Engaging the public & private sectors in data sharing

to improve maternal and newborn health in Uttar Pradesh, India

August 2013
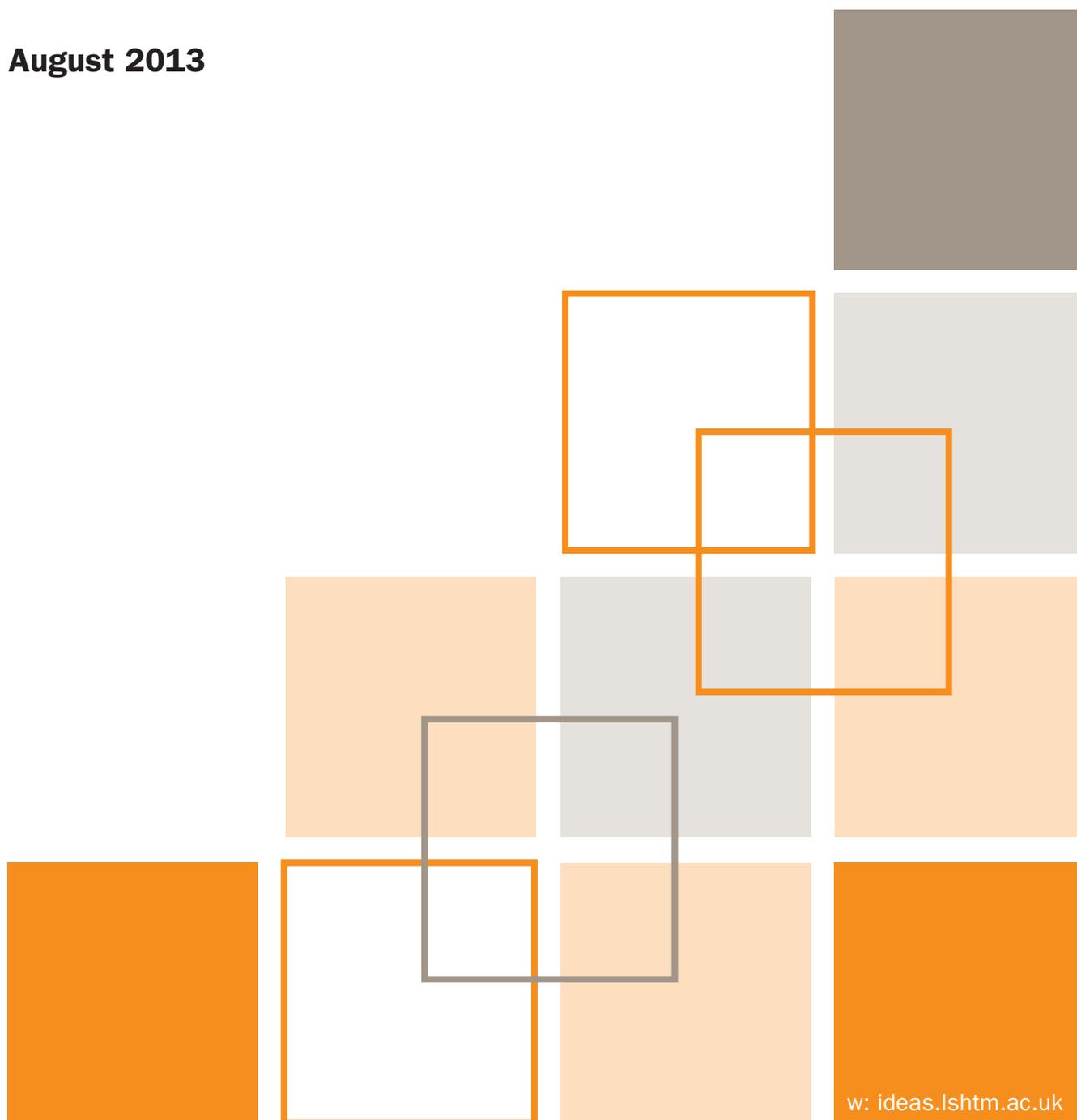
w: ideas.lshtm.ac.uk

KNOWLEDGE TO ACTION

phfi

PUBLIC
HEALTH
FOUNDATION
OF INDIA

IDEAS
Evidence to improve
maternal & newborn health

LONDON
SCHOOL *of*
HYGIENE
&TROPICAL
MEDICINE

Copyright London School of Hygiene & Tropical Medicine

w: ideas.lsthm.ac.uk

ISBN - 978 0 902657 95 X

Table of Contents

Key messages

Background

The private for-profit health sector in India delivers around 80% of outpatient treatment and 60% of hospitalisations, and includes more than three quarters of human resources for health. The sector includes solo doctor clinics, small hospitals and big corporate hospital chains, as well as many informal providers. The formal private health sector has grown rapidly without regulatory frameworks and quality assurance. Quality of care is variable and there is lack of adherence to standard treatments, protocols or pricing. Limited information is shared with public health information systems.

Aim

To develop an engagement strategy with the private for-profit health sector in Uttar Pradesh, India. The broader underlying goal is to develop and pilot a district level Data Informed Platform for Health (DIPH) for improved local health decision-making in maternal and child health including both the public and private health sectors.

Methods

We reviewed literature, and examined national plans and programme documents to identify lessons from successful public-private engagements for maternal and child health and collate key policies related to the private health sector in India. We sought inputs from 27 national, state and district level stakeholders for developing a strategy to engage with the private sector for a DIPH.

Findings

In India, **public-private partnerships** for service delivery and financing represent a key area of engagement with the private sector, especially for maternal and child health. Examples include the Merrygold network, a clinical social franchise, and the Sambhav voucher scheme, in which poor households can exchange vouchers for health services in selected city hospitals in Uttar Pradesh. Engagements related to data recording and reporting from the private health sector have been less successful. There are **gaps in reporting** even notifiable diseases like Tuberculosis. There is limited data available on the private sector at the national level. **Legal provisions can facilitate data exchange and synthesis**: a binding legal framework may be available when the Clinical Establishments Act, passed by the Indian Parliament in 2010, is implemented.

Proposed engagement strategies
Stakeholder consultations suggested that before the Clinical Establishments Act is implemented, the private sector might best be engaged by:
1. Relationship building among key private and public sector stakeholders.
2. Sensitisation of private and public sector groups and individuals with the concept of a DIPH.
3. Inclusion of selected private sector players in the DIPH
4. User-friendly data collection and management.
5. Provision of both financial and non-financial incentives to encourage and reward private players. ◼

Executive summary

This study was conducted with the objective of developing a strategy to facilitate improved engagement with the private for-profit health sector in Uttar Pradesh, India.

The goal was to obtain buy-in from the private health sector for a district level public health evaluation platform, known as the Data Informed Platform for Health (DIPH). The DIPH, when operational, will enable improved tracking and analysis of programme implementation strength in maternal and child health, by synthesising health information from public and private sources and enhancing its use in local decision making, and comparing maternal and child health (MCH) programme performance across districts (see page 23 for more information on the DIPH). During August-September 2012, a team assessing the technical feasibility of the DIPH found that obtaining information from the private health sector would be a key challenge. It is this challenge that we seek to address through the present study. Besides identifying areas of opportunity for a successful engagement strategy, our other objectives were to examine available literature for lessons on successful engagements between the public and private health sectors and to examine key policies related to the private health sector in India.

The private for-profit health sector in India is very large; it includes 60-75% of human resources for health, including specialist providers. It is the major provider of health care, responsible for about 80% of outpatient treatment and 60% of hospitalisations. In Uttar Pradesh (UP) the private health sector provides around 95% of healthcare for acute illnesses, including childhood diseases such as diarrhoea and acute respiratory infections, and more than 85% of healthcare for chronic illnesses. The sector is independent and fragmented, consisting primarily of solo

Photo above: Informal health provider clinic © Meenakshi Gautham

proprietorship clinics, small hospitals and a growing number of corporate hospital chains, concentrated in urban areas. It also contains a very large informal sector abundant in rural areas. The formal private health sector has grown rapidly without adequate regulatory frameworks, which has resulted in poor quality of care, unethical practice (such as unnecessary treatment procedures and tests), and arbitrary high pricing. In the absence of regulatory frameworks, there is also limited information about this sector at the national level and in public health information systems.

To achieve the study objectives we reviewed literature on engagements between the public and private sectors, especially those related to MCH services such as immunisation in India. We also examined existing national plans and programme documents to determine the different types of policy and programmatic recommendations for the private health sector in India. We sought inputs from 27 key national, state and district level stakeholders, private as well as public, to guide our engagement strategy development. These included representatives of professional medical associations of gynaecologists and paediatricians who are important players in MCH services, and also associations of general practitioners and hospitals at the state and district level. We consulted with selected public sector bodies whose work takes account of the private sector (e.g. the Central Bureau of Health Intelligence (CBHI), the National Health Systems Resource Centre, and the Clinical Establishments Act section of the Ministry of Health and Family Welfare.

The literature review highlighted

that key domains for public-private health sector engagements in developing countries, mostly driven by the public sector, include regulations, information gathering (e.g. data sharing on immunisations and deliveries), financing (e.g. through contracting or provision of supplies), service delivery partnerships, and provision of information and technical assistance. In India, public-private partnerships for service delivery represent a key area of engagement with the private sector, especially for MCH. In UP, the Merrygold franchise and the Sambhav voucher scheme are good examples of public-private partnerships, designed to increase access to low cost or free MCH services by poor households. The Merrygold scheme is a social franchising scheme in 35 districts. A public trust known as the Hindustan Latex and Family Planning Promotion Trust (HLFPPT) invites eligible hospitals to join the Merrygold franchise for an annual fee; in return, the hospitals receive Merrygold branding and promotion as providers of MCH and family planning services at fixed rates. In the voucher scheme, private hospitals in five large towns are accredited by the State Innovations in Family Planning Services Agency (SIFPSA) to provide below poverty line households with maternal and reproductive health and family planning services in exchange for vouchers. The Rashtriya Swasthya Bima Yojana (RSBY), a national health insurance scheme, is an example of public-private engagement in health financing. RSBY beneficiary households (below poverty line households) are entitled to a hospitalisation cover of up to INR 30,000, applicable to any five members of the household.

> " The engagement strategy reflects an underlying need for building greater trust and better relationships between the public and private health sectors, and setting in motion a systematic and well-coordinated process of maternal and child health data synthesis that can become a part of the system."

The IDEAS project

IDEAS aims to improve the health and survival of mothers and babies through generating evidence to inform policy and practice. IDEAS uses measurement and evaluation to understand which health innovations deliver the greatest impact on maternal and newborn survival at scale in Ethiopia, northeast Nigeria and Uttar Pradesh state, India.

w: ideas.lshtm.ac.uk

Beneficiaries pay only INR 30 as a registration fee while central and state governments pay the premium to a private insurer selected by the state government on the basis of a competitive bidding process. The insurer invites eligible hospitals for empanelment upon acceptance of RSBY terms and conditions.

Engagements related to data recording and reporting from the private health sector have met with less successful outcomes in India. There are gaps in reporting even of notifiable diseases like tuberculosis, which is a compulsory legal requirement. To set up difficult collaborations with the private health sector, it may be useful to take stock of lessons from successful partnerships. Our review suggested the following: working in a consultative mode with the private sector, developing contextually appropriate strategies, constant networking and communication with key stakeholders (could be mediated by an intermediary body), and creative incentivising.

Our review of national plans and documents confirmed that public -private engagements for financing and service delivery have made more headway in India than legal/ regulatory frameworks that facilitate information and data sharing. There is very limited data available on the private sector at the national level. At the state and district level, routine data flows from the private to the public health sector are limited to data of uncertain quality on institutional deliveries and notifiable diseases like TB. However, a significant recent development, the Clinical Establishments Act (passed by the Indian Parliament in 2010), promises to provide a legal platform for data synthesis across the public and private health sectors, when it is

fully implemented (it is adopted but not yet implemented in UP). A national autonomous accreditation body - the National Accreditation Board of Hospitals and Healthcare Providers (NABH) -provides voluntary accreditation for the private sector, but is limited to big hospitals in large cities, and its routinely obtained hospital data is out of public access. The Ministry of Health and Family Welfare is in the process of setting up a National Health Portal that may create an alternative online platform for publicly accessible data, such as online registration details of private facilities and providers.

Until these initiatives begin to play a greater role in public-private MCH data synthesis, there are opportunities that other existing engagements provide for our DIPH work: these include the RSBY hospital information (collected through insurance companies); MCH services-related information collected through the Merrygold and voucher schemes; and data collected through public-private collaborative training programmes in the state. We will need the state government's support and facilitation to set up collaborations with these initiatives, although their present scale is quite limited.

Through consultations with stakeholders, we identified five key features of a strategy to build the private health sector's engagement with the DIPH. These include (1) relationship building among key private and public sector stakeholders; (2) sensitisation of private and public sector groups and individuals with the concept and methodology of a DIPH; (3) inclusion of selected, responsive private sector players in the DIPH; (4) user-friendly data collection and management, so

that private providers do not feel burdened; (5) and provision of a variety of financial and non-financial incentives to encourage and reward private players for their participation such as transport allowance, sponsored exchange visits, certificates of participation and joint authorship in publications.

We also identified an existing district level meeting platform that could be leveraged for engaging stakeholders from the public and private sectors. This is the District Health Society, a body set up in each district under the National Rural Health Mission (NRHM) that includes key stakeholders from the public and the private for-profit and not-for-profit health sectors. The Societies meet frequently (almost every month) under the chairpersonship of the District Magistrate (administrative head of the district) to review MCH related programmes and services under the NRHM. These monthly meetings could serve as a useful platform for IDEAS to network closely with both health sectors and to facilitate closer networking and consultations between the two sectors.

The engagement strategy that has emerged through our discussions reflects an underlying need for building greater trust and better relationships between the public and private health sectors, and setting in motion a systematic and well-coordinated process of MCH data synthesis that can become a part of the system in due course. There will be numerous challenges involved and IDEAS will have to play a strong facilitating role to bring together both sectors for this important and useful piece of work. ■

Introduction

Photo above: Name board of private doctors © Meenakshi Gautham
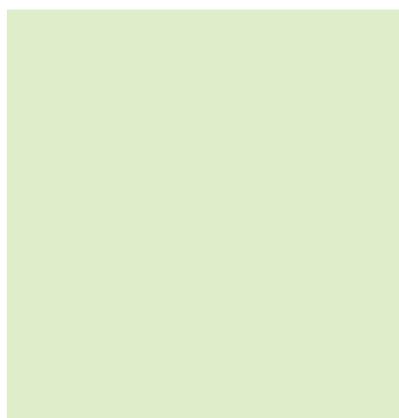
The private for-profit health sector is an important player in India's health system, but there is limited engagement between this sector and the public sector, especially with respect to information sharing. The Bill & Melinda Gates Foundation funded IDEAS project is seeking to establish a comprehensive data based platform for improved programmatic decision making at the district level. This Data Informed Platform for Health (DIPH – see page 23) will synthesise data from the public and private health sectors in Uttar Pradesh (UP), the IDEAS focus state in India. Towards this goal, the IDEAS project team sought to understand the broad scope and policy climate related to the private sector in India, and look for inputs from private sector stakeholders in UP for developing an engagement strategy for information sharing by this sector. This report provides an account of the private sector and the key features of an engagement strategy that the study team was able to identify. In this introductory chapter we highlight the importance of the private health sector in India to confirm its place as an essential component of our DIPH.

The role and extent of the private sector in the Indian health system

Role
The private for-profit sector in India is the major provider of health care for about 80% of outpatient treatment (78% in rural areas and 81% in urban areas) and 60% of hospitalisations (58% rural, 62% urban) (NSSO, 60th round, 2004). Private expenditure accounts for 78% of the total health expenditure in India, with a substantial portion (71.13%) being out of pocket expenditure incurred by households (National Health Accounts, 2004-05). More than 75% of this total health expenditure is spent on private providers and on curative care. Curative care accounts for 90% of household expenditure (NHA, 2004-05).

Extent
The private sector witnessed a period of rapid growth during the 1990s that coincided with India's shift towards economic liberalisation and privatisation (NCMH, 2005). India's Eighth Five Year Plan (1992-97) encouraged private initiatives, private hospitals and clinics, and the government offered incentives such as subsidised land, tax concessions for medical research, reduced import duties and low interest loans for setting up private facilities (Rao, 2012). Medical colleges increased from around 112 in 1980 to 356 in 2013, and the number of private colleges currently exceed the number of government ones (194 private and 162 government colleges - MCI 2013). A facility survey in eight districts found that while public sector facilities increased by only three times between 1980 and 2004 (from 593 to 1605), private facilities increased by more than eight times during the same period (from 677 to 5715) (NCMH, 2005).

During this period the private sector has grown independently, without adequate regulatory frameworks, cost control or quality assurance mechanisms (NCMH, 2005). National level data on the quantity and quality of the private sector is limited and patchy and much of it comes from small scale, cross sectional studies, the most notable one being an eight district/

eight state study commissioned by the Government of India's National Commission on Macroeconomics and Health (NCMH, 2005). This study documented that 61% of a total of 9457 facilities run by qualified and licensed healthcare providers (in the 8 districts) were private, and 75% of specialists, 85% of technology services and 75% of dental, mental health, orthopaedic, vascular disease and cancer treatment services were in the private sector. The study also found that the private sector was concentrated in urban areas. Two-thirds of the facilities, 79% of beds, 75% of specialists and 90% of expensive diagnostic equipment were in urban areas. The ratio of the public-private sector was 60:40 in rural areas compared to 10:90 in urban areas. The presence of the private sector in the poorest 15 blocks was negligible.

Organisation

Organisationally, the private sector has been found to be fragmented, with 91% of the facilities run by sole proprietors. These may include individual practitioners or small nursing homes having 1-20 beds, serving an urban and semi-urban clientele and focused on curative care (NCMH, 2005). Over the last two decades, several big and small corporate hospital chains have also developed, such as Indraprastha Apollo Hospitals and Fortis Healthcare.

There is a very large informal health sector within India's private sector, consisting of different types of unlicensed and informally trained biomedical and traditional practitioners who are a frequent source of outpatient care for common illnesses like fever, diarrhoea, and coughs and colds in rural communities and also among

> **Key findings from a survey of the private health sector across eight districts in India (2005):**
>
> - 75% of specialists and 85% of technology were in the private sector
> - 49% of hospital beds were in the private sector; 79% of these in urban areas
> - 75% of dental, mental health, orthopaedics, vascular disease and cancer treatment services were provided by the private sector
> - Only 24% of villages had a private facility as compared to 88% of towns
>
> Source: National Commission on Macroeconomics and Health 2005

the urban poor (De Costa, 2007; Gautham, 2011; Das 2012). Small studies provide data on the extent of the informal sector too. A survey of all healthcare providers in the central Indian state of Madhya Pradesh enumerated 24,807 qualified doctors (75% private; 80% in urban areas) and 89,090 unqualified informal providers (90% in rural areas) (De Costa and Diwan, 2007). Nonetheless, the informal private sector in India remains on the margins of institutional frameworks (Pinto, 2004; Gautham, 2011), is unrecognised and controversial and therefore a challenge to engage with.

Quality

The absence of a regulatory health framework is of special concern with respect to the private health sector, as the situation has resulted in a lack of minimum standards followed by facilities in terms of physical infrastructure, treatment procedures and pricing (Venkat Raman, 2005).

The unguided growth of this health market has led to malpractices such as unnecessary diagnostic tests and surgeries and very little treatment information shared with patients. There is evidence of other unethical practices such as a nexus between doctors and pharmacies, and fee splitting for referrals. Pricing is generally high, arbitrarily determined and therefore variable. There are many overlaps between the public and private sectors such as 'hidden costs' of drugs and equipment in public facilities, and private practice by public sector doctors. However, this situation has not deterred the growth and utilisation of this sector.

The private sector in Uttar Pradesh

The proportion of private health expenditure to total health expenditure in Uttar Pradesh is 87%, higher than the national average of around 80% (NHA, 2004-05). Health utilisation data suggest that, as in the rest of India, much of this expenditure goes towards purchasing private healthcare. The share of the state's public health sector has increased in institutional deliveries from 24.5% in 2007 (DLHS-3) to 45.6% in 2010-11 (AHS – UP, 2010-11), but the public sector is sought by only 3.8 % of sick persons seeking care for acute illnesses and 9.9% seeking care for chronic illnesses (Annual Health Survey UP, 2010-11)

The private sector in UP is also autonomous and self financed as in the rest of India. It consists largely of solo doctor clinics providing primarily outpatient care, and single-speciality and multi-speciality hospitals providing both outpatient and inpatient care.

During July – August 2012, while studying the technical feasibility of implementing a DIPH in UP, an IDEAS study team collected available data on the organised private sector in UP from the State Medical Faculty in Lucknow, and from the Chief Medical Officers' (CMO) records in two districts, Unnao and Sitapur (IDEAS Feasibility Study India Report, 2012). This data is presented in Tables 1.1 and 1.2. There are 15 private medical colleges in the state compared to 12 government ones and the number of hospital beds in the private sector (208,000) far exceeds the number of beds in the public sector (63,950).

Even non-allopathic facilities (i.e. ayurvedic, unani and homeopathic facilities) are registered with the CMO's office[1]. Table 1.2 shows that Unnao and Sitapur districts have more private sector facilities that public ones. The majority of the private facilities are solo clinics and among these, the non-biomedical ones (ayurvedic, unani and homeopathic ones) are in a majority.

While 50% of the public facilities (comprising all the Community Health Centres in both districts) are empanelled with the Rashtriya Swasthya Bima Yojana[2] (National Health Insurance Programme), fewer private hospitals are empanelled. In our field visits we did not come across private registered solo clinics or hospitals in villages; they were mostly in district centres. Government health facilities were spread out across villages and were not limited to district or block centres. The more remote ones faced staffing challenges.

Objectives of the study

The overarching goal of this study was to seek inputs into a strategy to bring together the public and private health sectors at the district level, to share MCH related information in a common platform for improved decision making and planning for improved MCH outcomes.

The study objectives were to:
- Review different types of engagements between the public and private health sectors and identify key lessons for successful engagement.
- Collate key policies related to the private health sector in India, at the national and state level.
- In collaboration with key stakeholders, identify opportunities of mutual interest regarding data utility and development of a well-defined strategy of engagement for DIPH. ■

[1] Current norms for registration only include a minimum number of beds and more than one doctor for a multispecialty hospital. There used to be a periodic renewal of registration (every year), but we heard that this had been stopped as the High Court gave a stay on yearly renewals (in 2008), so some districts were renewing but many were not. The CMO's office usually registers whoever applies for a registration, and they are visited once to check if their facilities match with their reported information about the facility. There are no routine inspection visits for assessing the quality and functioning of facilities.

[2] RSBY was launched by the Ministry of Labour and Employment, Government of India in 2008 to provide health insurance coverage for Below Poverty Line (BPL) families. Beneficiaries under RSBY are entitled to hospitalisation coverage up to Rs. 30,000/- for most of the diseases that require hospitalisation. The government has fixed the package rates for the hospitals for a large number of interventions. Pre-existing conditions are covered from day one and there is no age limit. Coverage extends to five members of the family which includes the head of household, spouse and up to three dependents. Beneficiaries need to pay only Rs. 30/- as registration fee while central and state government pays the premium to the insurer selected by the state government on the basis of a competitive bidding.

Table 1.1 - Medical colleges and hospital beds in the public and private sectors in Uttar Pradesh

	Public	Private
Number of medical colleges	12	15
Number of hospital beds	63,950

(includes primary and secondary health facilities, district hospitals and medical college hospitals) | Total: 208,000

(includes private medical college hospitals as well as all other private hospitals in) |

Source: State Medical Council, Uttar Pradesh, 2012

Table 1.2 - Public and private facilities in two selected districts* of Uttar Pradesh

Type of facility	Public	Private
Primary Health Centres (PHCs)	20	Not available
Community Health Centres (CHCs)	19	Not available
CHCs upgraded to First Referral Units	4	Not available
Solo proprietorship allopathic clinics	Not available	196
Solo proprietorship non-allopathic clinics	Not available	1103
Hospitals	2	71
Facilities empanelled with RSBY**	20 (19 CHCs and 1 hospital)	11(hospitals)

(source: CMOs' records in Unnao and Sitapur, September 2012)
*These were Unnao and Sitapur districts, that were the locations for the IDEAS feasibility study for the DIPH (details on their selection criteria are provided in the IDEAS Feasibility Study India Report, 2012)
**Rashtriya Swasthya Bima Yojana (National Health Insurance Scheme)

Photo above: Private laboratory © Meenakshi Gautham

Methods

We employed two broad methods to achieve the study objectives: (1) a review of literature on public and private health sector engagements in developing countries, and of health sector plans and programmes in India; (2) a strategy development process to engage with the private sector; this included key informant interviews and group discussions at national, state and district levels.

The study team conducted national and state level interviews in March 2013, while a national level consultation meeting with different stakeholders was conducted in Delhi on 8th April 2013. The reviews were conducted from March-May 2013.

considered irrespective of study design. Studies that discussed partnerships, engagements or relations between public and private health sectors in developing countries were included. Studies in developed countries were excluded. A total of 53 studies were identified and synthesised using a narrative approach. Of these, 33 studies were about India and 20 about other developing countries. The findings have been used to provide an overview of different types of engagement and lessons regarding public-private health sector engagements in developing countries (See chapter starting on page 15).

Scoping review on public-private engagement in the health sector

A scoping review was carried out to identify different areas and types of engagement between the public and private health sectors in developing countries, with a special focus on India. The review also identified evidence on lessons for engaging with the private sector. Basic searches were carried out in Pubmed, Google Scholar and Indmed databases using the keywords 'private', 'public sector', 'health', 'engagement' and 'developing countries'. All available evidence was

Review of private health sector in national plans and programmes

No single policy document in India addresses the private health sector. The most recent health policy was articulated in 2002. We therefore reviewed a number of government plans and programme documents to identify current strategies on engaging with the private health sector. We searched key government documents including the national Five-Year Plans for economic and social development, committee reports and legislations. We limited our search to those policies and

"

We sought inputs and ideas from diverse stakeholders at the national, state and district levels to determine the best and most practical strategies of obtaining and sustaining the engagement of the private sector..."

recommendations that are currently applicable to the Indian health system or are likely to have significant implications on the health system in the future. We reviewed the report of the National Commission on Macroeconomics and Health (2005), Mission Document and Implementation Framework of National Rural Health Mission (2005), Twelfth Five Year Plan (2012-17), Clinical Establishment (Registration and Regulation) Act of 2010 and report of the High Level Expert Group on Universal Health Care in India (2012) (Table 2.1).

In our analysis we first identified the emerging themes about which each of these policy documents provided recommendations related to the private sector. These included regulation; quality assurance; data capture, management and sharing within the health sector; service delivery; finance; planning and management; and training and development of human resources. We summarised the major policy issues surrounding the private sector along these key thematic areas, and then we used findings from our interviews to evaluate each area with respect to the potential for collaborations with the private sector.

Engagement strategy development

We sought inputs and ideas from diverse stakeholders at the national, state and district levels to determine the best and most practical strategies of obtaining and sustaining the engagement of the private sector in our DIPH work. Following individual contact, we organised a joint consultation of all these stakeholders on 8 April, 2013 (see Appedix II for List of Participants).

Key informant Interviews
We held key informant interviews at the national level (Delhi), state level (Lucknow) and district level (See Appendix I for list of interviewees). Rae Bareli district was selected for the district level interviews as it had: (i) the presence of all of the 4 Gates funded projects that IDEAS is concerned with[3]; (ii) active professional associations at the district level; (iii) convenient access from Lucknow. We identified and approached senior officials representing the following different bodies related to the private sector. The selection criterion was that participants should be senior representatives of all the organisations (Table 2.2).

We used snowballing techniques to identify state and district level informants from the national level respondents. Interviews were based on guides developed for different categories of stakeholders (See Appendix III for interview topic guides). Twenty interviews were conducted – ten at national, seven at state and three at district level. Informed verbal consent was obtained before commencing each interview. Major areas of enquiry were: (a) informants' organisational role and background, (b) role and function of the organisation in relation to the private health sector, (c) information available, particularly on the private health sector, (d) informants' views on the current regulatory climate for the private health sector, and (e) views on public-private health sector engagement with recommendations for a sustainable engagement strategy for information sharing. (See Appendix III for topic guides). We carried out a descriptive analysis, identifying and categorising common themes emerging from the data.

Group consultation
We organised a group consultation with national level stakeholders in Delhi. Our objective was to introduce the group to IDEAS' implementation strength and DIPH work, create awareness of data overlaps between our groups, and seek suggestions for developing our engagement strategy with the private health sector. The seven participants included senior representatives of government health information repositories, accreditation bodies, academic institutions and professional associations. Key deliberations were noted and included in our final suggestions and recommendations on an engagement strategy.

Ethical approval
The IDEAS project has obtained ethical clearance from the Health Ministry Screening Committee of the Indian Council of Medical Research in India and by Observational/ Interventions Ethics Committee of the London School of Hygiene & Tropical Medicine, UK. ∎

[3] These include (i) The Surestart project implemented by PATH; (ii) The Manthan Project implemented by Intrahealth International; (iii) The Better Birth project implemented by Harvard University School of Public Health, in collaboration with the World Health Organization (www. who.int), Populations Services International (www.psi.org), India, Community Empowerment Laboratory (www.shivgarh.org); (iv) The Community Mobilisation and Behavior Change project implemented by Public Health Foundation of India in collaboration with The Population Council, Rajiv Gandhi Mahila Vikas Pariyojana, Boston University and Community Empowerment Laboratory.

Table 2.1 - Health sector policy review documents

Document name	Brief description
Report of the National Commission on Macroeconomics and Health (NCMH) (2005)	This report by India's NCMH contains a critical appraisal of India's health system and recommendations on strengthening it to achieve essential healthcare for all.
Mission Document of National Rural Health Mission (NRHM) (2005)- Plan document	This document, prepared by Government of India (GOI), contains the programme objectives, proposed strategies and areas of action under NRHM (2005-12).
NRHM Implementation Framework · Detailed action plan	This is also a GOI document containing the detailed plan for NRHM programme implementation including service delivery, decentralization and community participation
Twelfth Five Year Plan (2012-17) · Plan document	Prepared by GOI, this document lays out India's economic and social sector plan; indicates vision and areas of action in health, and accompanying budgetary requirements.
Clinical Establishment (Registration and Regulation) Act of 2010 · Act of Parliament	The Act of the Indian parliament provides a legislative framework for the registration and regulation of all clinical establishments in the country.
Report of the High Level Expert Group on Universal Health Coverage in India (HLEG) (2012) · Recommendations	This report by the HLEG presents a framework for providing easily accessible and affordable healthcare to all Indians. It includes recommendations on infrastructure, workforce, drugs and technologies and also social determinants of health.

Table 2.2 - Stakeholders participating in the private sector study

Level	Stakeholder category	Organizations included	No. of key informants
National	Key policy making bodies	Ministry of Health and Family Welfare; Planning Commission	2
	Public-private partnership in human resource training	Public Health Foundation of India	1
	Accreditation body	National Accreditation Board for Hospitals and Healthcare Providers (NABH)	1
	Health information repositories	Central Bureau of Health Intelligence (CBHI); National Health Portal	2
	Professional associations	Federation of Obstetricians and Gynecologists' Societies of India (FOGSI); Indian Academy of Pediatricians (IAP)	3
	Technical support institution	National Health Systems Resource Centre (NHSRC)	1
State	Professional associations	FOGSI; IAP; UP Nursing Homes Association; Lucknow Obstetricians and Gynecologists' Society; Practicing Gynecologists' Association	5
	Health information repositories	National Rural Health Mission, UP	1
	Technical support institute	State Institute of Health and Family Welfare (SIHFW)	1
District	Professional associations	UP Nursing Homes Association; IAP	3
		Total	**20**

Private health sector

**Types of engagement
and lessons learned**

Photo above: Outside a private
health clinic © Meenakshi Gautham

A scoping of the different types of
past and present engagements
between the public and private
health sectors in developing country
contexts can provide valuable lessons
towards building an evidence based
plan of action for implementing the
DIPH in UP. This chapter is based on
a scoping review of such
engagements. Its objective is to
summarise and highlight the lessons
learned by programme implementers
and researchers on building and
sustaining such engagements. These
lessons have emerged from
programme evaluations or policy
analyses on engagement of public
and private health sectors.

A key limitation is that most papers
reviewed were written from the
perspective of the public sector
engaging the private health sector in
a controlled manner for achieving
national public health goals. Hence
the types of engagements relate to
how the government or public health
system would approach engagement
with the private health sector, and
not vice versa. However in this
analysis we have attempted to look
for features of successful
partnerships that have taken the
private health sector's interest into
account and attempted to create
more equal relationships between
the private and public health sectors.

Types of engagements between
public and private health sectors

Regulation
Regulation is a rule of order having
the force of law, prescribed by a
superior or competent authority.
Through regulation the government
defines the scope of the private
health sector and rules for its
functioning. Regulation also
prescribes minimum standards of

care and penalties for violations, and
can also be used to expand access
and equity (Smith, Brugha & Zwi
2001). In Delhi, India, for example,
the state government has made it
mandatory for identified private
hospitals in Delhi to reserve a
proportion of their outpatient and
inpatient facilities for free treatment
to poor patients. (Government of
Delhi 2011)

Information provision / technical
assistance
The government could also provide
information or technical assistance
through communication and training
to help the private health sector
comply with appropriate quality
standards to improve access and
quality of care (Mills et al. 2002).
Disseminating information on
standards of care or best practice
guidelines and providing continuing
medical education open to both the
public and private sector are an
example of such techniques of
technical assistance by the
government (Sood et al. 2011).

Financial assistance – subsidies,
contracting and direct purchase
Governments often assist private
health sector financially in the form
of land grants, tax relief or subsidies,
such as purchasing medical
equipment or drugs (Bennett et al.
2005). The government may do so to
improve access to care. In India,
under the tuberculosis control
programme, drugs and vaccines are
supplied free of cost to private
facilities to increase coverage with
effective diagnosis and treatment
(Uplekar 2003). Subsidies could also
be conditional to specific services or
outcomes. For example, subsidies or
tax relief could be tied up with free
treatment of poor population by
private facilities (Sood et al. 2011). In

Brazil, mechanisms such as tax exemptions, low-interest loans, and market guarantees for locally produced products for the private sector are being explored to enable free healthcare for all (Victora et al. 2011).

Service delivery

Partnership with the private health sector is an important means of expanding the coverage of healthcare (Smith, Brugha & Zwi 2001). The policy focus on public-private engagements in the health sector in India is in fact largely on service delivery through public-private partnerships (PPP). Initiated in the late 1960s for social marketing of condoms, private participation is now a key strategy for expanding coverage of immunisation, family welfare, polio, TB, HIV/AIDS care, leprosy and malaria control programmes (Revankar 2008). The NRHM has an explicit strategy for promoting PPPs for achieving public health goals, identifying key thematic areas and modes of engagements as well as laying out management plan for such initiatives at the state and district levels (Government of India 2005).

In UP there are two ongoing major public-private health sector engagement programmes under the State Innovations in Family Planning Services Agency (SIFPSA)[4] project – the Merrygold network and the voucher scheme. The Merrygold scheme is a social franchising scheme in 35 districts. Hospitals joining the Merrygold franchise, for an annual fee, provide maternity and family planning services at fixed rates and benefit from Merrygold branding and promotion (The IDEAS project, LSHTM 2012). Under the voucher scheme, SIFPSA has accredited 65

private hospitals in five large towns to provide below poverty line households with free maternal and reproductive health, family planning services, and a general check-up in exchange for reimbursable vouchers (The IDEAS project, LSHTM 2012). The private sector is also being engaged through the national health insurance scheme called the Rashtriya Swasthya Bima Yojana (RSBY), under which private hospitals are empanelled to provide specific services to RSBY members free of cost; they are then reimbursed according to rates determined by the scheme (IDEAS project, LSHTM 2012).

Monitoring or information gathering or data sharing

Registration, periodic monitoring and routine data reporting from the private health sector helps governments to maintain information on the size and composition of the private health sector and also monitor their activities regularly. Such information is crucial for designing public policy on the private health sector, planning and implementing public health programmes and evaluating outcomes of health interventions.

One of the key requirements of a DIPH is sharing of data on a periodic basis. However, data recording and reporting from the private health sector in India has been found to be sub-optimal. Studies have pointed out obvious gaps in reporting of even notifiable diseases, which is a compulsory legal requirement (Duggal 2008, Revankar 2008). Unless there is effective enforcement backed by regulation, it is difficult to ensure compliance with such requirements. It is expected that the Clinical Establishments Act would be able to achieve this.

The Integrated Disease Surveillance Project (IDSP) of the Government of India (being implemented since 2005) is making efforts for improved data reporting from private sector through participation of private doctors/ hospitals as sentinel centres (Revankar 2008). The Central Bureau of Health Intelligence (CBHI), the nodal agency for health information in India, shares formats through its website for reporting by all providers in the public as well as private sector. Reporting from the private sector is, however, negligible.

A model of intensive district-level surveillance of childhood vaccine preventable diseases was tested in Vellore, Tamil Nadu (Revankar 2008). To encourage data reporting from the private sector, private hospitals and clinics were supplied with printed, self-addressed, post-paid cards to be mailed with desired data. This was supplemented with periodic visits to facilities, educating the providers and supply of free vaccines to participating clinics. Data storage was computerised and monthly data summary bulletins were shared with all participating facilities. Private centres reported about half the vaccine preventable diseases in rural residents (46% in 1995) and almost all (99%) in urban residents. Reporting from public facilities was actually poorer as disease incidence indicated non-attainment of immunisation targets (Jacob John et al. 1998).

Key lessons on public-private health sector engagement for data sharing

Engaging the private health sector in a sustainable manner is a challenging task as it involves attention to multiple aspects. There are important lessons in the literature on how such engagements can be nurtured or sustained. These lessons were extracted from the discussion or recommendation sections of papers; they related to the authors' analysis of what contributed to successful or sustainable partnerships or engagements.

- *The public health sector should work in a consultative mode with the private sector.* Working with the private sector in a consultative mode to develop possible mechanisms for partnerships, monitoring and coordination systems and legal and regulatory framework would help build confidence in the system and inculcate ownership. In Tanzania a strategy for engaging the private sector in integrated delivery of insecticide treated nets through a voucher scheme proved to be successful because of (a) consultative programme development involving all stakeholders, (b) quarterly coordination meetings of all stakeholder representatives and (c) large scale pilot-testing to fine-tune the implementation strategy (Savigny et al. 2012).

- *Policy objectives and strategies for the public health sector engaging with the private sector need to be tailored to specific contexts*, which differ between and within country settings, and take into account the complexity and difficulties involved. Comprehensive mapping of the private sector (location, qualifications, training levels, facility capacity and coverage) is therefore very important before strategising engagement (Brugha & Pritz-Aliassime 2003).

- *Private sector engagement by researchers to achieve inter-sectoral participation is beneficial but requires constant networking & communication as the process is not self-sustaining.* Frequent transfers of key government personnel and a project-based, donor-driven approach in developing intervention strategies often impede efforts towards public-private engagements (Manandhar et al. 2008).

- *Charismatic leadership and vision of the personalities steering a partnership initiative, both from the private and public sectors, plays a critical role in developing a partnership.* Compelling circumstances or relationships based on trust could be critical in triggering partnership initiatives. For example, a well-known senior cardiologist from the private sector was instrumental in encouraging other private providers to participate in a scheme for low cost cardiac care to the poor in the Indian state of Karnataka (Venkat Raman & Björkman 2008).

- *Incentives play a very important role in increasing private sector engagement.* These may include provision of logistics and supplies such as free or subsidised drugs, equipment, vaccines, information education and communication (IEC) materials and maintenance of equipment related to national health programmes (Kapilashrami, Sood and Sharma 2008). Incentives to the private sector for participation in a district level disease surveillance programme in India included free vaccine supplies and continuing medical education sessions for participating physicians (Jacob John et al. 1998). ■

[4]'State Innovations in Family Planning Services Agency' (SIFPSA) is a registered society created in 1992 under the Government of India-USAID joint 'Innovations in Family Planning Services' (IFPS) project, to reorient family planning services in UP. SIFPSA enabled flexibility in the flow and management of public funds and helped in involving both g overnment as well as non-governmental sector in family planning service delivery.

Private health sector

Recommendations in India's national plans and programme documents

The growth of the private sector has been guided by market forces rather than by principles of equity and efficiency defined by a unifying policy framework. There is no single policy document covering the private health sector in India. We reviewed the country's national plans and programme documents that have attempted to systematically define a vision for India's overall health system and have in the process also provided key recommendations for India's private sector. In this chapter we present major policy recommendations related to the private sector available in these documents and their current status of implementation with respect to seven thematic areas that were also the most relevant from a data sharing perspective in a DIPH.

Regulation

Policy recommendations in national plans and documents
The lack of a well defined and effectively enforced regulatory framework characterises India's entire health sector, but is of special concern with respect to the private sector. The NCMH report (NCMH, 2005) strongly recommended that anomalies in health services, such as unnecessary treatment procedures and arbitrary pricing need to be curbed through legislated regulatory frameworks. It further recommended regulations not just for service providers but also for devices and the health insurance sector (by establishing a mechanism for arbitration). The 12th Five Year Plan has additionally recommended legislation requiring drug companies to disclose payments made to doctors for research, consulting, lectures, travel and entertainment, as these

may influence their prescription practices (Planning Commission, GOI, 2013). The 12th Five Year Plan, the NCMH and the NRHM mission document (NRHM, GOI, 2005) have also recommended mainstreaming and regulating India's informal private health sector.

Present status of implementation
A major outcome is that the Indian Parliament passed the Clinical Establishments Act in 2010 and this new legislation will make it mandatory for all clinical establishments – public and private- to conform with prescribed quality standards, share data on nationally required parameters, display pricing, and be subjected to routine prescription audits. The CE Act has yet to be adopted and implemented by all the states and the centre is urging the states to move ahead. In UP existing regulation is limited to a mandatory registration of health facilities in the district CMOs' office. The Indian Medical Association in UP has obtained a High Court stay on periodic renewal of this registration, and so it is a one-time registration in most districts. Other active legislation (in India and in UP) includes the Post Natal Diagnostic Test Act to prevent sex determination tests that lead to sex selective abortions, and the Consumer Protection Act to protect patients against any wilful medical negligence or malpractice.

In a parallel and alternative development the National Health Portal, a project of the Ministry of Health and Family Welfare expected to be launched between August-October 2013, is considering online voluntary registration of private facilities and providers. As an incentive, the registration would connect them to a large clientele.

"

Legislation is critical for establishing a regulatory framework and for the creation of standardised and mandatory data sharing mechanisms.

Potential implications for data sharing in a DIPH

Legislation is critical for establishing a regulatory framework and for the creation of standardised and mandatory data sharing mechanisms. Once the CE Act is implemented, it will create greater opportunities for integrating a variety of data into the DIPH.

Quality assurance

Policy recommendations in national plans and documents

Quality assurance is one of the primary goals of regulation since implementation of treatment standards and protocols is a priority to address drug resistance, promote rational prescriptions and use of drugs, and contain health care costs. Quality assurance recommendations encompass both voluntary (e.g. accreditation) as well as enforced mechanisms introduced through legislation. The NCMH report recommended the development of standards, treatment protocols and unit pricing; the accreditation of private hospitals for social insurance schemes; and the setting up of a National Accreditation Council to license various accreditation agencies. The NRHM mission document recommended the accreditation of private facilities for conducting institutional deliveries under the government's JSY scheme. This document also proposed and

defined a set of quality standards for the public sector, known as the Indian Public Health Standards (IPHS), and the HLEG report (PHFI, 2011) endorsed these standards by recommending that private facilities contracted under UHC should also adhere to the IPHS, and a National Health and Medical Facilities Accreditation Unit be created to serve as a regulatory & accreditation body. Mandatory adherence to quality standards would require legislation and these recommendations have been described earlier under 'regulations'.

Present status of implementation

The National Accreditation Board for Hospitals and Healthcare providers (NABH), established in 2007 is the only functioning national level accreditation body. NABH implements a high quality accreditation process for both private and public facilities, and has accredited more private (85%) than public hospitals (15%), mostly in big cities. It has separate norms for public facilities (like PHCs and CHCs) and also for non-allopathic facilities. NABH lacks regional bodies that can promote its accreditation process and it relies on regional professional bodies to do so. Accredited facilities share facility and service data with NABH but this is confidential and used for providing feedback to each facility.

Under the Clinical Establishments Act (adopted but not yet implemented in UP) state councils set up under the Act will have the right to inspect clinical establishments, make suggestions for improving quality of care and report on implementation of standards. All clinical establishments should ensure compliance with standard treatment guidelines as issued by the government from time to time.

Potential implications for data sharing in a DIPH

The CE Act authorities and the NABH can both help with developing as well as tracking quality indicators to measure implementation strength of programmes for the DIPH. We could explore with NABH if any broad anonymous data could be shared without trespassing confidentiality.

Data capture, management and sharing in the health sector

Policy recommendations in national plans and documents

Several government committees have recommended the setting up of comprehensive national databases. The 12th Five Year Plan recommends the setting up of a composite Health Information System that includes disease surveillance (in the public and private sectors), tracking of human resources, registries of clinical establishments, drug and equipment manufacturing units, and laboratories. The Plan states further that the professional councils at the national and state levels should continually update their HR records, taking into account internal and international migration. This would be a very important first step towards the setting up of a live database on health human resources in the country. Going by the various recommendations in the documents

we reviewed, the country's major data requirements can be summarised as:

- Real time data on human resources and clinical establishments (12th Plan).
- Real time data on services provided through the public and private health sectors (HLEG, 2012).
- Data on allied health sectors and services (drugs and vaccines, equipment, laboratories) (12th Plan).
- Disease surveillance data (NCMH, 2005, 12th Plan).
- Data on performance monitoring of inputs, outputs and outcomes (HLEG, 2012).
- Setting up of a robust health IT network to connect all public and private facilities and governing departments through information exchanges (HLEG, 2012).

Present status of implementation
There is very limited private sector data available in the consolidated health information systems at the national level (e.g. database of the Central Bureau of Health Intelligence) or at the state and district levels (e.g. the state Health Management Information System or HMIS). The state HMIS collects voluminous data on government health facilities and services (especially focusing on maternal and child health) which is collected and managed through a computerised portal that is password protected. Private sector data presently integrated into the district HMIS includes data on institutional deliveries, data on some notified diseases like TB and polio (as part of the polio eradication campaign in India).

Other publicly available private sector data includes the one-time registrations of private facilities in the CMO's office. Some data on training in which the private sector is participating is available at the State Institute for Health and Family Welfare (SIHFW), a nodal health training centre. The service delivery PPPs in the state (Merrygold franchise and Sambhav voucher scheme) also have their own data collected on standardised formats but this data does not come into the district level HMIS. All other data collected by private facilities is ad hoc and not shared with the public sector. There are Quality Assurance (QA) cells being set up as district units under the NRHM programme; when ready they may try to include data on quality parameters from private facilities.

The major gaps in data systems include a lack of private sector data in the national and state/district level databases, and also in the analysis and utilisation of public sector data for improved planning and monitoring of public health programmes at decentralised levels of decision making.

Potential implications for data sharing in a DIPH
Whilst building a more robust and comprehensive database (on facilities, providers, users and services etc) for both sectors may require significant government stewardship and legislation (such as the CE Act), there is a definite role that IDEAS can play to facilitate increased synthesis of existing data across the two sectors and improved utilisation of this data towards public health programmes decision making. Through a DIPH we can provide support towards developing stronger collaborations between the public and private sectors by working with both sectors, and strengthening

district forums like the District Health Society and Quality Assurance cells. We can make a beginning with the data that is already being shared such as in the PPPs, notified diseases and training programmes. Our present study (focused on engagement building strategies with the private sector) suggests that it is possible to engage with the private sector through focused and simple data collection processes acceptable to all, and backed by creative incentivising and motivation (details in 'Developing an engagement strategy' chapter, page 24).

"

...it is possible to engage with the private sector through focused and simple data collection processes acceptable to all, and backed by creative incentivising and motivation."

Service delivery

Policy recommendations in national plans and documents
The NRHM mission document and the 12th Plan envisage public-private partnerships as being guided, incentivised, and regulated by the public sector through a variety of contracting in mechanisms. The NCMH report also recognised and advocated a separate but pre defined role for the private sector – one of market segmentation with separate service domains for the two sectors to improve market efficiency and

avoid duplication of treatment. The HLEG has made a strong call for involving the private sector in a universal package of healthcare in which 75% outpatient and 50% in patient services would come under a National Health Package (NHP) of guaranteed services under UHC. Private sector providers, beds and facilities would be contracted into district health systems to meet rapid capacity increases.

Present status of implementation
There are two major service delivery PPPs presently in existence in UP: the Merrygold franchise across 35 districts and the Sambhav voucher scheme in 5 big cities. Both provide low cost or cashless MCH services to poor households. These PPPs face challenges with respect to the acceptability to private providers of costs determined by the public sector, and the collection of equally good standardised information by all members. The limited data collected in these models is also not integrated into the public sector HMIS. Other examples of successful PPPs include the polio campaign and TB control that included good incentives for and good coordination with private providers.

Potential implications for data sharing in a DIPH
A start can be made by exploring the data available with the PPPs and the potential for integrating this into the DIPH.

Finance

Policy recommendations in national plans and documents
The following types of financing models, including contracting and health insurance have been proposed for purchasing private sector services for public health:
- Contracting private sector providers and facilities for cashless treatment of patients- NCMH report.
- Vouchers given to households to receive care from accredited and contracted private providers – NCMH report.
- Capitation based financing – a fixed amount/capita to be paid (to private providers) for members enrolled with private providers in lieu of assuring members access to all services listed. Providers bear entire risk – NCMH report.
- Mandatory health insurance for all, with low premiums and large risk pool - NCMH report.
- Different types of combinations of health insurance models: Private health insurance for rich and government provisioning for the non-rich; combination of private and social health insurance with combined risk sharing; low cost health insurance by large hospitals for the surrounding population base – NCMH report and 12th Plan.

The 12th Plan and HLEG reports envisage that the current high levels of private financing of healthcare will decline in future as the government introduces newer models of more efficient and equitable financing including through corporate contributions and tax revenues.

Present status of implementation
The Rashtriya Swasthya Bima Yojana (National Health Insurance Scheme) launched by the GOI on 1 April, 2008[2] is the main government subsidised health insurance for the poor in India which allows them to avail themselves of cashless hospitalisations from private providers. RSBY is operational at the

district level in UP too, but the private facilities have very limited interaction with the state health system. They are monitored by the insurance companies and meet with the district CMO only for grievance redressal (related to payments). There is no data sharing, or participating in any planning or review exercises between the RSBY hospitals and the district health system. The Sambhav voucher scheme in UP is an example of contracting in private facilities for public health services.

Potential implications for data sharing in a DIPH
Hospitals that are accredited for RSBY services are required to maintain detailed patient data that they submit to the insurance company for reimbursements. This information does not currently enter the public health HMIS but IDEAS can explore how to source and include some of this into the DIPH.

Planning and management

Policy recommendations in national plans and documents
To improve coordination and planning with the private sector, the NRHM mission document envisaged a District and State level Institutional Mechanism – a District and State Health Society - for the inclusion of the private sector in the district and state level health planning processes. The HLEG envisages an umbrella role for private insurance companies in future - contracting private and government hospitals, controlling costs, enrolling customers, managing customer complaints and tracking cost and quality of services.

Present status of implementation
Although district health societies have private sector representatives (e.g. Indian Medical Association members), their role seems to be cursory rather than significant. There is greater participation of professional associations in health programme planning at the national and state level where they participate in discussions on public health programmes and campaigns.

Potential implications for data sharing in a DIPH
The platforms for engaging with the private sector do exist at the district level and they can be strengthened with IDEAS facilitation. RSBY insurance companies are beginning to play an umbrella role in contracting public and private hospitals but there is no data sharing by them with the public system. This could be harnessed for the DIPH.

Training and development of human resources

Policy recommendations in national plans and documents
The NCMH report and the 12th Plan have called for better distribution of medical colleges across the different Indian states, especially in the less prosperous states in the north. With this in sight, the HLEG has recommended PPPs in medical education with conditional reservations of 50% seats for local candidates, and a 20% reimbursement by the government to private medical colleges and hospitals that are set up in areas that are not remunerative. The NRHM further recognised the role that the private sector could play in development of human resources (HR) for health and recommended

partnerships with the for-profit and not-for -profit sectors for recruitment (e.g. contractual staff), in-service training, capacity building, and the management and performance appraisals of human resources.

Present status of implementation
We found strong partnerships between professional associations (gynaecologists and paediatricians) and the state HR training systems to develop very useful, relevant and non-conventional training programmes such as a 16 week training programme in Emergency Obstetric Care (with caesarean section) for government doctors (developed and certified by FOGSI), and an 18 week training programme in Life Saving Anaesthesia Skills.

Potential implications for data sharing in a DIPH
IDEAS can integrate useful data on HR trainings through public-private collaborations. This data is partly available in SIHFW in Lucknow and partly in the offices of the district CMOs.

Conclusions

Several national plans and programme documents provide important recommendations about the private sector in relation to regulations and quality assurance, building comprehensive data systems, financing models, role of the private sector in service delivery partnerships, training and HR and planning and coordination. Although there are gaps in development of regulatory and quality assurance and data sharing systems, some interesting developments are underway such as the CE Act (passed by Parliament in 2010, but not yet

implemented in most states). There is also a national accreditation body - the NABH - for voluntary private sector accreditation, and a National Health Portal that may create alternative online mechanisms for data sharing by the private sector. Public-private engagements for financing, service delivery, and HR training and development have made more headway than the legal/ regulatory frameworks. There are several opportunities that these existing engagements provide for our DIPH work, including the sharing of RSBY hospital data, data collected through the Merrygold and voucher schemes, and data collected through collaborative training programmes. The District Health Society Platform created through the NRHM mission document could provide a useful platform for engaging the private sector in joint dialogue and consultations. ∎

Executive Summary: IDEAS Feasibility Study Report for establishing a Data Informed Platform for Health, India, 2012

IDEAS seeks to establish a Data Informed Platform for Health (DIPH) at the district level in Uttar Pradesh (UP) by synthesising local health information from public and private sources and enhancing its use in local decision making. The DIPH would enable improved tracking and analysis of programme implementation against outcomes in maternal and child health. To assess the technical feasibility of establishing a DIPH at the district level in UP, a study team comprising members from the IDEAS project and from the Public Health Foundation of India carried out a feasibility study in August – September 2012. The objective was to assess public and private structures, environment, interactions, information flows, data sources, categories and quality of data, to determine the need and the potential of a DIPH, and to outline key challenges. The team visited two districts: Unnao and Sitapur, one to the north and one to the south of Lucknow. They met key informants in the National Rural Health Mission (NRHM) and the health directorate at the state and district levels and visited public health facilities at the tertiary, secondary and primary levels. The team also met with representatives of the not-for-profit and for-profit private sectors and a few functionaries of the Integrated Child Development Services scheme in the Department of Women and Child Development.

In both districts the structure and functioning of the public sector was quite similar, following a three-tier system that is the national norm, and a hierarchical supervisory system headed by a Chief Medical Officer at the district level. Since the NRHM was launched in 2005-06, NRHM units have been established at the state and district level and function closely with the health directorate, but with a special focus on institutional deliveries and Accredited Social Health Activists (ASHAs), a new cadre of village link-workers created under the NRHM. The NRHM has also introduced a new online system for data capture right from the level of Block Primary Health Centres; the current focus of this system is on maternal and child tracking, deliveries under the Janani Suraksha Yojana (cash incentive scheme for institutional deliveries) and related financial reporting, and some general facility reporting. The data was used in a limited way for programme planning and reviews; the current preoccupation was with immunisations and institutional deliveries. Secondary data show that there are more institutional deliveries at government facilities than private ones in UP, but the private sector is much more sought after for acute illnesses, including those among children. In fact the main difference between the two districts was in the number of private nursing homes: Unnao, a slightly better off district closer to two big towns, had 42 private nursing homes, while Sitapur, more rural and further away from Lucknow, had only 29. Due to time constraints we could not visit as many private clinics and hospitals as we would have liked to, nor include the informal private sector in our data collection exercise, and this was a major study limitation. However, we could build a deductive assessment of the bigger picture based on discussions with a broad range of stakeholders and also by reviewing secondary data. Our findings revealed that the private commercial sector in both places was quite disconnected from public sector programmes and district information systems, whereas the not-for profit sector worked closely with the system, but had limited presence.

In this scenario, the DIPH will be a useful tool to compare implementation strength of programmatic inputs and performance outputs across different districts and also pinpoint gaps and shortcomings in inputs for improving performance. The DIPH is technically feasible especially due to the presence of a district NRHM unit that is conversant with an online MIS. The main challenges include getting the private commercial sector to share data, to improve the quality of public sector data that is collected manually at the village level, and to increase use of data in local decision making. We can address these challenges by introducing strategies for critical inquiry, and by innovative use of available technologies. Together with the state government we can also explore creative incentives for the private sector to share information. Use of innovative and cutting edge initiatives will create greater enthusiaim for developing and sustaining a DIPH amongst district officials.

Developing an engagement strategy for the Data Informed Platform for Health

A key objective of this study was to gather inputs from important stakeholders towards building an engagement strategy for the private sector's participation in the DIPH. In this chapter we present a brief summary of our consultations with the diverse private and public stakeholders whom we met at the national, state and district levels, and the key features of an engagement strategy that emerged from our discussions with them (Table 5.1).

Summary of consultations with stakeholders

National level

One of our first discussions was with a small group of national stakeholders (private and public) (see Appendix I for list of participants) with whom we exchanged information about the overlaps between the DIPH and the various existing platforms for data sharing in India. These include the NABH accreditation process that draws routine data from private accredited facilities, the Central Board of Health Intelligence - an apex body for health statistics in India, and the National Health Portal, a new initiative (expected to be launched in August-October 2013) of the MoHFW to synthesise all health related data at national and regional levels. There was general agreement that a DIPH at the district level (along with a strategy to engage the private sector) could be of utility to all the other initiatives too. Further, we learned from the representatives of professional associations (of gynaecologists and paediatricians) that they collaborated closely with national and state governments towards maternal and child health programmes such as development of

standardised protocols (e.g. for neonatal resuscitation) and of training curricula (e.g. for trainings in emergency obstetric care and safe birth attendance). Representatives of these associations provided us with valuable state and district level contacts for UP and advised us to start our networking with organisations rather than individuals. They suggested we begin with mapping existing data sources and platforms that can be of use in the DIPH work, and seek the state government's facilitation as well.

State and district level

At the state and district level too, professional associations of different types were important stakeholders for us. We learned about the structure, membership and functions of these associations, their strength at the district level and their participation in public health activities that might be relevant for a DIPH. We learned that the specialists associations (gynaecologists and paediatricians) are primarily based in big cities rather than at district level because a minimum number of members (around 30) is required to form a society; specialists are usually not present at the district level in large numbers, and the ones that are, join their nearest city association. The Lucknow Obstetricians and Gynaecologists Society (LOGS), affiliated to the Federation of Obstetricians and Gynaecologists in India (FOGSI) works closely with the state government providing assistance and certification (by FOGSI) on two important training programmes- an emergency obstetric care (EMOC) training for medical officers in the government and a Skilled Birth Attendants (SBA) training for doctors and nurses. The Indian Association of Paediatricians

(IAP) in UP also provides technical assistance to the government for specialised training programmes such as neonatal resuscitation. They are called to provide support on NRHM programmes dealing with MCH such as in immunisation campaigns. The UP Nursing Homes Association (UPNHA) includes hospitals headed/owned by allopathic doctors as members. Most of these are also members of the Indian Medical Association. UPNHA and the IMA have a stronger presence at the district level. They also conduct voluntary public health activities such as health camps and have been involved in the polio campaign with the local health department, but their overall engagement with the local government is more limited than that of the specialists' associations.

We obtained several suggestions for a private sector engagement strategy from these stakeholders that dealt with practical details such as the selection of private providers, data collection formats and methods, and types of incentives. These have been further elaborated in section 5.2. and in Table 5.1. The overall tenor of our discussions with stakeholders at the state and district level was quite positive. From their statements, they did not seem averse or unwilling to share data if it was connected with a public health goal. Our personal observation is that while many of these providers will be willing to engage with us, especially if we can establish good rapport and a trusting relationship with them, most of them may not have the time or the capacity to participate in an intense 'implementation strength' exercise with us. We will need to carefully select a small group with whom we can work closely for the more in-depth analysis.

Key features of an engagement strategy

We analysed and organised all the findings related to an engagement strategy in a framework that distinguishes between the key features of a potentially successful strategy to obtain the private sector's engagement with the DIPH and the 'brokering' role of IDEAS in two ways – developing engagements between the private sector and the DIPH, and also between the public and private sectors for a DIPH (Table 5.1).

The main features of an engagement strategy are presented below as sequential steps, although in reality many of the steps, especially those related to relationship building and sensitisation, will overlap and are likely to unfold as an iterative process.

Existence of good rapport and relationships between key influential private and public stakeholders and IDEAS.

Private sector influential groups include professional associations of medical practitioners in the private sector, and in the public sector the health department, the NRHM district programme management unit and the District Health Society. IDEAS will need to identify all these forums and build good relationships with each of these as well as strengthen those forums that bring together players from the private and public sectors regularly to so that they engage better with each other. IDEAS may need to seek the state government's facilitation for a district level DIPH.

Familiarisation of private and public sector groups and individuals with the concept and methodology of a DIPH, and its significance for decentralised public health decision-making

Since health is a state subject, health related decisions have to be taken at the state level. Different states may or may not be keen on data recording or sharing and there is also limited awareness about data sharing platforms among different stakeholders. Therefore a key task for IDEAS would be to create awareness for a DIPH at the state and district level, amongst all local stakeholders, private and public. The awareness could work in two ways – stakeholders would learn about the DIPH and IDEAS would be updated about new initiatives being proposed or implemented (e.g. collection of information on ORS and Zinc indicators by the Indian Association of Paediatricians for diarrhoea and ARI referrals for pneumonia. These are being made available on their website, data.gov.in, and could be accessed by others).

IDEAS could make presentations in public-private forums like DHS or in the health partners' forum at the state level (held by the NRHM state office for non- governmental health partners). IDEAS could also network with new national public initiatives such as the National Health Portal and the organisations related to the Clinical Establishments Act, and explore other intermediary organisations that associations work with such as JHPIEGO

Inclusion of selected, responsive private sector players in the DIPH to generate a positive force that will affect others positively.

At the district level the majority of hospitals and clinics are single doctor owned. We need to keep in mind that many of these private doctors may not cooperate or may drop out early.

Therefore an important suggestion that we received from many stakeholders was to identify the most socially oriented doctors in the district and begin with them. Younger enthusiastic doctors could also be targeted as they are may be more socially motivated than older ones.. Similar champions for the DIPH will also need to be identified in the public sector at the state and district levels.

Easy and comprehensive data formats and collection and analysis processes, so that private providers do not feel burdened

As private providers will not have time to extract and collate data for the DIPH, and they may not be willing to share all their data, IDEAS must develop data recording and collection procedures and confirm the acceptability of the data to be shared. We heard from one provider that the data to be collected should only be of public health importance, and should not have medico-legal implications. A clear, uniform format should capture this data. Examples of data could be the number of MCH patients or number of referral patients. Among patients from remote areas this could also includematernal and newborn cases handled by traditional birth attendants or ANMs; home or institutional deliveries etc. The responses could be coded and include ranges instead of exact

numbers. So for example, for number of cases of a certain condition, the responses could be: 1-5 patients, 6-10 patients, more than 10 patients. IDEAS will also need to work out reliable modalities for data collection such as through appointed data collection staff, who may even be from the public sector and who collect data from private doctors on data formats on a daily or weekly basis.

It would be a good idea for IDEAS to start with examining the data with the PPPs and its usefulness for a DIPH. These include the Merrygold franchise and the Sambhav voucher scheme. Private providers also share some data with the health department, such as data on TB, polio, infant deaths and immunisation. These may also be examined for their usefulness.

   IDEAS will need to explore the most suitable platforms where data can be integrated as well as ensure that it is compatible with the public sector HMIS. One of our respondents shared that integration and validation of data sets within the public health system itself is a big problem, and has not yet been effectively achieved. There are problems of interoperability between the government's various health information systems but standards are currently being defined for electronic health records, and should improve in the near future.

Provision of a good mix of encouragement and motivation for private players for their participation
IDEAS may need to devise a variety of ethical and uniform incentives to reward and encourage private providers. These may include transport allowance, sponsored

exchange visits, and recognition such as certificates, memberships or names in publications in exchange forproviders' time and cooperation. IDEAS may also need to examine ways in which the state health department can facilitate the data sharing process – for example by periodically issuing letters or announcements.

Conclusions and next steps forward

The steps outlined above represent only the starting point of an engagement strategy with the private sector. To operationalise this strategy it will be necessary to define institutional forums and leadership either within governmental organisations (e.g. the NRHM state/district health societies) or other bodies that are likely to be set up around the BMGF's Technical Support Unit planned in UP that can own the process from the beginning. The initial process of locating this work will require discussion and consensus building with key decision makers in all concerned organisations. Once the institutional forums have been defined, we can proceed with building further relationships and sensitising other key stakeholders in the private sector, identifying the numerous private

sector players to reach out to at the district level, and developing the data processes and ways of incentivising those who are willing to participate. The existing disconnect and mistrust between the public and private health sectors, the lack of or limited data systems and record keeping in the private sector, uncertain data quality in both the public and private sectors, and the unwillingness of the private sector to share data and information, are likely to pose critical challenges to this work. To overcome these challenges and to enable the processes of public-private engagement and MCH data synthesis it would be essential to get this process integrated into existing forums, and a great deal of focus must be laid on establishing clearly the value of this forum for all stakeholders from the very beginning, to make it a part of the health system.

   The various features of this strategy reflect an underlying process of building greater trust and better relationships between the public and private health sectors, and setting in motion a systematic and well coordinated process of MCH data synthesis that can become a part of the system in due course. There will be numerous challenges involved and IDEAS will have to play a strong facilitating role to bring together both sectors for this piece of work. ■

"

To operationalise this strategy it will be necessary to define institutional forums and leadership...that can own the process from the beginning. These can be governmental organisations or other bodies linked to the Bill & Melinda Gates Foundation's Technical Support Unit planned in Uttar Pradesh."

Table 5.1 - Key features of an engagement strategy and the role of IDEAS to facilitate the engagement

Key features of a strategy to build the private sector's engagement with a public health oriented DIPH	Role of IDEAS to facilitate the engagement	
	Between private sector and DIPH	Between public and private sectors for a DIPH
1. Existence of good rapport and relationships between key influential private and public stakeholders and IDEAS.	Identification of and relationship building with all important private stakeholders (e.g. professional associations related to MCH) at the national, state and district levels	Identification and strengthening of platforms of engagement for public and private stakeholders (e.g. the District Health Society, the QA cells, the National health Portal) Engagement with state health department (e.g. for MCH).
2. Sensitisation of private (and also public) sector groups and individuals with the concept and methodology of a DIPH, and its significance for decentralized public health decision making	Meetings/consultations with key stakeholder groups and individuals at the national, state and district levels	Harness public sector support – make presentations in public-private forums like DHS or in the health partners' forum at the state level (held by the NRHM state office for non- governmental health partners). Also network with new national public initiatives such as the National Health portal and bodies related to the Clinical Establishments Act.
3. Inclusion of selected, responsive private sector players in the DIPH to generate a positive force that will affect others positively.	Identify and bring in private providers who are already socially oriented, or young and enthusiastic providers who are keen to engage.	Identify similar enthusiastic champions for the DIPH in the public sector at the state and district levels.
4. User-friendly data formats and collection and analysis processes, so that private providers do not feel burdened	Develop data collection formats and procedures that are acceptable to private providers. Appoint data collection staff if needed. Determine that the data can be integrated into or 'read' by the public sector HMIS.	Examine the utility of data sharing from PPPs with existing data collection systems – the Merrygold network, Sambhav voucher scheme, the RSBY accredited hospitals, any reporting on diseases of public health significance like TB and polio, and any HR/trainings related data.
5. Provision of a variety of incentives to encourage and and reward private players for their participation	Consider provision of different types of incentives, not necessarily financial, but appropriate, uniform and ethical.	Examine ways in which the state health department can facilitate the data sharing process – by periodically issuing letters or announcements.

References

Basu S, Andrews J, Kishore S, Panjabi R, & Stuckler D. (2012) Comparative Performance of Private and Public Healthcare Systems in Low- and Middle-Income Countries: A Systematic Review. *PLoS Med 2012;* 9(6): e1001244. doi:10.1371/journal.pmed.1001244.

Bennet S, Hanson K, Kadama P, Montagu D. *Working with the non-state sector to achieve public health goals.* Working paper no. 2. Washington DC: The World Bank; 2005.

Bhandari D. Public private partnership in health care. *Health Administrator* 2008; 21(1-2):26-31.

Brugha R, Pritz-Aliassime S. Promoting safe motherhood through the private sector in low- and middle-income countries. *Bulletin of the World Health Organization* 2003;81(8):616-623.

Das J, Holla A, Das V, Mohanan M, Tabak D, & Chan B. In Urban And Rural India, A Standardized Patient Study Showed Low Levels Of Provider Training And Huge Quality Gaps. *Health Affairs 2012,* 31**,** 2774–2784.

De Costa A & DiwanV. 'Where is the public health sector?' Public and private sector healthcare provision in Madhya Pradesh, India. *Health Policy 2007,* 84**,** 269-276.

De Savigny D et al. Introducing vouchers for malaria prevention in Ghana and Tanzania: context and adoption of innovation in health systems. *Health Policy and Planning* 2012;27(suppl. 4):iv32–iv43.

Duggal R. The notifiable disease syndrome. *Health Administrator* 2008;21(1-2):79-80.

Gautham M, Binnendijk E, Koren R & Dror D M. 'First we go to the small doctor': First contact for curative health care sought by rural communities in Andhra Pradesh and Orissa, India. *Ind J Med Res 2011;* 134, November 2011**,** 627-638.

Gangadharan K. *Utilization of health services in urban Kerala: a socio-economic study* [unpublished thesis]. Puducherry, India: Pondicherry University; 2010.

Government of Delhi. *Fresh guidelines regarding free treatment provided by identified private hospitals to the eligible patients of EWS category.* 2011. Available from http://bit.ly/13s6G9o (accessed 18 June 2013).

Government of Uttar Pradesh, department of medical health and family welfare. *Project implementation plan, Uttar Pradesh health systems strengthening project.* Lucknow: Government of Uttar Pradesh; 2011.

International Institute for Population Sciences (IIPS) and Macro International. *National family health survey (NFHS-3), 2005-06: India: Volume II.* Mumbai: IIPS; 2007.

International Institute for Population Sciences (IIPS) District Level Household and Facility survey-3 (DLHS-3) Fact Sheet UTTAR PRADESH, Mumbai: IIPS; 2007-08

Jacob John T et al. Disease surveillance at district level: a model for developing countries. *The Lancet* 998;352(9121):47–50

Jahan BI. *Public private partnership in Uttar Pradesh health care delivery system- UPHSDP as an Initiative.* Available from http://www.cehat.org/go/uploads/PPP/bibisratpaper.pdf (accessed 13 April 2013); 2009.

Kapilashrami MC, Sood AK, Sharma BBL. Involvement of private sector in health: suggested policy guidelines and mechanisms. *Health Administrator* 2008;21(1-2):19-22.

Leavell R. Public and private sector partnership in health care. *Health Administrator* 2008;21(1-2):34-37.

Manandhar M et al. Intersectoral debate on social research strengthens alliances, advocacy and action for maternal survival in Zambia. Health Promotion International 2008;24(1):58-67.

Medical Council of India. List of medical colleges teaching MBBS. Weblink: http://www.mciindia.org/InformationDesk/ForStudents/ListofCollegesTeachingMBBS.aspx (Accessed 20 June 2013)

Mills A, Brugha R, Hanson K, McPake B. What can be done about the private health sector in developing countries? *Bulletin of the World Health Organization* 2002; 80(4):325-30.

Ministry of Health and Family Welfare, Government of India. *National health accounts India 2004-05.* New Delhi: Ministry of Health and Family Welfare, Government of India; 2009.

Ministry of Health and Family Welfare, Government of India. *National Rural Health Mission. Mission Document.* New Delhi: Ministry of Health and Family Welfare, Government of India; 2005.

Ministry of Health and Family Welfare, Government of India. *National Rural Health Mission - Framework for implementation.* New Delhi: Ministry of Health and Family Welfare, Government of India; 2005.

National Commission on Macroeconomics and Health. *Report of the national commission on macroeconomics and health.* New Delhi: Ministry of Health and Family Welfare, Government of India; 2005.

National Health Systems Resource Centre. *NRHM in the Eleventh Five Year Plan (2007-12).* New Delhi: National Health Systems Resource Centre; 2013.

National Sample Survey Organization, Government of India. *Morbidity, health care and the condition of the aged. NSSO 60th round (Jan – Jun 2004). Report no. 507.* New Delhi: National Sample Survey Organization, Government of India; 2006.

Office of the Registrar General and Census Commissioner, Government of India. *Annual Health Survey 2010-11 Fact Sheet – Uttar Pradesh*. New Delhi: Office of the Registrar General and Census Commissioner, Government of India; 2012.

Peters DH et al. *Better health systems for India's poor: findings, analysis and options*. Washington D.C.: The World Bank, 2003.

Planning Commission, Government of India. *Twelfth five year plan (2012-2017). Social Sectors. Volume III.* New Delhi: Sage Publications; 2013.

Public Health Foundation of India (PHFI). *High level expert group report on universal health coverage for India*. New Delhi: PHFI; 2011.

Rao PH. The private health sector in India: a framework for improving the quality of care. *ASCI Journal of Management* 2012;41(2):14–39.

Revankar CR. Public-private partnership in public health programmes in India. *Health Administrator* 2008;21(1-2):24-25.

Sinha H. *Revenue sustainable model for health sector in Uttar Pradesh*. Lucknow, India: Centre for Action Research and Developmental Studies; 2006.

Smith E, Brugha R, Zwi A. *Working with private sector providers for better health care. An introductory guide*. London: Options Consultancy Services Limited and London School of Hygiene and Tropical Medicine; 2001.

Sood N et al. Firm-level perspectives on public sector engagement with private healthcare providers: survey evidence from Ghana and Kenya. *PLoS ONE* 2011;6(11):e27194. doi:10.1371/journal.pone.0027194

The Clinical Establishments (Registration and Regulation) Act of 2010. New Delhi: Government of India; 2010.

The Clinical Establishments (Central Government) Rules, 2012. New Delhi: Government of India; 2012.

The IDEAS project, London School of Hygiene and Tropical Medicine. *Data informed platform for health. Feasibility study report. Uttar Pradesh, India.* London: LSHTM, 2012.

Uplekar M. Involving private health care providers in delivery of TB care: global strategy. *Tuberculosis* 2003;83(1-3):156-64.

Venkat Raman A. *Private sector in health care delivery in India. Reading material for report of the National Commission on Macroeconomics and Health 2005* [no date]. Available from http://bit.ly/17eflNY (accessed 5 April 2013).

Venkat Raman A, Björkman JW. Public/private partnership in health care services in India. *Health Administrator* 2008;21(1-2):62-77.

Victora CG et al. Health conditions and health-policy innovations in Brazil: the way forward. *The Lancet* 2011;377(9782):2042–53.

Acronyms

Acronym	Meaning
ANM	Auxialliary Nurse and Midwife
ARI	Acute Respiratory Infection
AYUSH	Ayurveda, Yunani, Siddha & Homeopathy
CAG	Comptroller and Auditor General
CBHI	Central Bureau of Health Intelligence
CE	Clinical Establishments
CHC	Community Health Centre
CMO	Chief Medical Officer
DHS	District Health Society
DIP	District Implementation Plan
DIPH	Data Informed Platform for Health
DM	District Magistrate
EmOC	Emergency Obstetric Care
EPI	Extended Programme of Immunization
FOGSI	Federation of Obstetricians and Gynecologists' Societies of India
FRU	First Referral Unit
GOI	Government of India
HIV	Human Immunodeficiency Virus
HIV/AIDS	Human immunodeficiency virus/ Acquired immunodeficiency syndrome
HLEG	High Level Expert Group
HMIS	Health Management Information System
HQ	Headquarters
HR	Human Resource
IAP	I ndian Academcy of Pediatrics
IDEAS	Informed Decisions for Actions to improve Maternal and Newborn Health
IDSP	Integrated Disease Surveillance Programme
IEC	Information, education and communication
IIPS	International Institute for Population Sciences
IMA	Indian Medical Association
IPHS	Indian Public Health Standards
IT	Information and technology
ITN	Insecticide Treated Nets
JHPIEGO	Johns Hopkins Program for International Education in Gynecology and Obstetrics
JSY	Janani Suraksha Yojana (Maternal Protection Scheme)
LOGS	Lucknow Obstetricians and Gynecologists' Society
LSSA	Life Saving Skills in Anaesthesia

Acronym	Meaning
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MCI	Medical Council of India
MCTS	Mother and Child Tracking System
MoHFW	Ministry of Health and Family Welfare
NABH	National Accreditation Board for Hospitals and Healthcare providers
NADHI	North Arcot District Health Information
NCMH	National Commission on Macroeconomics and Health
NFHS	National Family Health Survey
NHA	National Health Accounts
NHP	National Health Package
NHRDA	National Health Regulatory and Development Authority
NHSRC	National Health Systems Resource Centre
NGO	Non-Governmental Organization
NRHM	National Rural Health Mission
NSSO	National Sample Survey Organization
ORS	Oral Rehydration Solution
PGA	Practicing Gynecologists' Association
PHC	Primary Health Centre
PHFI	Public Health Foundation of India
PPP	Public-private partnership
PSU	Public Sector Unit
QA	Quality Assurance
RSBY	Rashtriya Swasthya Beema Yojana (National Health Insurance Scheme)
SBA	Skilled Birth Attendance
SIHFW	State Institute of Health and Family Welfare
SIFPSA	State Innovations in Family Planning Services Agency
SIP	State Implementation Plan
TB	Tuberculosis
UHC	Universal Health Coverage
UP	Uttar Pradesh
UPCOGS	Uttar Pradesh Chapter of Obstetricians and Gynecologists' Societies
UPNHA	Uttar Pradesh Nursing Homes Association

Appendices

Appendix I – List of Participants: Public & Private Sector Engagement Towards Development of a Strategy for Measuring Implementation Strength of Maternal and Child Health Programmes and Services, PHFI, 8th April 2013

No.	Organisation	Designation
1	Central Bureau of Health Intelligence, Government of India	Director
2	Indian Academy of Pediatricians	Ex-President (2009)
3	Federation of Obstetricians and Gynecologists' Societies of India (FOGSI)	President
4	National Health Systems Resource Centre, Government of India	Senior Consultant
5	Centre for Health Informatics and Project director, National Health Portal, Government of India	Director
6	NABH (National Accreditation Board for Hospitals and Healthcare Providers)	Chief Executive Officer
7	London School of Hygiene and Tropical Medicine	Reader in Epidemiology & International Health and PI, IDEAS project
8	London School of Hygiene and Tropical Medicine	Senior Scientific Coordinator
9	Public Health Foundation of India	Senior Public Health Specialist
10	London School of Hygiene and Tropical Medicine	Country Coordinator, IDEAS Project
11	Public Health Foundation of India	Senior Research Associate

Appendix II – List of Key Informants in in-depth interviews

No.	Organisation	Designation
National Level		
1	Ministry of Health and Family Welfare, Government of India	Joint Secretary (Clinical Establishments)
2	Planning Commission, Government of India	Advisor (Health)
3	National Accreditation Board for Hospitals and healthcare providers (NABH)	Director
4	National Institute of Health and Family Welfare (NIHFW)	Director, Centre for Health Informatics and Project Director, National Health Portal
5	Central Bureau of Health Intelligence (CBHI), Government of India	Director
6	Public Health Foundation of India	Program Manager
7	National Health Systems Resource Centre (NHSRC)	Senior Consultant, Public Health Administration
8	Federation of Obstetricians and Gynecologists' Societies of India (FOGSI)	President
9	Indian Academy of Pediatricians (IAP)	Hon. Secretary General
10	Indian Academy of Pediatricians (IAP)	Executive Board, IAP Delhi
State Level		
1	Federation of Obstetricians and Gynecologists' Societies of India (FOGSI)	Former president, FOGSI, & current Head of Obstetrics & Gynecology, King George Medical University, Lucknow
2	UP Nursing Homes Association (UPNHA)	President
3	Lucknow Obstetricians and Gynecologists' Society (LOGS) and Practicing Gynecologists' Association (PGA)	President
4	M&E Division, National Rural Health Mission (NRHM)	Consultant, Quality Assurance
5	Indian Academy of Pediatricians (IAP)	President
6	SIHFW	Asst. Professor & Nodal Officer for EmOC trainings
7	Lucknow Obstetricians and Gynecologists' Society (LOGS)	Secretary
District Level		
1	UP Nursing Homes Association (UPNHA) & Indian Medical Association (IMA)	Ex-Secretary & member
2	UP Nursing Homes Association (UPNHA)& Indian Medical Association (IMA)	Ex-President & member
3	Indian Academy of Pediatrics (IAP)	Member

Appendix III – Interview guides

Organisations that maintain comprehensive information on the private health sector

1. Name of organisation and key informant details
2. Role and functions related to the private health sector (with a focus on UP)
3. What information is available on the health sector, in general, and then with a focus on the private health sector. Look for information related to:
   • profile of the private sector, any related statistics – national level and state-wise for UP
   • policies – current and proposed for future (in the pipeline or thinking stages)
   • regulations, Acts and status of implementation
   • any information on public-private engagements (especially in UP)
4. Views, recommendations, and any further references

Regulatory and accreditation bodies

1. Name of organisation and key informant details
2. Broad functions (general with respect to the private health sector, and more specific in relation to regulation and accreditation)
3. Mode and nature of interactions with the health sector, and specifically with the private health sector.
4. Different types of regulations/accreditations that this body is involved with.
5. Status of implementation of regulations in the private sector
6. Types of data available with the organisation, especially in relation to the private sector. What data is in the public domain, what can be shared?
7. Review samples of data.
8. View and opinions on current status of regulatory climate for the private sector. What changes are required? How can these be brought about? Would any incentives be required? If so, which ones?
9. Views on public-private engagements – what exists, what is required, how can this be improved in a sustainable way?

Selected professional and other private sector associations

1. Name of organisation and key informant details
2. Structure, membership and functions (with special focus on private sector)
3. Any activities in public health (e.g. camps etc done privately), and data available on these activities, what data can be shared, (especially related to services). Who plans and who conducts these activities? Is any information on services and users shared with the public health administration?

4. Contact with the public health systems – type of contact, frequency, purpose.
5. Any big or small areas of engagement with the public sector? Probe for:
   • Service delivery partnerships
   • Any other contractual tasks
   • Data sharing
   • Others
6. Gather details on each of these engagements – the processes, extent of involvement, outcomes, incentives, challenges, sustainability.
7. Views on engagements – present and future, how can these be brought about?
8. Any further references
9. Different types of regulations/accreditations that this body is involved with.
10. Status of implementation of regulations.
11. Types of data available with the organisation, especially in relation to the private sector. What data is in the public domain, what can be shared?
12. Review samples of data.
13. View and opinions on current status of regulatory climate for the private sector. What changes are required? How can these be brought about? Would any incentives be required? If so, which ones?
14. Views on public-private engagements – what exists, what is required, how can this be improved in a sustainable way?

Public-private partnership programmes

1. Name, designation and brief background of respondent:
2. Name of program:
3. Details of the programme
   • Objectives
   • Partners involved
   • Description and current status
4. Participant status / profile
5. Nature of data maintained, if any [such as Trainee records].
6. Partnerships / engagement with public sector
   • Data sharing
   • Others
7. Future plans and further references

IDEAS project

IDEAS (Informed Decisions for Actions) aims to improve the health and survival of mothers and babies through generating evidence to inform policy and practice. Working in Ethiopia, northeast Nigeria and the state of Uttar Pradesh in India, IDEAS uses measurement, learning and evaluation to find out what works, why and how in maternal and newborn health programmes.

IDEAS is funded between 2010 and 2015 by a grant from the Bill & Melinda Gates foundation to the London School of Hygiene & Tropical Medicine.

ideas.lshtm.ac.uk
ideas.lshtm.ac.uk/our-research-questions
ideas.lshtm.ac.uk/why-ideas-important

London School of Hygiene & Tropical Medicine

The London School of Hygiene & Tropical Medicine is a world-leading centre for research and postgraduate education in public and global health, with 4000 students and more than 1300 staff working in over 100 countries. The School is one of the highest-rated research institutions in the UK, and was recently cited as one of the world's top universities for collaborative research.

www.lshtm.ac.uk