

## CHAPTER – II

### METHODOLOGY

For the purpose of this study, the private sector was broadly defined as those non-governmental organizations or individuals who provide health services either ‘for-profit’ or ‘not-for-profit’ (‘non-profit’). Specifically included are (for-profit) nursing homes, hospitals and private commercial contractors/agencies, and (not-for-profit) developmental organizations, charitable institutions, community based organizations and local self government bodies.

At the outset, the study was planned using case study methodology. Initially it was proposed that five case studies each, from five different states in India, on public-private partnership would be compiled. A mailed survey was attempted to list all possible examples of public private partnership (PPP) initiatives in more than 20 states. Letters were sent to the health secretaries requesting for a list of PPP initiatives in their respective states. This was followed up with direct consultations with several state health departments. The policy reforms options database -PROD (<http://www.prod-india.com/>) was also used to prune the list of possible examples of PPP initiatives in different states. Further consultations were held with health sector experts at the ministry of health (GoI) and bilateral and multilateral development funding agencies (World Bank, WHO, ECHFW, DFID, etc). The project directors attended two workshops on health sector reforms, and public-private partnership in health held at Hyderabad and Delhi respectively. Based on these consultations, a tentative list of 26 case studies was short listed for detailed documentation. In the meanwhile, draft version of instruments for data collection (Interview schedules and information checklists) was prepared. There were 2 sets of information checklists and 8 sets of interview schedules that were prepared. These schedules and checklists were meant to compile data on: a) Contract details; b) Profile of the public agency; c) Profile of the private agency; d) Interview with public health staff; e) Interview with private agency manager; f) Interview with health ministry officials; g) Patient FGD; h) Interview with public hospital administrators; i) Interview with patients and beneficiaries; and j) Interview with private agency/ NGO staff. To pretest the checklists and the methodology, a pilot study was conducted on the contracting of CT Scan and MRI services and the lifeline fluid store at Sawai Man Singh (SMS) Hospital, Jaipur.

A consultative workshop was held in Delhi in March 2005. Based on the feedback and suggestions, necessary modifications were made in the methodology, checklists, and interview schedules. After considerable debate during the consultative workshop (about the true meaning of public-private partnership) it was agreed that only those initiatives that have an explicit agreement between the government (public sector) and the private or NGO organizations, whereby the partners agree to work together in a formal manner, could qualify as public-private partnership initiative. The spirit behind the choice of such partnership examples is explained in the previous chapter (chapter-1). Based on this criterion the number of case studies to be compiled was pruned to only 16 but spread over nine different states. These states from where the case studies had been compiled are from Tamil Nadu (1), Karnataka (4), Andhra Pradesh (2), Gujarat (2), West Bengal (2), Madhya Pradesh (1), Uttaranchal (1), Rajasathan (2), Delhi (1) (number of case studies in the parenthesis).

Care was taken to select partnership projects which could provide variety in terms of the nature of partnership. Some of these states have had the World Bank initiated health systems development projects in place and some of them under sector investment program (SIP) of the European Commission for Health and Family Welfare (ECHFW). Also, the study spanned a wide range of health services. They include clinical services as well as non-clinical support services, located in rural and urban areas, stationary establishments as well as mobile

services. More specifically they include diagnostic services, general curative care, maternal and child health services, community health financing activities, health promotion activities and ICT-based health service provision. In Tamil Nadu, Uttaranchal, and West Bengal the PPP initiatives that was documented relate to mobile health services: the first one relates to emergency ambulance, the second one relates to diagnostic and general health care provision and the third relates a combination of the above two. Some of the PPP initiatives ranged from super specialty, tertiary care hospitals (Apollo Hospital, Raichur, and SMS hospital, Jaipur) to primary care (Karuna Trust in Karnataka) to slum communities (Arpana Swasthya Kendra, Delhi, and Urban slum care in the district town of Adilabad, Andhra Pradesh). Community health insurance initiatives in two states were also documented (Arogya Raksha scheme, Andhra Pradesh and Yeshasvini scheme, Karnataka). Other partnership initiatives studied include telemedicine and tele-health project (Karnataka), and contracting out cleaning, kitchen and laundry services (West Bengal). There is a lack of clarity on the exact status of Rogi Kalyan Samiti, a hospital autonomy initiative under decentralised context, by local self government in the city of Bhopal. The RKS in the JP hospital, Bhopal (Madhya Pradesh) was taken up to understand whether it fits in to the PPP framework.

Background details on the projects and schemes were compiled as follows:

- Profiles of implementing agencies – history, organizational structure, management board, business/services provided;
- Procedures followed in signing the partnership (contract) deed – decision-making process, competitiveness and transparency in selection process, criteria for selection, time taken;
- Scope and coverage of services under agreement;
- Eligibility conditions for the private agency – minimum investment, prior experience;
- Specific clauses in the MOU – maximum duration of the contract, pricing and service specification, billing and payment mechanisms, managerial flexibility, supervision and monitoring, quality control, employment/service conditions to the staff, physical infra-structure support, subsidies and incentives, penalties and fines, exit clause, grievance redressal system, performance evaluation, renewal of contracts;
- Clauses related to public health objectives – specific services and subsidies to poor, women and children
- Feedback of stakeholders – state and central bureaucrats, public health facility managers, private agency managers, beneficiaries, staff in both public agency and the private agency, community leaders.

Interviews were conducted with stakeholders such as beneficiaries (patients), health staff in both public and private agencies, bureaucrats, health facility managers, private agency manager, and representatives from the community.

Background information about the partner agencies was obtained from annual reports, bulletins, and other organizational publications. Stakeholder perspectives on partnerships were obtained through interviews and focused group discussions. Newspaper clippings and anecdotal evidence were also gathered.

In February 2006 a **review workshop** was held in New Delhi to disseminate the major findings of the study as well as to seek feedback to finalize the research report.

A **CD-ROM** containing details about the project, and the outputs from the project has been prepared. The research study also compiled a detailed annotated bibliographic database on public-private partnership. There are more than 800 entries in the reference/ annotated bibliographic database. This data base is expected to be hosted at the ICSSR-IDPAD website.

**Limitations of the Study:** The research study had set out to undertake an exhaustive review of the current status of PPP in the health sector in India. During the course of the research study, it was apparent that there is little understanding on subject area due to paucity of both conceptual and empirical evidence. Though this gave us a great deal of advantage to work on, but the operational managers at the field level could not comprehend many of the questions and issues on which we were seeking their feedback. Similarly there exists a perception among the beneficiaries that, it is either the government or the private sector which is providing the health services, all by themselves and not under any collaborative agreement. There is little understanding that there exists a partnership. In such conditions it was difficult to objectively review the beneficiaries' view points in the partnership. The study set out to compile an exhaustive volume of information, but in most of the cases either the documentation is poor or the data was kept confidential. There was also paucity of information (primarily due to non inclusion of contract clauses) on cost or pricing, quality control, performance monitoring, incentives, dispute settlement, penalties, etc. The operatives or managers were not fully aware of the contract details. Despite these limitations the authorities were co-operative in making available whatever documents that was 'permissible' for consultation.

This research study was primarily exploratory in nature. Perhaps we were highly ambitious in trying to conduct a comprehensive documentation of each and every nuance of the partnership examples, and had presented in this report as many relevant facts and details we could gather. While analysing the case studies, the report has brought out a number of hypotheses on issues that were not clear during our investigation. Some of these explanations require more in-depth investigation and clarity.