

Policy for **PUBLIC PRIVATE PARTNERSHIPS** in the Health Sector

Strategic Planning and Sector Reform Cell

**Department of Health and Family Welfare
Government of West Bengal**

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Abbreviations

AP	Andhra Pradesh
BOO	Build Own Operate
BOOT	Build Own Operate Transfer
BOT	Build Own Transfer
BPHC	Block Primary Health Center
CII	Confederation of Indian Industries
DoHFW	Department of Health and Family Welfare
GDP	Gross Domestic Product
GoWB	Government of West Bengal
MRI	Magnetic Resonance Imaging
NGO	Non Government Organization
PHC	Primary Health Centre
PPP	Public Private Partnerships
SOP	Standard Operating Procedures
SPV	Special Purpose Vehicle
UP	Uttar Pradesh

POLICY FOR PUBLIC PRIVATE PARTNERSHIPS IN THE HEALTH SECTOR

Government of West Bengal (GoWB) is committed to the concept that health of the people is safest in the hands of community itself. Though it is the responsibility of the Government to ensure that Health Status of all the people of West Bengal, especially the poorest and those in greatest need is improved, however, this responsibility cannot be fully discharged without active and organized participation of community through Panchayati Raj Institutions and Urban Local Self Governments. With this policy commitment and in the background of increasing demand and expectations for improved Health Care Services, resource constraints of public sector health systems, simultaneous growth of private sector coupled with very low coverage of health insurance and almost non-existent social health insurance systems, the Department of Health and Family Welfare (DoHFW), GoWB have been encouraging establishment of public private partnerships during last three years. This would involve collaboration with not only private sector but also with NGOs/CBOs and civil society. It will be supplemented by parallel efforts of the Government to launch different Health Insurance / Social Health Insurance Schemes targeted for vulnerable sections of population and to introduce Voucher Schemes for subsidising the health care provision in critical areas to reduce the out of pocket expenses of poor and vulnerable population to the extent possible.

The Public Private Partnerships implemented by Health and Family Welfare Department, Government of West Bengal will be aimed at consolidating the strengths of public sector as well as private sector and at the same time addressing the weaknesses of both the sectors.

The National Health Policy 2002 also states that “In principle, this Policy welcomes the participation of the private sector in all areas of health activities – primary, secondary or tertiary”. However, though Government of West Bengal will proactively engage with Private Sector in Public Private Partnerships in Tertiary and Secondary Level of Health Care, on mutually beneficial Terms and Conditions with adequate and proper safety net for the poor, such engagements at Primary Level will be carefully decided and shall generally attempt at providing alternative modes of health care delivery in underserved, remote and difficult to reach areas. Such efforts will be supplementary to the ongoing efforts of the Government at Primary Health Care Level and not in substitution of them.

This Public Private Partnership Policy document outlines various ways in which the diverse segments of the private sector can be engaged with the government for expeditious achievement of desired health outcomes.

A BACKGROUND

In a resource constrained environment, Government needs to make best use of all resources which could contribute to improve health of the population. The Private Sector in health is also important, but it is not always effective. The Government delivery system is extremely important, but it is also not always effective, and it is not enough. Public Private Partnerships is a means to improve performance and generate “value for money”, for both Public and Private Sectors. By promoting PPPs

the Government does not renounce its role and responsibilities towards people but attempts to intensify its efforts for providing better health care.

Trends of the last 10-11 years do not demonstrate increase in government spending in the health sector in terms of percentage of the total budget allocations as well as a percentage of the GDP. The public health investment in the country over the years has been comparatively low, and as a percentage of GDP has declined from 1.3 percent in 1990 to 0.9 percent in 1999, among the lowest in the world. In contrast India records a high private health spending, which is amongst the highest in the world. However, between 75-90 percent of public health spending is made by India's states, which are constantly facing severe fiscal crisis due to reasons over which they do not have much control. Though the State Government shall continue to mobilise and invest additional resources for the health sector, the Government is also conscious of the fact that the resource related issues can be addressed in a major way only by the National Government.

The bulk of public spending on primary health care is thinly spread and therefore is not as effective as is desirable. Referral linkages to secondary care are also somewhat deficient. State governments do not have the adequate funds to invest in infrastructure development of hospitals. Even if states have made investments in health infrastructure through externally aided projects, such improved facilities also tend to run down over the years in the absence of adequately funded maintenance systems and problems relating to management systems. Realising this the Government of West Bengal is going to launch a massive and ambitious programme titled "Health Systems Development Initiative (HSDI)", which, in addition to providing more resources to Primary Health Care, will also address the systems related issues. This will supplement the efforts of the Government to address these issues through on-going programmes like KfW funded and GTZ assisted Basic Health Project, West Bengal, European Commission (EC) supported Sector Investment Programme (SIP), infrastructure development through NABARD funded RIDF, grants from the Finance Commission and untied funds being provided to local bodies by State Government.

Public awareness of and expectations from health services provided by the government are rising rapidly making the management of public health systems and programmes more challenging than it was earlier. The private sector is expanding but issues like quality assurance and pricing mechanisms are yet to be adequately addressed. In this context, the proper regulation of Private Sector and introduction of modern accreditation systems has also become a pressing need, which is going to be addressed by Health and Family Welfare Department in a specified time frame. The Government is conscious of the fact that putting these systems in place is extremely essential to ensure that Public Private Partnerships provide quality health care to the people at affordable and reasonable price.

There is now substantial evidence that, despite massive investment by the state governments on health care the users of services are still spending huge amount either directly or indirectly to avail the services. As per “West Bengal – Health Policy Note”, on the basis of NSS data (1995-96), households total Out of Pocket expenditure health spending in **West Bengal was equal to Rs 193.70 per capita in 1995. This was slightly less than the all India average of Rs 222 per capita per year.** The estimate is that total OOP health expenditure is equal to 67.5% of total health expenditure. Projecting the above estimate to fiscal year 2001-02, under assumptions of an income elasticity of demand for health services equal to 1.2, would give an OOP health expenditure equal to Rs 489.4 per capita per year. To address this major issue the Government of West Bengal has decided to implement some pilot schemes for Health Insurance for targeted vulnerable sections of the population. A Task Force has been constituted to support the scheme design. Depending on the experience of pilots, they shall be up scaled and rolled out. The Government will provide financial support to these Schemes to ensure their viability. In addition to the Health Insurance for the targeted vulnerable sections of population, the Government is considering to implement Voucher Schemes in some identified areas as a supplementary mechanism.

The private sector accounts for most ambulatory curative care services in India, and this is true in the case of West Bengal as well. However, the poor still largely depend on the public sector for the majority of their hospital care needs. The private sector provides a bulk of outpatient care for those below the poverty line, much of which is of low quality and provided by untrained and largely unregulated practitioners.

However, it should be kept in mind that in West Bengal Public Sector facilities are providing 81% of Indoor admissions. Many of these people are not below poverty line. Among those above the poverty line, 69% utilized public facilities for inpatient care. What is more important to note is that among the wealthiest 20% of the population about 55% utilize public sector health care facilities for inpatient care. In country as a whole only 50% admissions are there in public sector. The picture is the same in State like Kerala, which has better health indicators than West Bengal. This will indicate the formidable challenge that is faced by public health care systems in West Bengal and is being addressed to the best of its ability in the face of resource crisis. There is clear evidence that a good part of public investment in Tertiary Care and Secondary Care Hospitals is being utilized by middle class and rich people. The budget for primary health care is only 35%. This needs to be increased. Public Private Partnerships by encouraging both for profit and not for profit private sector in tertiary and secondary health care will release the required additional funds for primary health care.

The National Health Policy 2002 states “since 1983 the country has been seeing increase in mortality through ‘life-style’ diseases - diabetes, cancer and cardiovascular diseases. The increase in life expectancy has increased the requirement for geriatric care. Similarly, the increasing burden of trauma cases is also a significant public health problem”. There is constraints of resources with the

government to invest in facilities to take care of the increasing burden of these emerging diseases. It is estimated that in the next ten years the cost of caring for diabetic patients alone would be crippling for health sector financing. Similarly, HIV infection will pose another major challenge.

State governments would be hard pressed to maintain allocations/spending on health care while dealing with increasing pressure to enhance public investment. Most multi/bi-lateral donor organisations do not wish to invest in tertiary medical care services provided by the government in India. Most of them are interested in and committed to improve Primary Health Care Systems. The promotion of Public Private Partnerships in Secondary and Tertiary Level Health Care should be analysed in this context. However, PPPs will be introduced in some specific areas of Primary health care such as operating ambulances and diagnostic centres with built-in safety net for the poor.

In the next 10 years in India, it is envisaged that average spending on health care delivery will almost double – from Rs 86,000 crore in 2000 – 2001 to over Rs 200,000 crore in real terms by 2012. Largest component of the health care spending is from the private sector and by 2012 it is expected to rise from the current level of Rs 69,000 crore to Rs 156,000 crore. In addition public spending could double from current Rs 17, 000 crore if the government reaches its target spending level of 2% of GDP, up from 0.9% today. Therefore, on the one hand the approach would be to increase the spending level of public sector as much as possible, on the other hand opportunities of increasing private sector investment shall be effectively utilised for the benefit of the public.

India has 1.5 beds per 1000 people, while middle income countries such as China, Brazil, Thailand and Korea have an average of 4.3 beds. West Bengal has approximately 1 bed per 1000 population. As compared to middle and high-income countries where registered physicians are 1.8 per 1000 people, in India we have 1.2 (of which only 0.5 are registered practitioners of modern medicine). West Bengal has approximately 0.6 registered Allopathic doctors per 1000 population. The state will require an additional 30,000 practitioners of modern medicine over and above the existing capacity to reach the ratio of one practitioner of modern medicine per 1000 population. This necessitates significant improvement of infrastructure. Across the country approximately 750,000 additional beds will need to be added to the existing base of 1.5 million beds. Additional 520,000 physicians will be required over and above the numbers that will be added through existing medical colleges, to reach a ratio of one practitioner of modern medicine per 1000 people. It is estimated that creating this capacity will require Rs100, 000 crore to Rs140,000 crore of investment over the next 10 years. After factoring in the expected capital investment by government and multilateral agencies during this period, it is estimated that almost 80% of this amount will need to come from the private sector. This will pose a massive challenge before the Government for proper regulation and accreditation of private sector on one hand and proper chanelization and utilisation of this investment for achieving the state health goals on the other.

Government of West Bengal is committed to decentralization. During last 27 years sincere and continuous efforts have been made for real empowerment of Panchayati Raj Institutions and Urban Local Self Governments. This has resulted in transferring of more and more authority and resources to them. One of the important areas of their responsibility is Health & Family Welfare.

The 73rd Constitutional Amendment Act of 1992 mandated, for the first time, permanence for the local governments, and created fully representative local government structures at three levels for rural areas. The main features of the 73rd amendment are – (i) recognition of *gram sabha* as a general body of electors at the village level, (ii) directly elected local self governments at three levels for rural areas (called Panchayats), (iii) conduct of regular elections at 5 year intervals, (iv) reservation of seats for scheduled castes and scheduled tribes in proportion to their population, (v) reservation of one third of the seats for women, including those of offices of chairpersons at all tiers, (vi) constitution of State Finance Commissions for considering the financial requirements of the local bodies and making appropriate recommendations to the state governments, and (vi) establishment of State Election Commissions for conduct of local body elections. The accompanying 74th constitutional amendment contained a provision for setting up of District Planning Committees (DPC) to prepare development plans for the district as a whole. This constitutionally mandated planning also includes the important area of Health & Family Welfare. We now have permanent de-centralised structures which can manage, monitor and oversee the health related activities at their respective levels.

Most of Panchayati Raj Institutions at all the three levels are trying to do their best to supplement the efforts of the State Government. However, their efforts are also constrained by resources and this issue is again linked with the policies of the National Government.

In this background the role and importance of other stakeholders in health sector, i.e. NGOs/CBOs/Private Sector/Civil Society especially for outreach activities and camps, apart from Government can be easily understood and realised.

Public-private partnerships in health sector can supplement the government's efforts in several ways enumerated below:

- By ensuring better access to services provided by non-profit private organisations with a proper safety net in regions or for groups that the government finds difficult to cover adequately
- Increased access of the poor to health care delivery systems through health insurance
- Increased number of people receiving health services
- Optimum utilisation of scarce public resources and their targeting for the poor
- Improved utilisation of facilities of both private and public sector
- Improved supply and availability of necessary equipment and medicines, etc
- Improved infrastructure and facilities

- Easing the pressure on the public sector health care facilities in primary, secondary and tertiary care level, mainly of the patients who have ability to pay
- Giving access to the poor and vulnerable sections of population to modern and state of art diagnostic facilities through PPPs having proper safety nets
- Reducing the market rates for different diagnostic tests / procedures etc. provided by for - profit private sector units

B SCOPE OF PUBLIC PRIVATE PARTNERSHIPS IN WEST BENGAL

Though the Government will play a proactive role in promotion of Public Private Partnerships and engagement with private sector, it will be careful in so far as selection of partners and design of partnerships are concerned. However, the information given below in this paragraph will give some idea about the range and scope of such collaborations.

B1 Public-private partnerships already in place

- a. Diagnostics and Others:
 - i. CT Scan established in 7 medical college hospitals.
 - ii. MRI installed in one medical college hospital.
 - iii. Agreements signed for diagnostic facilities in 19 Rural Hospitals for X-ray, USG and selected pathological examinations. 10 units already functioning.
 - iv. Dialysis of patients of Government Hospitals in a Joint Sector Hospital at lower rates as compared to market and even public facilities.
 - v. Running of 133 ambulances for emergency transport under management of NGOs/CBOs at the level of BPHCs.
 - vi. Three mechanised laundry units for 30 Hospitals in Kolkata for washing of linen.

- b. NGO Partnerships in AIDS Prevention & Control Programme undertaken by West Bengal State AIDS Prevention & Control Society:
 - i. Partnership with NGOs for implementation of 43 Targeted Interventions for highly vulnerable groups such as Female Sex Workers, Males having sex with Males, Users of injectible drugs and Bridge Population Groups such as truckers, migrant labours, street children and tea plantation workers covering few of the most uncovered zones of service delivery.
 - ii. Partnerships with NGOs for running 23 Voluntary and Confidential Counselling and Testing Centres.
 - iii. Partnerships with NGOs and CBOs for running 10 different centres in various hospitals under the Prevention of Parent to Child Transmission Project.
 - iv. Partnerships with 3 NGOs for providing care and support services for People Living with HIV/AIDS.

B2 Public-private partnerships proposals under consideration / implementation

- a. Establishment of a private medical college
- b. Establishment of a dental college
- c. Dialysis units in tertiary level hospitals

- d. Supply of centralised oxygen through pipelines by Private Partners in Medical College
- e. Establishment of a Cancer hospital
- f. Outsourcing the management of selected non functioning primary health centres located in remote and difficult to reach areas.
- g. Contracting in of services from private sector units by public sector in following four areas:
 - Provision of Dialysis Facilities to referred patients from the Government Hospitals.
 - Provision of MRI SCAN facilities to referred patients from the Government Medical Colleges and Hospitals.
 - Provision of Endoscopic Surgical facilities in the fields of Ophthalmology, Orthopaedics, Otolaryngology, General Surgery, Obstetrics & Gynaecology (both diagnostic and therapeutic) to referred patients from the Government Hospitals.
 - Provision of Cardio-thoracic surgical facilities (diagnostic and therapeutic / interventional) to referred patients from the Government Hospitals.
- h. Social Franchising Scheme to provide supplementary RCH related services in five poor performing districts in collaboration with private sector.
- i. Setting up of diagnostic facilities especially in primary health care level such as BPHCs and Rural Hospitals.
- j. Setting up of diagnostic facilities in secondary health care level hospitals as per requirement.
- k. Development of the centre of Pulmonology and the resource centre in the field of Pulmonary Medicine under joint venture with Government of West Bengal.
- l. Development of a Neo-natal and Maternal Health Institution.
- m. Establishment of a Super Speciality Eye Hospital.
- n. Establishment of a Neuro Sciences Hospital.
- o. Establishment of a Super Speciality Eye Hospital.

B3 Public-private partnership initiatives envisaged under Reproductive and Child Health Programme II

- i. The current social marketing scheme as envisioned by GOI is to be expanded and diversified and new social franchising initiatives will be developed.
- ii. Current contracting in approaches of both Health and Non-health professionals will be developed and expanded.

C THE NEW PARADIGM

In recent years out of the compulsions in the perspective explain in the foregoing parts there has been a paradigm shift in the policy planning of the Department and in view of this the following issues that have been adopted as a policy by the Department shall guide the overall approach in development of PPP.

1. To achieve the ambitious targets set by the DHFW there is a need to introduce courageous reforms, which represent a challenging agenda of re-orientation of the public sector. It has been recognized that government has a stewardship role to play in order to ensure both the public and the private health systems operate and interact in such a way that all parts of society and particularly the most vulnerable parts have access to affordable good-quality essential services. The reorientation of the public sector functioning will be based on building upon the massive and time-tested strengths of the public sector and they shall not be allowed to be diluted or ignored. To add to it, the Public Sector shall continue to address the limitations of the private sector after careful assessment.
2. Under the new strategy, the GoWB has decided to replicate and scale up successful service delivery experiences such as those initiated during the IPP-VIII project in the poor and uncovered areas of Kolkata, characterized by community participation and ownership, flexible delivery systems, and focus on results (outputs and outcomes). More Schemes of community-based workers will be designed and implemented .
3. It has been decided that it is important to distinguish more clearly between problems which have efficacious interventions exclusively as part of ambulatory care services – such as the life-threatening illnesses – and those which do not, such as reducing maternal and neonatal mortality. The later can be addressed mainly by actions to effect services at or near community level through preventive public health measures, awareness generation and community participation. The former typically also require higher-level services, usually beyond those that can be adequately financed or provided at the primary health center level. They will require addition of capacities in secondary and tertiary health care level facilities supported by appropriate health financing mechanisms through insurance policies to protect the vulnerable population.
4. To improve post neonatal and child mortality indicators, control communicable and non-communicable diseases, the focus shall be on *i*) disease prevention and health promotion, *ii*) nutrition and *iii*) ambulatory care, and activities. The targets shall include interventions which will: increase coverage of immunization; prevent those diseases for which there are already good preventive interventions; recognize at an early stage and promptly and effectively treat life threatening illnesses (especially ARI, diarrhea and malaria); and improve child feeding practices to prevent malnutrition; improve child nutrition; and increase age of marriage. How to do this on the face of fiscal constraints is the challenge that can be partly met by involving private partners including private medical practitioners in service delivery, community outreach and social mobilization.
5. For maternal and neonatal mortality reduction, improved antenatal care, increased coverage of institutional / supervised deliveries, and improved postnatal care are essential. First referral units need to play a critical role by providing 24-hour access to emergency obstetric care services.

6. The challenge shall be attempted to be addressed from several points of view: in secondary and tertiary care, further improving performance of public facilities, and making a better use of the growing capacity of private facilities under proper regulation and accreditation, in primary care, strengthening the coverage/quality and linkage of public providers (mainly ANMs and PHC staff and ICDS), engaging formal and informal non-government providers accompanied with their capacity building and regulation (which account for more than 80 percent of first-contact services), experimenting innovative delivery systems characterized by outreach activities, team-work, greater community participation and new accountability mechanisms based on results.
7. The Government appreciates the fact that attainment of many of the goals adopted by the DoHFW will be difficult to achieve in time without involvement of the private sector. It shall certainly lead to improved health services, building on the experience being accumulated in the national TB, Leprosy, AIDS and other programs (such as IPP-VIII), and on the other initiatives more recently initiated by the Department. However, these initiatives will have to be carefully evaluated and monitored.
8. The market share of the private sector in both rural and urban areas and for both inpatients and even more outpatients is large and increasing. For ambulatory care and sometimes for first aid and emergencies in remote areas, the first healthcare provider consulted, especially by the poor, is most frequently a Rural Medical Practitioner / traditional healers without formal qualification etc. Qualified private providers are also important, especially for those with higher incomes but also for the poor in some more developed areas. In some locations and for specific services NGOs are the most important providers. The Department will have to utilise the services of such private sector for meeting its goals with two pronged approach of proactive engagement and effective monitoring.
9. However, quality of treatment and care in the private sector, particularly quality of care provided by not-fully qualified providers, and process of overmedicalization of treatment are serious issues, which shall be addressed by the Government. There are several types of not-fully qualified providers, including practitioners of traditional forms of medicine who also administer allopathic treatment, faith healers, assistant pharmacists and drug sellers, etc. The anecdotal evidence available suggests that informal providers continue to practice irrational medicine, and can endanger their patients health by unnecessary and often unsanitary treatments, such as harmful injections, and over-prescription or under-prescription of antibiotics. For qualified providers, anecdotal evidence indicates that: a) their services are sometimes too costly and not accessible to the majority of the population: prices are not posted publicly, and they tend to be well beyond poor people's ability to pay; b) they tend to over-prescribe and provide unnecessary treatment, particularly to better-off patients (supply-induced demand).
10. A research team from the Massachusetts Institute of Technology and Princeton University, all working under the aegis of the institute's Poverty Action Lab, after conducting study in five states of the country, found that given the state of the public facilities, the main sources of health care are private practitioners and traditional faith healers. However, such practitioners are largely untrained and unregulated. The team found that 41% of those in the private sector who called themselves doctors said they had no medical degree, 18% had no medical or paramedical training at all, and 17% had not even graduated from high school. In

68% of visits to private clinics or practices patients were given an injection and in 12% patients were given a drip, compared with 32% and 6% in public facilities. Only 4% of visits to private facilities led to a laboratory test for diagnosis.

Another study by National Family Health Survey -2 in 1998-99 confirms irrational and over-prescription of medicines. The study also showed that on average 45% of medical or paramedical personnel were absent from government run sub-centres (serving a population of about 3600) and 36% were absent from the larger primary health centres (serving 48,000). The sub-centres were closed 56% of the time during their regular opening hours, at unpredictable times, discouraging people from walking an average of 1.4 miles from their village

The findings pertaining to the layout and content of the prescription show that the prescribing practitioner's name and contact details were missing from more than a quarter of the prescriptions. Three-quarters of the prescriptions did not include the Medical Registration Number of the practitioner and less than half had the full name of the patient. The majority of the prescriptions did not have clear instructions for the patient on how to use the medicines prescribed.

Most patients (80.7%) received more than one medicine per prescription; more than half (52.7%) received three or more medicines per prescription. 13.3% received 5 or more medicines. 21.5% of prescriptions had no details of the duration of treatment. Most prescriptions (23.6% of valid prescriptions) were for a period of 30 days.

11. The private sector has untapped potential to help deliver information and services that would address the priority health goals, but in order to utilise such potential a completely new approach of engagement shall be adopted by the Government. There have been small scale attempts of Community Health Insurance for disadvantaged communities in several areas of the country by NGOs in collaboration with insurance companies which need to be further examined and scaled up.
12. Some priority areas for PPP have already been identified which are either under implementation or examination. These have already been indicated in Section C under the heading "Scope of PPP". However, the list given there is only illustrative and not exhaustive.
13. Another area where the private sector could play a potentially important role is in improving maternal health; both by providing antenatal and postnatal care services, as well by contributing to step up coverage of emergency obstetric care services and immunization services for the infants at least in the urban areas. For the latter, secondary care facilities both in the public and private sector shall play a critical role.
14. Although it is common to see the provision of supervised deliveries as the responsibility of the state. Department of Health & Family Welfare, Government of West Bengal shall look at all the options for supervised delivery including deliveries performed in private sector.
15. Finally, for other secondary care and tertiary services, whose impact on priority health outcomes is more limited, more emphasis on private sector investment in hospitals will be given to help the Government to create fiscal space for reallocation of funds to activities in support of essential services. This will also help create bed space for the poor in public hospitals. It shall be ensured that the

agreements between government and private sector in tertiary, secondary and primary care have proper safety net for the poor. Proper costing of services to be provided under such agreements are bound to reflect in prices which will generally bring down the prices for such services provided in exclusive for profit private sector.

16. A gradual and planned increase in involvement of the private sector in provision of hospital beds by setting up more private nursing homes and hospitals, together with greater rationalization of the current system of user fees and their retention at public hospitals shall be attempted. In order to achieve the above, the GoWB shall develop an institutional framework for enhancing the quality of care in the private sector, which would include licensing, an accreditation system, and a continuous programme of quality monitoring and evaluation. This may require setting up of an Independent Board / Authority in due course.

D SOME PARTNERSHIP MODELS

The Department of Health and Family Welfare (DoHFW), GoWB would adopt measures to translate the policy framework into operational strategies. It has been the national and international experience that following types of public private partnership models can be established for different areas, objectives and situations. DoHFW, GoWB would also adopt suitable models on case to case basis for engaging in partnerships in different areas.

Model 1 Working with Civil Society

The Government is committed to the concept that health of the community is safest in the hands of the community. It has already been stated that it is the responsibility of the Government to ensure that Health Status of all the people of West Bengal, especially the poorest and those in greatest need is improved, however, this responsibility cannot be fully discharged without active and organised participation of community and civil society through Panchati Raj Institutions and Urban Local Self Governments. The Government's role is to empower the communities and work with them for service delivery in some identified areas.

Salient Features:

- a. Clear identification and documentation of areas/schemes where Civil Society could be involved
- b. Schemes to be easily available and accessible
- c. Clear guidelines for pre grant appraisal to be developed and guidelines to form a part of the scheme
- d. Strategies to be developed for institutional strengthening of NGOs /CBOs including developing governance and management systems

The Department of Health and Family Welfare, GoWB will invite NGOs/CBOs to partner in the following areas:

- i. Behavioural change communication initiatives focussing on improved household practices especially child bearing and rearing, small family norm, increasing age at marriage of girls, improving health seeking behaviour, promoting higher utilisation of government healthcare facilities.
- ii. Advocacy support initiatives aimed at promoting partnerships with the community and community based organisations such as self help groups, youth clubs, mahila mandals, village health committees etc.
- iii. Responsibility for provision of specific support services such as emergency transportation, sanitation and maintenance of public hospitals as well as the running of diagnostic facilities.
- iv. NGOs/CBOs would also be considered for taking responsibility of managing operations of selected PHCs and Sub Centres, located in remote and

inaccessible areas on experimental basis with the involvement of local doctors / nurses.

- v. NGOs/CBOs would be invited to set-up and operate medical and para-medical educational institutions in the State.

Some illustrations of the areas in which PPPs can be implemented are:

- Outsourcing non-clinical (cleaning, catering, building maintenance including asset management) support services
- Buying in / outsourcing clinical support services (such as diagnostic services)
- Buying in / Outsourcing specialized clinical services (such as dialysis) or routine procedures
- Private financing, construction and leaseback of a new public hospital (Build Own Operate-BOO)
- Private financing, construction and operation of a new public hospital (Build Own Operate Transfer -BOOT)

Authorizing patients from the OPD of a government hospital to a private facility at a fixed predetermined price

Model 2 Service Agreements

Outsourcing, as a model, is similar to “Buying a Product” except that unlike the latter the former covers the entire service package for a particular area, like the complete diagnostic set up could be outsourced by the DoHFW, GoWB to a private partner to provide all diagnostic tests that the DoHFW, GoWB wants.

Salient Features:

- a. Some Outputs are easy to measure
- b. Prices are determined in advance
- c. Better clarity of transactions and responsibilities
- d. Easy to control
- e. Commitment depends on the type and length of the contract
- f. No long term risk involved
- g. Low risk for both the partners

Critical Success Factors	Clear definition of outputs Good monitoring Good contracting experience with legal know how
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Advantages	Cost effectiveness
Limitations	Monitoring and quality assessment

Model 3 Buying a Product/Service

Buying of a product or service will be usually preferred by the DoHFW, GoWB to meet gaps/demands in services for a short period of time. This option might not always be a cost effective solution and therefore will be a short-term solution to the need. Usually products purchased are in form of specialised services, like conducting of lithotripsy, dialysis, etc.

Salient Features:

- a. Simplest of all forms
- b. Outputs are easy to measure
- c. Prices are determined in advance
- d. Better clarity of transactions
- e. Easy to control
- f. No long term commitment
- g. No long term risk involved
- h. Low risk for both the partners

Critical Success Factors	Clear definition of outputs Good contracting experience with legal know how
Advantages	No legal entity required to deliver Can help in managing short term sudden increase in demand of a particular service
Limitations	Could in certain circumstances be costly Requires proper monitoring and quality assessment

Model 4 Joint Venture Company

Joint Venture, as a model for private sector participation, entails both the DoHFW, GoWB and the private sector partner bringing in equity capital, which need not necessary be in monetary terms for the DoHFW, GoWB. DoHFW, GoWB will enjoy a

proportionate share in the equity in the company for the opportunity, space, market, authorization, good will, etc. that it will provide to the private sector for operating a particular service or a set of services.

Salient Features:

- a. Both DoHFW, GoWB and private sector partner will bring in some value, which is tangible in nature and could be quantified for determining allocation of percentage shares in the company
- b. Risks will be shared by both the partners, but here the stake as compared to Model 1 is limited because there is no long term commitment as in the BOT (Model 1).
- c. Returns, in form of cash or services/goods (non cash), are shared between both the partners proportionate to the equity allocation
- d. Simple to set up
- e. Government’s involvement in the governing board may slow down the progress
- f. Usually it is difficult to monitor “benefits in kind” (such as social benefit).
- g. Government may not have expertise in the relevant area

Critical Success Factors	Clarity of roles of the partners Good monitoring system Clearly laid out exit policy
Advantages	Feature ‘a’
Limitations	Features ‘f’ and ‘g’

Model 5 Social Marketing and Franchising

The DoHFW, GoWB will work closely with the private sector/NGOs to use their extensive marketing and distribution capability to promote social services/products to meet community needs through a combination of social marketing and social franchising approaches.

Salient Features:

- a. Inbuilt strategies for financial sustainability
- b. Improved access to health care
- c. Increased efficiency, coverage and utilization of services
- d. Standardised quality and uniformity of delivery

- e. Objectives and performance criteria are carefully defined though difficult to monitor
- f. Effective decentralized implementation systems are institutionalised
- g. Encourages healthy competition in delivery of services
- h. Standard Operating Procedures (SOP) are put in place and implementation team is well trained on the SOP.

Critical Success Factors	Features 'a', 'e', 'f' and 'h'
Advantages	Features 'b', 'c', 'd', 'g'
Challenges	Setting up of effective service delivery management systems and procedures Setting up mechanisms of total quality management and continuous quality improvement through regular monitoring

Model 6 Build, Operate and Transfer

Build, Operate and Transfer Model is usually preferred for projects involving large size and long duration lease (upto 30 years). In this option the private sector will bring in the required capital investment, build and operate the facility as per the specified outputs of DoHFW, GoWB. At the end of the lease period, the facility will be handed over to the DoHFW, GoWB.

Salient Features:

- a. Contractor (usually a consortium of private partners) provides a running facility.
- b. DoHFW, GoWB will specify clear outputs
- c. Payments by DoHFW, GoWB will be linked to and will be proportionate to achievement of outputs by the private sector partner
- d. Balance of risk will get transferred to the private partner – optimal risk sharing
- e. Usually of a long term duration
- f. Needs good and efficient monitoring system, which is not easy to set up.
- g. Control over the facility will be retained by the DoHFW, GoWB
- h. A Special Purpose Vehicle (SPV) will be created by the private sector partner for implementation of the particular project. The SPV could be a

separate company or a legal entity, which comes into existence exclusively for the purpose of that particular initiative and the life of such entity will be coterminus with the life of the project under consideration.

Critical Success Factors	Features 'c', 'd' and 'g'
Advantages	Features 'c', 'd' and 'g'
Limitations	Features 'e' and 'f'

E SPECIFIC AREAS FOR PPP IN WEST BENGAL

Within the overall framework of different models indicated in Section D above the following specific areas can be considered both by the Government as well as private partners for PPPs.

E1 Tertiary & Secondary Level

- E1.1 Outsourcing support services such as diagnostic and pharmacy services in government hospitals of West Bengal, to specialised private partners meeting prescribed quality standards. CT Scan and MRI Scan centres have already been initiated with private partners in some of the tertiary care hospitals in the state.
- E1.2 Government hospitals in West Bengal partnering with private hospitals for provision of specialised medical services to patients referred by the government hospitals.
- E1.3 PPPs to upgrade/establish and operate specialised treatment services/wards and facilities (including diagnostic services) within government hospitals in West Bengal.
- E1.4 GoWB may invest in land and building of a new or an existing hospital. For example, the private partners could bring in the equipment, be given executive management roles; with Department of Health and Family Welfare, Govt of West Bengal participating in the governing board. In this case the partnership can be in the form of a joint venture or a management consortium with voting rights of both partners protected. In order to provide safety net for the poor, certain percentage of services shall be provided free of cost by these joint venture organisations to identify poor patients.
- E1.5 The DoHFW, GoWB may involve a well established private partner in the management of an existing public hospital under an agreement with the objective of getting additional investment and improved management.
- E1.6 The DoHFW, GoWB may invite private partners to invest in setting-up and operating fair price pharmacies in government hospitals.
- E1.7 Operational management of catering, laundry, sanitation/cleaning and waste management, gardening, security and parking are some of the support services that would be priority areas for PPP.
- E1.8 Partnerships for using the larger government hospitals for Gol approved medical research including drug trials will be also be explored.
- E1.9 Shelter and sheds for the attendants of the patients and other civic amenities like public toilets.
- E1.10 Medical Waste disposal systems

E2 Primary Healthcare Level

- E2.1 The Department of Health, GoWB may handover management of a few non-optimally functioning health sub centres and Primary Health Centres, located in remote and inaccessible areas to private/NGO partners on experimental basis under agreements beneficial to both the parties.
- E2.2 The Department of Health, GoWB would partner with private players to set up and operate a network of diagnostic centres in the State covering all the BPHCs/Rural hospitals with appropriate range of diagnostic services on a fee for service basis with safety net for the poor.
- E2.3 The DoHFW, GoWB may invite private partners/NGOs to provide emergency transportation and trauma care services. A considerable number of ambulances are already operational in several districts in partnership with NGOs.
- E2.4 Private pharmaceutical manufacturers/distributors could partner with the Department of Health, GoWB to set-up & operate a network of fair price pharmacies for generic drugs (essential drugs lists) operated from within/outside the government hospital facilities.
- E2.6 Private distribution and rural marketing companies could partner with the DoHFW, GoWB to market contraceptives and maternal and child health related drugs and supplies at agreed prices.

This is to again clarify that the above mentioned examples are only illustrative and a lot of other innovative schemes and approaches can be implemented.

This is to also clarify that operational schemes under different models mentioned above will have to be prepared separately in detail and there can be wide variations of the schemes designed under different heads mentioned above. Such detailing is beyond the scope of this policy document.

F GUIDING PRINCIPLES

1. The PPP models will only be used where it is appropriate and where it can deliver value for money. Most of the models will have proper and adequate safety nets for the poor and vulnerable population. Enhanced competition, innovation, optimal risk transfer, the use of whole life costing, improved asset maintenance are some of the expected benefits of the PPP approach. But these potential benefits shall not be taken for granted and must be demonstrated on the basis of evidence in each case. A robust and transparent process for assessing the value for money of each project would therefore be essentially adopted. Proper systems for monitoring and evaluation will also be put in place.

2. The PPP approach will be used where the private sector can offer innovative design, management skills and expertise, which can facilitate risk reduction and can bring substantial benefits.
3. The PPP model will not be used where the transaction costs of pursuing PPP are disproportionately high as compared to the overall value of the project.
4. Under the PPP model, private partners will enter into appropriate partnerships and take responsibility for the quality of service they provide through the particular project. To ensure the success of a project, optimal sharing of risk between the Department of Health and Family Welfare, Government of West Bengal and private sector would be promoted, with each partner retaining the risk, which they are best placed to manage.
5. The success of PPP arrangements shall depend in large measure on the sustained participation of the Department of Health and Family Welfare, Government of West Bengal and the private partners in **real partnerships** to deliver quality healthcare services to the people.
6. Innovative cost recovery and financially self-sustaining strategies will receive preference in all areas of PPP.
7. Pro poor strategies to ensure easy and equitable access to health services will be given preference.
8. Approaches suggesting innovative strategies entailing no major financial burden on DoHFW, GoWB will be given preference.
9. The Department will generally frame the models/schemes for different areas of PPP and publish them as government policy documents as and when they are ready. Usually the partners will be selected through the process of press tendering after such models / schemes are finalised.
10. The processing of the proposals which are very special in nature and do not strictly fall in the models described in this policy document may be done on case-to-case basis, only if after initial assessment they are found to be of larger public interest.