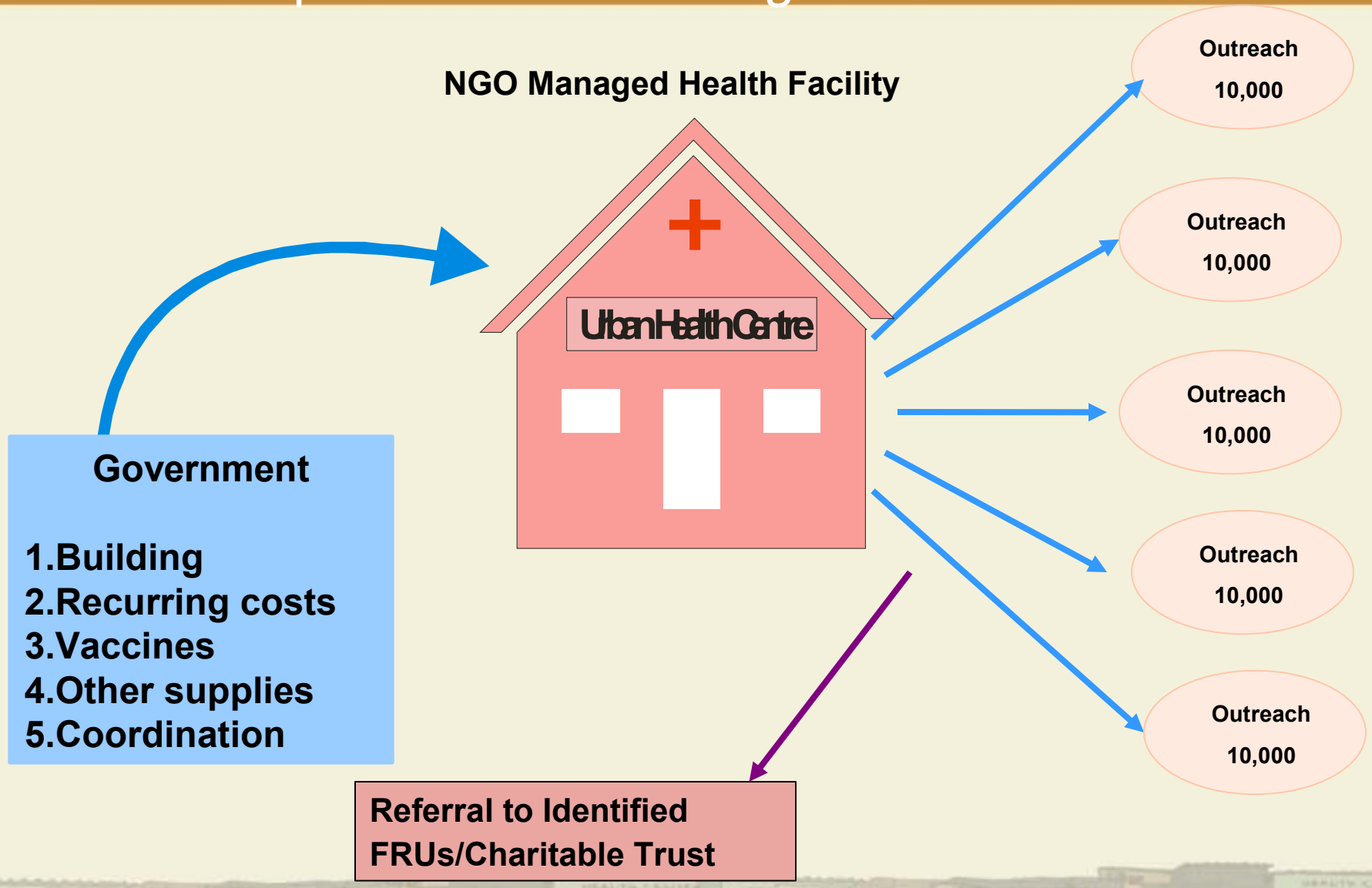
PPP Approach # 1

Partnership with NGOs: *Using Govt. Infrastructure*

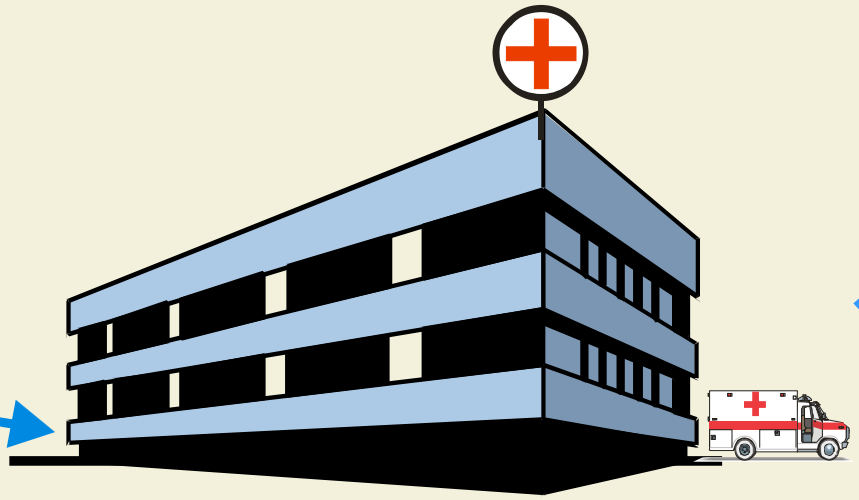


e.g., Arpana Trust manages a MCD health center in Molarbund, Delhi; Sumangli Seva Ashram and others, Bangalore

PPP Approach # 2

Partnership with NGOs: *Using Private Infrastructure*

Govt. contracts hospital to provide outreach and Referral services



Outreach 10,000

Outreach 10,000

Outreach 10,000

Outreach 10,000

Outreach 10,000

Referral for 2nd tier services

Government

3. Equipment costs
4. Vaccine
3. Other supplies
4. Coordination

e.g., Govt. of Assam contracted Marwari Maternity Hospital to deliver primary health and referral services in urban poor habitations in Guwahati

PPP: Approach # 3

Part-time Outreach Services to slums by Private Doctors

Socially Committed Private Doctor
[receives honorarium from Govt]
(about 3-4 hrs every Sunday)

Week 1 → **Slum1** 3000 popln

Week 3 → **Slum2** 3000 popln

Week 2 → **Slum 3** 3000 popln

Week 4 → **Slum 4** 3000 popln

Nodal Govt./Municipal Dispensary

1. Vaccines
2. Other supplies
3. Coordination

2nd tier Govt./Private Centre

Referral from slums to Govt. Dispensaries or 2nd tier Govt/Private centre

Social Mobilization by NGO

- Identifies and trains link workers
- Supports community mobilization
- Supports outreach services
- Builds linkage between community, health providers

District Urban RCH Unit Coordinates with private doctors, NGOs, nodal Dispensary, Coordinates periodic review

E.g. IPP VIII and CUDP 3 in 40 cities of West Bengal
Estimated cost per month: Rs. 25000; Cost per person : Rs. 2 per month

Under the govt. immunization scheme there is provision of Rs. 1400 for 4 camps to be held in a slum per month

PPP: Approach #3.. contd

Other forms of Partnership with Private Doctors

- Private doctors can provide health services in government health facilities on fee sharing/part time basis. Specialists can volunteer for few hours each month. [IPP VIII Kolkata and Delhi (Arpana)]
- Govt. referred cases (neonates, obstetric, childhood illnesses) are treated at Private facility which can be then reimbursed. [e.g. TN]
- Govt. can give "child health vouchers" to parents of newborns for series of services they can avail at private doctor's facility [Kolkata, Udaipur]
- Once-a-week-OPD subsidy: Private Pediatricians (and others) can provide substantially subsidized services for the poor once a week for a specified time at their clinics [Meerut, Haridwar, many cities]

PPP Approach # 4

Partnership with the Corporate Sector

- Supplement Health Investments and services needed to address urban health challenge
- Sharing of expertise pertaining to demand generation, marketing and management
- Advocacy for enhanced attention to health of urban poor population

CSR is not just charity; it is an integral part of doing business

-View expressed by several leading Corporate leaders

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PPP Approach # 4 .. Contd

Example of Corporate supported Urban Health Efforts:

Ranbaxy Mobile Health Clinic

Social mobilization and RCH Service Team

Government

1.Vaccines
2.Other supplies
3.Coordination

Slum cluster 1
10,000 popln.

Slum Cluster 2
10, 000 popln.

Slum Cluster 3
10,000 popln.

Referral to Identified FRUs/Charitable Hospital

Services provided : OPD, immunization, ANC, IUD insertions, health education, counseling, Referral and lab tests

Estimated cost: Capital cost – 7.5 lac, annual recurring cost – 10 lac

Experiences and lessons from facilitating PPP in Agra

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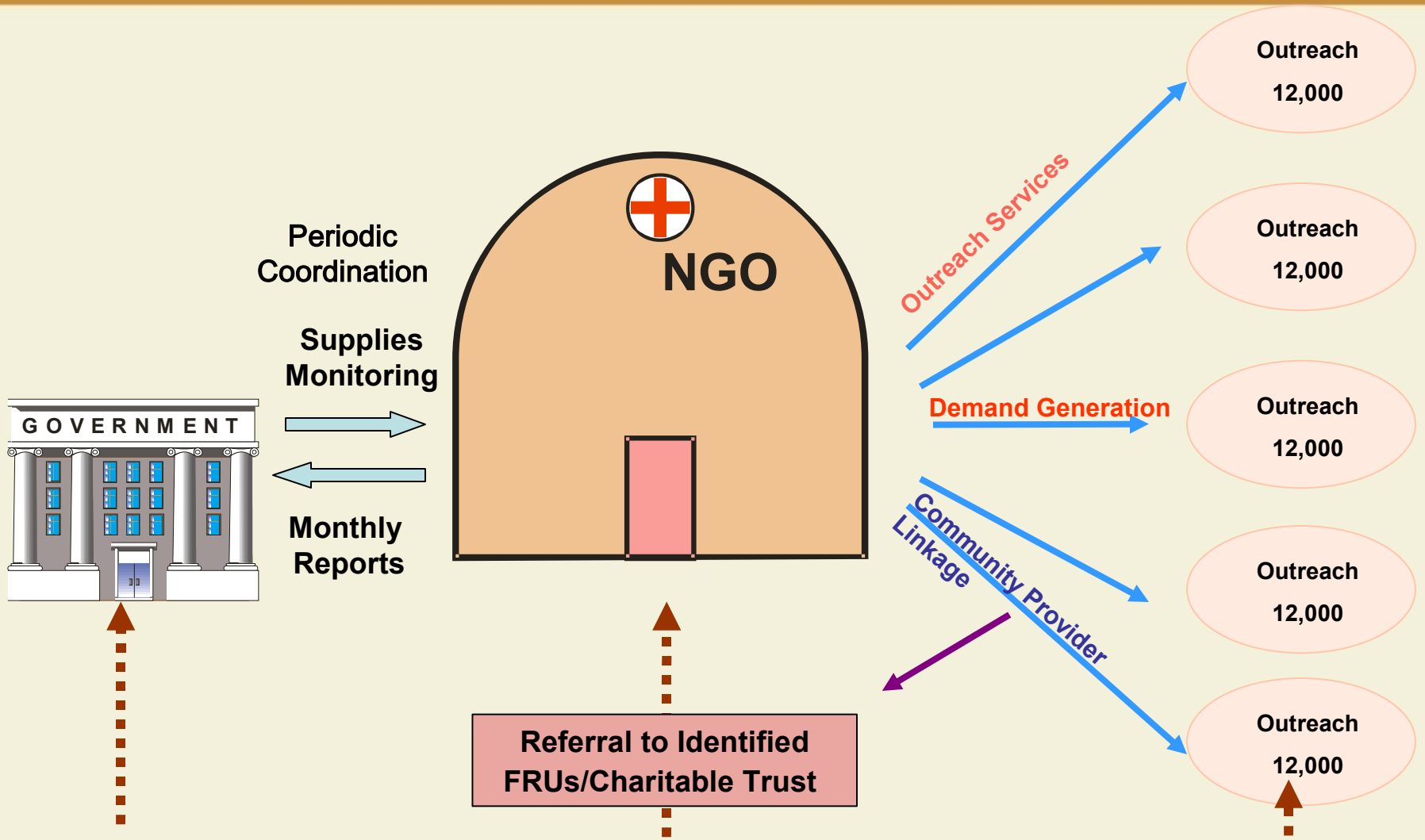
Approach # 5: *PPP in Agra* [covers 60,000 Slum population]



UHRC provides support for capacity building, coordination and system strengthening

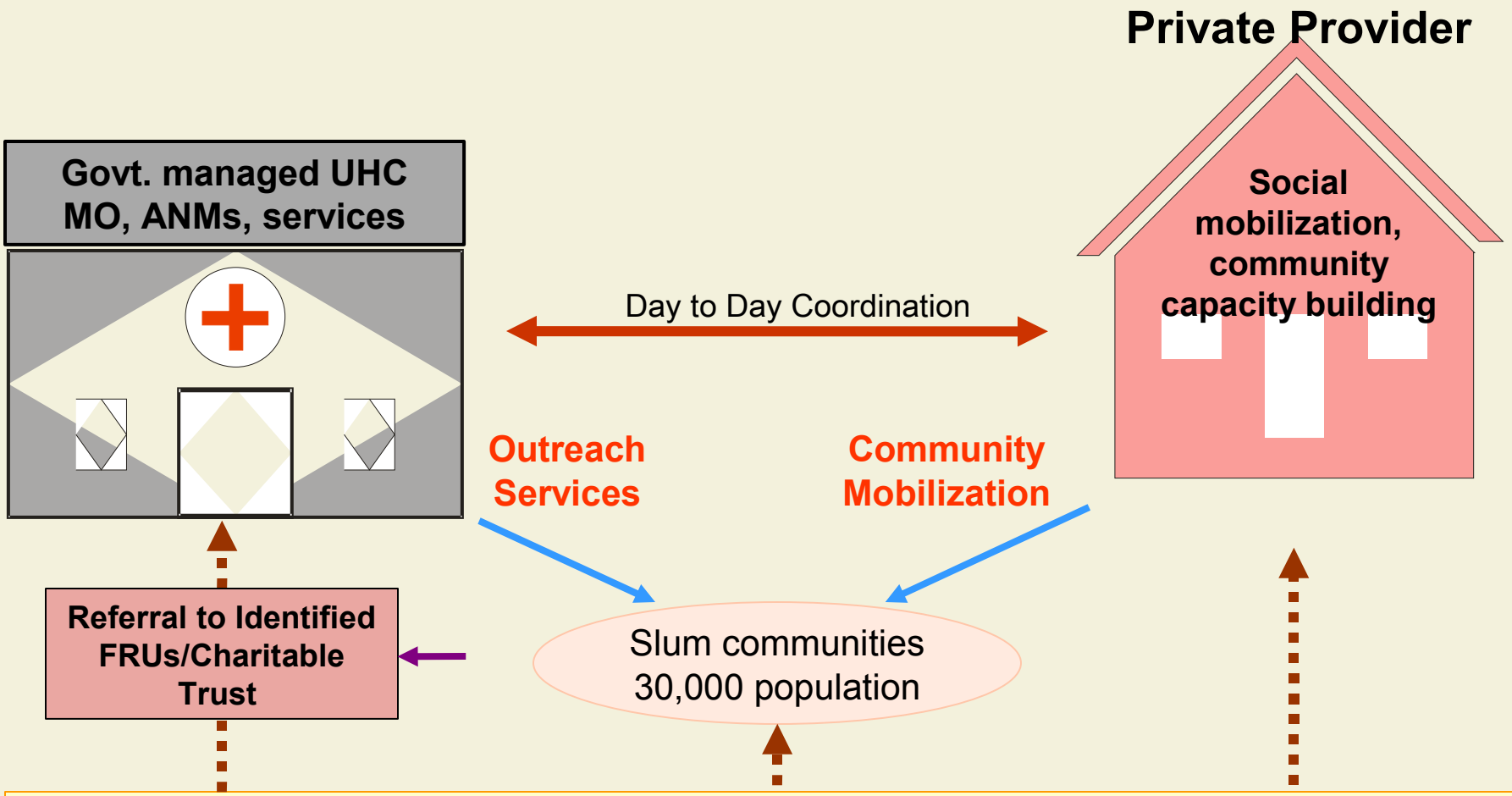
Total monthly cost – Rs. 1,72,000

Monthly budget: Community demand generation and service delivery

Line items A. Personnel Cost	Unit Cost		Total Budget (Rs.)
	Qty	Rate	
A.1 UHC Staff			
(a) Lady Medical Officer	1	17,000.00	17,000.00
(b) ANMs (5)	5	5,500.00	27,500.00
(c) Ayah cum Office Assistant	1	3,000.00	3,000.00
(d) Lab Assistant	1	5,500.00	5,500.00
A. 2 NGO Staff for community mobilization			
(a) Project coordinator	1	10,000.00	10,000.00
(b) Community organizers (6)	6	3,000.00	18,000.00
(c) Link Volunteers (1 for 1800 slum population -32)	32	500.00	16,000.00
(d) Accountant	1	5,000.00	5,000.00
Total Personnel cost			*102,000.00*
B. Travel and Transportation Cost			
(a) Project Coordinator's, Community Organizers and Link Volunteers travel (rview meetings) -lump sum			12,280.00
(d) Mobility support (fuel expenses @500/- per camp) for outreach camps *; 1 camp would cover more than 1 slum in most cases	18	500.00	9,000.00
Total travel and transportation cost			21,280.00
C. Establishment and program activities cost			
C.1 Establishment and office expenses (UHC rent, electricity, telephone, stationery etc.)			10,500.00
C.2 Program Activities -IEC/BCC, Capacity building activities etc.			23,000.00
Overheads:			15,728.00
Total Other Direct cost			*49,228.00*
Grand Total			172,500.00

Total monthly Cost : Rs. 1,72,000; Cost per person: Rs. 3/- per month

Approach # 6: *PPP in Agra* covers 30,000 Slum population



UHRC provides support for capacity building, coordination and system strengthening

Outreach services include treatment of minor illnesses, ANC, immunization, birth spacing, health education

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Total monthly Cost: Rs. 90,000

Summary Monthly budget: Community demand generation and Linakge with Govt. UHC

Line items	Unit Cost		Total Budget (Rs.)
	Qty	Rate	
A. Personnel Cost			
NGO Staff for community mobilization			
(a) Project coordinator (full time)	**1**	**9,000.00**	**9,000.00**
(b) Community organizers (4)	**4**	**3,000.00**	**12,000.00**
(c) Link Volunteers (1 for 1800 slum population -20)	**20**	**500.00**	**10,000.00**
Total Personnel cost			***31,000.00***
B. Travel and Transportation Cost			
(a) Project Coordinator's travel Rs. 70/- per day * 18 days	**18**	**70.00**	**1,260.00**
(b) Community Organizer's travel Rs. 40/- per day * 22 days *6 persons	**132**	**40.00**	**5,280.00**
(c) Link Volunteers travel for review meetings Rs. 50/- per person	**20**	**50.00**	**1,000.00**
(d) Mobility support (fuel expenses @500/- per camp) for outreach camps *; 1 camp would cover more than 1 slum in most cases	**12**	**500.00**	**6,000.00**
Total Travel and transportation cost			**13,540.00**
C. Establishment expenses and Program Activities cost			
Establishment and office expenses (electricity, telephone, stationery etc.) -lump sum			**6,000.00**
Program Activities -IEC/BCC, Capacity building activities etc. -lump sum			**30,000.00**
Total Establishment expenses and Program Activities cost			**36,000.00**
Overheads:			**8,460.00**
Grand Total			**89,000.00**

Total monthly Cost : Rs. 89,000 ; Cost per person: Rs. 3/- per month

Roles and Responsibilities of Partners: *Agra PPP*

Govt.

- Coordinate District UH Task Force to provide support and inter-sectoral linkages
- Provide vaccines and other supplies through nearest UHC
- Coordinate with referral unit to attend to referrals from private partners' area
- Provide UHC and outreach services in approach # 6
- Conduct periodic reviews and provide supportive supervision/guidance

NGO

- Recruit adequately capable health (M.O., ANMs) and social mobilisation project staff
- Provide/enhance access to first tier RCH services and referral services for 2nd tier health care as required.
- Submit monthly indent for required RCH supplies and records of services and statement of expenditures
- Develop a financial and institutional sustainability plan in order to sustain their efforts beyond RCH II

UHRC

- Provide technical and programmatic directions, including organizing capacity building programs
- Develop Monitoring and Reporting formats through a consultative process and provide to partners.
- Facilitate effective coordination between DMHFW, Agra, NGO partners, and State level Urban Health Task Force

Sd /- Chief Medical Officer Agra	Sd /- Executive Director UHRC	Sd / - Director NGO

Lessons Learned: *Agra PPP*

- Gentle and genuine dialogue, assessment of critical needs, joint development of plan to respond to needs, builds trust which is critical to success.

- Formal documentation within Govt. system– by way of letters of request, minutes of meetings, etc.

- Perseverant efforts to play catalytic/facilitator role:
  - Appreciate and begin with what Govt. stakeholders have
  - Involve decision makers at critical junctures
  - Identify and encourage champions within the govt. system
  - Remain open to ideas/feedback, be flexible and responsive

- It is vital to initiate sustainability efforts early to complement Govt/donor resources and sustain health improvements

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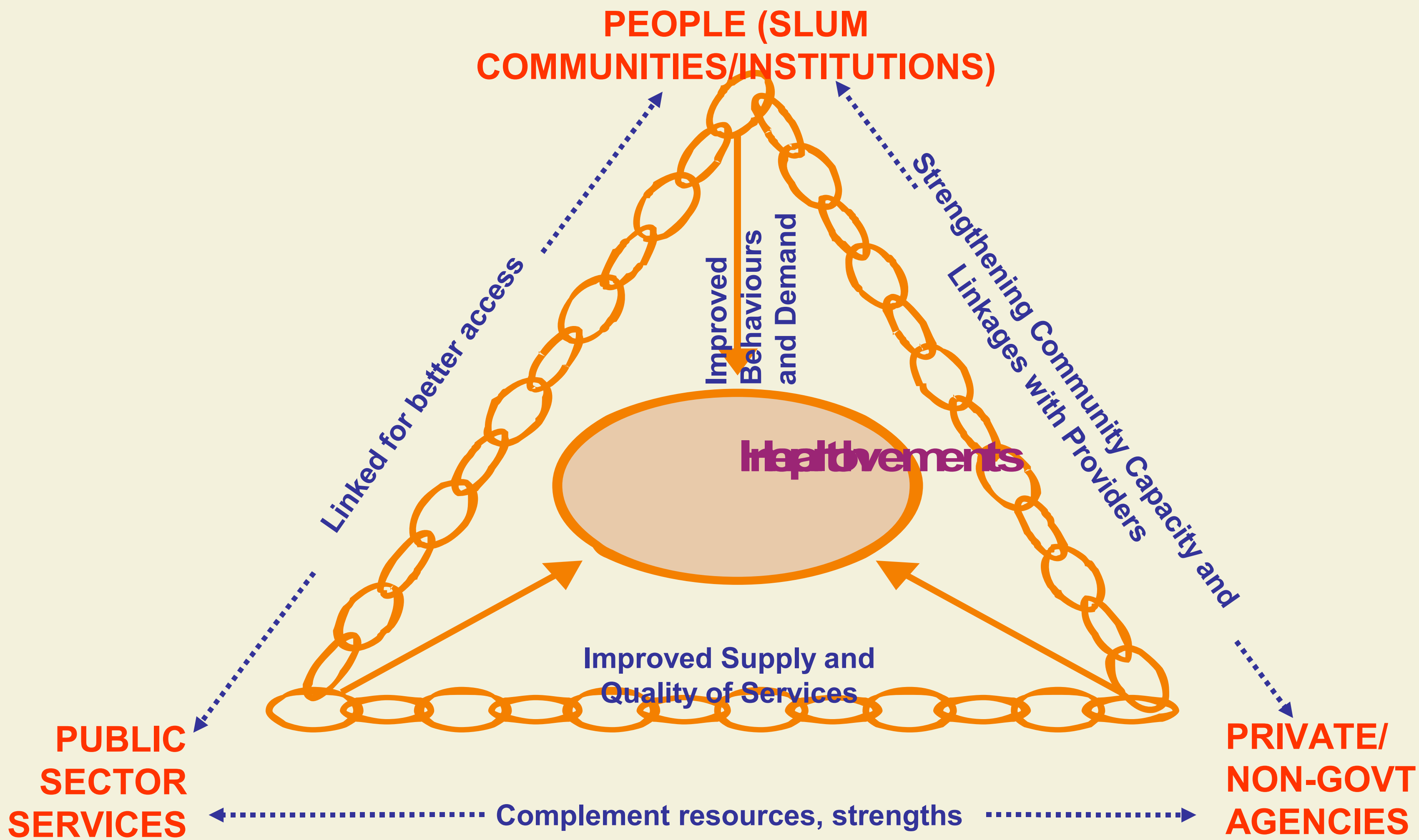
Cross-cutting principle:
Let us remember to include the “people” as key partners

Public-Private-People Partnership



The slum communities are essential partners in this effort to achieve optimal behaviors, penetration to most- vulnerable pockets, sustain health improvements

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Key Challenges in popularizing PPP

- Limited acceptance of PPP approach among public and private counterparts
- Lack of effective mechanism for identification of appropriate NGO
- Lack of experience in developing and administering partnership instruments (MOUs, Agreements)
- Need to streamline operational aspects of partnership and fund release modalities
- Sustainability of such partnerships beyond project funding

Suggested steps for Operationalising PPP

Identify Potential Private Partners; Build Mutual Trust

- Consolidate learn lessons from working PPP examples to sensitize potential partners
- Engage in confidence and trust building consultation with identified potential partners with facilitation by a neutral (3rd) party.
- Identification of capable NGOs based on health program experience, commitment to the poor, management capacity

Develop Operational Partnership Agreement

- Evolve a partnership arrangement which is workable for govt. as well as private partner through a consultation process on a clearly identified purpose that it will fulfill
- Collective courageous minds could work out a workable, time bound action plan with measurable results
- Develop/refine a partnership agreement (MOU) through a consultative process
- Streamline operational aspects of partnership and fund release modalities

Suggested steps for Operationalising PPP [contd.]

Provide Services to Urban Poor through PPP

- Capacity building of NGOs on quality service delivery; of govt. on management of PPP
- Service or performance based payment mechanism rather than focus on processes; maintaining private partners' managerial autonomy improves outcomes.
- Develop sustainability of partnerships to sustain health improvements

Time is Essence in Public Health

PPP can be an important strategy for meeting the critical public health challenge of quickly expanding services and reach to the urban under-served

PPP enables use of existing Public and Private infrastructure (where available) and capacities to expand services

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Let us work in partnership to enable slum communities to build a healthy and productive tomorrow for these children

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