Increasing private sector accountability in improving Reproductive, Maternal, Newborn, and Child Health Services: Evidence from six states in India

Authors: Sudhir Maknikar, Arti Bhanot, Neha Kashyap, Ajay Gambhir

1.0 Background

India has made noteworthy progress in reducing maternal and child mortality since the declaration of the Millennium Development Goals (MDGs) in 2000. In order to further accelerate progress and meet the Sustainable Development Goals (SDGs) 2030, cohesive action is required from myriad stakeholders, including the government, the private health sector, social entrepreneurs, development partners, donors, and non-government partners.

In India, 61% of the 1.37 million hospital beds available in the country are in the private sector.[1] Evidence shows that there are wide inter-state differences in the distribution of private sector hospitals and beds, and that private sector actors tend to build facilities in more prosperous districts.[2] National health accounts data reveal that the government sector (national, state, and local) account for only 20% of all health expenditures, whilst 78% of expenditures operated via out-of-pocket payments, one of the highest percentages in the world.[3] Apart from a few large corporate hospitals, the majority of private sector hospitals are small establishments, and nearly 85% have less than 25 beds.[4]

The growth of the private sector in the provision of health services across India has raised concerns regarding standards and processes in private sector clinical practice.[5] Aberrant behavior amongst private providers, including unnecessary diagnostics, over-prescriptions, unnecessary clinical procedures, inadequate facilities and equipment, and unethical practices, have been commonly identified in various studies.[6,7,8] While government policies on engaging the private sector through public-private partnerships (PPP), insurance, and other schemes exist, their implementation has not been rigorously reviewed and successes or challenges have not been documented. The effectiveness and sustainability of PPPs have been widely researched in other sectors, including infrastructure, telecommunications, and power, but such research and modelling is currently unavailable for the health sector. This research gap can be attributed to the difficulty of measuring success and returns on investments linked to health services. Though research is limited, existing literature has categorized PPP models in healthcare into six groups: increasing access (mobile health units), affordability (community health insurance), efficiency (functional autonomy to hospitals), financing (joint ventures), outreach (partnering with grassroots organization), and risk transfer (contracting).[9]

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[1] The Planning Commission of India (2011).

[2] Uplekar, M. and George A. (1994), *Access to healthcare in India: present situation and innovative approaches*. The Foundation for Research in Community Health. November 1994.

[3] RSBY (2016). www.rsby.in Accessed on November 29, 2016

[4] The Planning Commission of India (2011) planningcommission.nic.in/aboutus/committee/strgrp/stgp…/ 11_Chapter%209.doc Accessed on November 18, 2016

[5] Venkat Raman, A. (2013) *Private sector and public-private partnership in heath service delivery in India*. India Infrastructure Report 2013.

[6] Ibid.

[7] Kumar, C. and Prakash, R. (2011) *Public-Private Dichotomy in Utilization of Health Care Services in India*. Consilience: The Journal of Sustainable Development Vol. 5, Iss. 1 (2011), Pp. 25-52.

[8] Nandraj, S, et al. (2001) *Private health sector in India.* Centre for Enquiry into Health and Allied Themes. February, 2001.

[9] S.Rajasulochana, U. D. (2009). The Economics behind Public-Private Partnerships (PPPs) in Health Sector. Retrieved from Cehat.org: http://www.cehat.org/go/uploads/PPP/rajasulochanapaper.pdf

In the Indian context, rising demands for quality care, limited healthcare investment by the government, and a growing number of private players in the healthcare and insurance sector makes the need for quality and accountability an imminent reality.

John Snow, Inc. (JSI) India, in partnership with IPE Global, has been implementing the United States Agency for International Development (USAID)-supported Vriddhi project, which provides technical support to the Government of India's Ministry of Health and Family Welfare (MOHFW) to scale up the Government's Reproductive, Maternal, Neonatal, Child, and Adolescent Health (RMNCH+A) Strategy. Vriddhi supports 6 state governments in Delhi, Haryana, Himachal Pradesh, Jharkhand, Punjab, and Uttarakhand and 30 High Priority Districts (HPDs) to scale up RMNCH+A interventions. As part of this initiative, JSI conducted a landscape assessment of RMNCH+A service delivery in the private sector, aiming to collect evidence for developing a private sector engagement strategy for RMNCH+A with a focus on the six Vriddhi priority states. The key objectives of the assessment were as follows:

1) To assess RMNCH+A practices in the private sector, vis-à-vis the high-impact RMNCH+A interventions identified in the Government's RMNCH+A Strategy;
2) To understand the challenges faced by private sector providers and their readiness to implement high-impact RMNCH+A interventions; and
3) To provide evidence-based recommendations for improving access to RMNCH services through engagement with the private sector.

2.0 Approach and Methodology

The assessment was carried out from August-September 2016. Using a mixed-methods approach, information was gathered from over 300 respondents, including facility-based private providers, in-patience departments (IPD), out-patient department (OPD) only clinics, professional associations, and government and social enterprises across the six states. The assessment was conducted in two districts in Jharkhand and in one district for each of the remaining five states. The sample distribution is presented in the table below.

Table 1: Distribution of Landscape Assessment Sample

State	High Priority Districts (30)	District Selected for Assessment	In-Patient Department (IPD)	Out-patient department (OPD) Only
Delhi	2	North West Delhi	12	4
Haryana	5	Hisar	15	6
Himachal Pradesh	4	Chamba	4	12
Jharkhand	11	Gumla, Saraikela	25	20
Punjab	5	Gurdaspur	17	10
Uttarakhand	3	Haridwar	14	7

The assessment findings were disseminated and discussed during a national consultation held on 21 February 2017 in New Delhi. The consultation involved a diverse range of participants, including representatives from national and state governments; professional associations, such as the Federation of Obstetricians and Gynaecology Societies of India (FOGSI), Indian Academy of Paediatrics (IAP), and Indian Medical Association (IMA); social entrepreneurs; and national stakeholders from development partners and donor agencies.

3.0 Key Findings

3.1 Adherence to legal frameworks and standardized guidelines by private sector providers

Overall, only 37 of 87 IPDs had legal registration to provide medical services. In the North-West Delhi and Saraikela districts, compliance to the Clinical Establishment Act[10] or similar state-specific acts was high, while only 1 of 17 IPDs in Gurdaspur and none of the 15 IPDs in Haridwar were registered under this act. Very few facilities were accredited under recommended systems, such as the National Accreditation Board for Hospitals (NABH) and the International Organization for Standardization (ISO). Some facilities had been accredited in the past but had not renewed their accreditation, due to the time-consuming nature of the accreditation process as well as perceived absence of any substantial benefits following accreditation.

Patient safety in the private sector was adversely affected due to non-adherence to standard guidelines for patient management. The assessment found that none of the facilities were providing all RMNCH services as per global or national guidelines. There were gaps in knowledge of contemporary treatment guidelines, and certain practices were suspect and inconsistent with rational, responsive, and reliable quality of care.

Some reasons for lack of adherence to global and national guidelines were:

- Lack of inputs based on new evidence to newer guidelines, either from the government or professional associations;
- Unwillingness to deviate from knowledge and practices gained during medical school training, although many providers had graduated many years or decades ago;
- Inadequate time invested by private providers to seek newer, more up-to-date information; and
- Absence of standard operating procedures (SOPs) in most facilities.

While professional associations are expected to play an important role in developing treatment guidelines and in encouraging their members to adhere to those guidelines, the three associations covered in this assessment – IAP, National Neonatology Forum (NNF), and FOGSI – have only disseminated treatment guidelines to their members and do not monitor and enforce adherence.

3.2 Availability of, versus capacity for, RMNCH services in the private sector

There is a huge gap between desired levels and availability of RMNCH services in the private sector. Only one third of facilities included in this assessment provided the entire range of RMNCH services, including reproductive health (including family planning and safe abortion care), maternal health (antenatal, intrapartum, and postpartum care), newborn care, and child health services. The most commonly provided service was delivery care, which in most cases included vaginal delivery and Caesarean-section (C-Section) facilities. The number of reported C-Sections was much higher than the estimated proportion of obstetric complications that would mandate C-sections. Many facilities that were providing delivery care stated that they did not provide newborn care services, missing crucial service delivery opportunities at birth.

The assessment found a shortage of pediatricians; obstetricians and gynecologists are the dominant IPD service providers. In addition to limited specialists for pediatric care, IPDs offering newborn and child care services also had infrastructure deficiencies – of 41 such IPDs, only 10 had a Neonatal Intensive

[10] The Clinical Establishments (Registration and Regulation) Act, 2010 was enacted by the Government of India to provide for registration and regulation of all clinical establishments in the country, with a view to prescribe the minimum standards of facilities and services provided by those facilities.

Care Unit (NICU) and 26 had a Newborn Care Corner (NBCC). In addition, the Government of India recently released guidelines on antibiotic of choice for neonatal sepsis, based on the latest global evidence. However, private sector providers were unaware of these changes, and most relied on the cephalosporin group of drugs for treating sepsis, as opposed to the recommended combination of amoxicillin and gentamicin. Similarly, many providers were not following the recommended guidelines for treatment of common childhood illnesses such as diarrhea and pneumonia. Many were not aware of the correct dose of zinc for diarrhea management, and quite a few prescribe higher order antibiotics, such as the cephalosporin group, for treatment of pneumonia. Irrational use of antibiotics for treatment of neonatal sepsis was rampant, even in the presence of pediatricians.

3.3 Readiness to partner with the government on RMNCH schemes

The Government has introduced a health insurance program entitled *Rashtriya Swasthya Bima Yojana (RSBY),*[11] which requires private health facilities to empanel. However, private providers have reservations about in empaneling in such schemes, citing that the cost of services in this program does not cover actual costs incurred by private facilities and that reimbursements are delayed. In contrast, the assessment found that government representatives suspect the private sector of submitting inflated bills and wrongful claims under this program. Government officials interviewed at national, state, and district levels stated that lack of client data sharing by private providers, even when they are contract-bound under the government schemes to do so, was a major challenge in partnerships.

The assessment also found that most private providers did not follow any scientific model for pricing their services or for subsidizing their services to the poor, but determined prices by competition and colleagues' recommendations. Government representatives and private providers stated that the risks in PPPs such as these are varied, and include financial risks, performance and accountability risks, risk of confrontation between stakeholders, and reputational risks for the private sector.

The responsibility for creating an enabling environment is not solely that of the government. There is an absence of a platform and/or coalition to foster, mentor, and sustain private sector engagement to coordinate treatment protocols, capacity building, surveillance systems, information networks for pricing and sourcing quality drugs, and patient referral mechanisms.

3.4 Client perspectives on the quality of private sector RMNCH services

The assessment found that clients prefer going to private doctors when seeking treatment for a sick child or for women who previously experienced complications at government hospitals. Almost all clients interviewed highlighted ease of access as a top reason for private sector preference, especially in case of emergency, as well as a misplaced belief that government services are only for those who cannot afford to pay. Interviewees stated that, with private sector providers, they "can go any time, as the doctor is available round-the-clock;" that they "do not have wait in queue for their turn;" and that the "doctor is available even over phone." However, clients also revealed a preference for government facilities when doctors were available and accessible around-the-clock.

Clients said that they found private hospitals to be cleaner, although they offered lesser services than government facilities. Many women recounted that they received counselling on birth preparedness, danger signs for mothers and for newborns, early initiation and exclusive breastfeeding, postpartum contraception, and Kangaroo Mother Care in government hospitals but not in private facilities, highlighting gaps that adequate, quality nursing care can fill in the private sector.

[11] RSBY is a government health insurance scheme wherein, for less than 1 USD, low income workers and their families can avail health insurance coverage up to 600 USD.

4.0 Recommendations: Developing a strategic roadmap to engage the private health sector

Based on these findings, JSI India proposed the following recommendations to create a strategic roadmap for private sector engagement:

- A decentralized institutional mechanism, such as a health PPP cell, should be established at both state and sub-state levels to design, implement, and monitor partnerships with the private sector. This should be created based on lessons learned from previous PPP experiences and from this assessment. Operations of such an institutional mechanism should be led by policymakers and reviewed at least annually at the national level through a PPP committee led by the MOHFW Joint Secretary. Further, grievance redressal mechanisms for private health care providers empaneled under government schemes should be institutionalized.
- The Government of India should develop working PPP guidelines based on successful experiences of different states. Memoranda of Understanding (MOUs)/contract agreements, control mechanisms, monitoring and evaluation, feedback systems, etc. should be designed to oversee the implementation of PPPs with regulation mechanisms in place.
- The Government of India should demystify and popularize existing and all new private sector engagement approaches for both service providers and clients through targeted information, education, and communication campaigns, as is being done for the *Pradhan Mantri Surakshit Matritva Abhiyan,* a national initiative based on philanthropic philosophy to offer fixed day, free antenatal care services every month by private providers.
- Government guidelines and protocols should be available on websites of professional associations, in print materials such as journals and newsletters, and during Continuing Medical Education (CME) programs. Sample SOPs for services that are not covered by current guidelines should be created and made available for private practitioners through e-forums, conferences, etc.
- Using success stories about increased revenues/client load and patient satisfaction, professional associations should promote accreditation with NABH or ISO through a step-wise approach, starting with pilot facilities and simpler quality improvement mechanisms. The focus of accreditation should be on continuous improvement in the organizational and clinical performance of health services, not merely a certificate or assuring compliance with minimum acceptable standards.
- Monitoring and evaluation should be strengthened, with PPP cells as the nodal agency. Random quality checks by state level officials, including qualitative and quantitative benchmarks for performance, should be developed. The Management Information System (MIS) should become the mandatory management tool for assessing trends and the efficiency of the PPP system.
- Development partners should provide technical assistance to national and state governments for private provider engagement through review and testing of existing and new models.
- Quality guidelines should be framed with assistance from professional associations, which already have experience in preparing quality assurance tools. These guidelines can form the basis of accreditation as well as of benchmarks and performance-based indicators.
- Opportunities for cross-learning and sharing among professional associations through electronic platforms, annual combined meetings/conferences and other mechanisms need to be created.
- Engaging private and government medical training institutes in PPPs is critical for long term gains in creating a better informed workforce.