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SCALING UP RMNCH+A INTERVENTIONS

National Consultation Developing Strategic Roadmap to Engage Private Health Sector for Maternal, Neonatal and Child Health

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JSI INDIA

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VRIDDHI: Scaling up RMNCH+A Interventions funded by **USAID** provides policy and techno-managerial support to the Ministry of Health and Family Welfare (MoHFW), Government of India at the national level and direct support in planning, implementing and monitoring the scaling up of RMNCH+A interventions across the states of Delhi, Haryana, Himachal Pradesh, Jharkhand, Punjab and Uttarakhand.

Background

Need to engage private health sector

India made noteworthy progress in reducing maternal and child mortality since the declaration of the Millennium Development Goals (MDGs) in 2000. To further accelerate progress and meet the Sustainable Development Goals (SDGs), 2030, cohesive action is required from the myriad stakeholders- governments, private health sector, social entrepreneurs, development partners, donors and non-government partners. Given its rapid growth and ability to innovate, private healthcare has an important role to play in complementing public health systems and supporting governments' efforts to reach the SDGs. But these businesses need support to reach scale, become more inclusive and have a significant impact in saving the lives of women and children.

We need new models of collaboration among the public and private sectors. We need to think more creatively about innovative ways to draw on all available expertise and resources to provide healthcare to those in greatest need. We need to tap into the vast potential of private health providers to deliver high-quality, affordable, and accessible care to those at highest risk of maternal and child mortality.

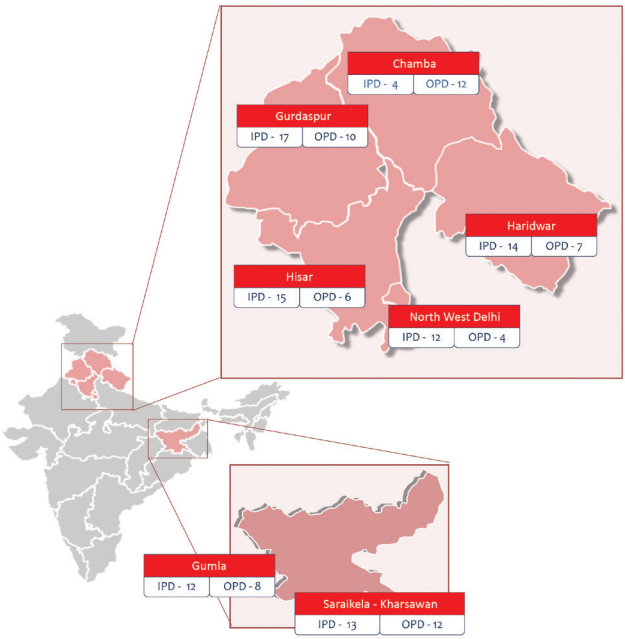
The challenge is to create a new service paradigm that both generates revenue so that these clinics, nursing homes, charitable hospitals are viable, and provides quality health services that are affordable to the poor. The frequent criticism of private healthcare, is that it is not always regulated and that quality of care is sometimes poor.

VRIDDHI Project: Establishing an enabling environment and creating Public - Private health sector linkages

United States Agency for International Development (USAID) supported VRIDDHI is a technical partner to the Ministry of Health and Family Welfare, Government of India to scale up Government of India's Reproductive Maternal Neonatal Child and Adolescent Health (RMNCH+A) strategy. VRIDDHI supports six state governments of Delhi, Haryana, Himachal Pradesh, Jharkhand, Punjab and Uttarakhand and 30 High Priority Districts (HPDs) to scale up RMNCH+A interventions. In these six intervention states, John Snow Inc (JSI) India, in partnership with IPE Global, is developing a strategic road map to engage with the private health sector for scaling up proven high impact RMNCH+A interventions. JSI and Auriga have conducted

a landscaping assessment of the private sector in these six states covering over 300 respondents, including in-patient facility-based (IPD) private providers, out-patient department (OPD) only clinics, professional associations, government and social enterprises. This qualitative assessment of qualified private sector providers aims to understand the current status of private sector engagement in delivering RMNCH+A services and major challenges to be addressed as priority. Sample distribution of IPD and OPD providers is presented in figure 1.

Figure 1 Sampled 87 IPD and 59 OPD providers across seven HPDs in six assessment states



To disseminate the findings of this landscape assessment and initiate discussion for developing a strategic roadmap to engage effectively with the private health sector for increasing access to RMNCH intervention in the six states, JSI is organizing a National consultation on 21st February, 2017 in New Delhi. We are inviting a diverse group of participants such as representatives from National and State Governments, professional associations (Federation of Obstetricians and Gynaecology Societies of India - FOGSI, Indian Academy of Paediatrics-IAP and Indian Medical Association-IMA), Social entrepreneurs, Public Private Partnership (PPP) champions, and national stakeholders from development partners and donor agencies.

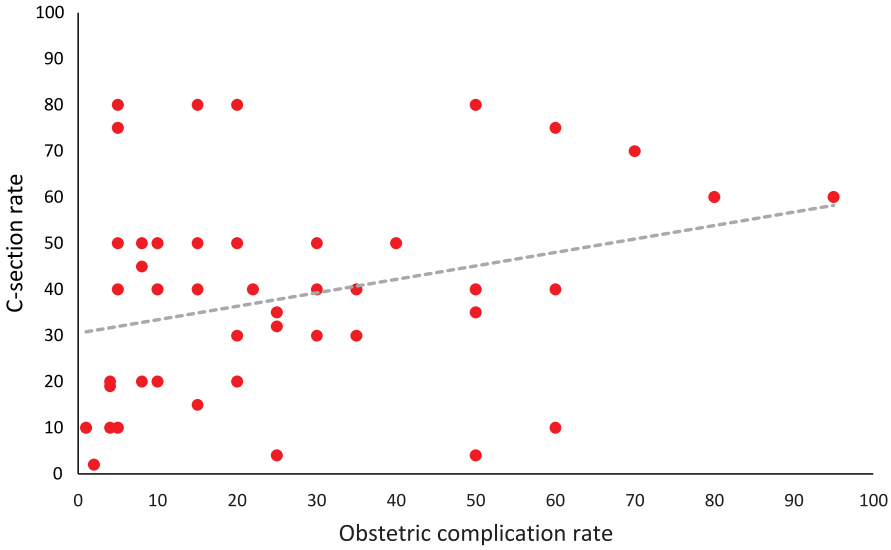
Key findings

Availability and accessibility of RMNCH services in private sector

There was a huge gap between desired levels and availability of RMNCH services in private sector. Only one third of the facilities provided entire range of RMNCH services, that is, reproductive (family planning, safe abortion), maternal (antenatal, intrapartum and postpartum care), newborn care and child health services. The commonest service to be provided was delivery care, which in most cases included normal vaginal delivery as well as C-section. Many of these facilities that were providing delivery care stated that they did not provide newborn care services.

Unlike reproductive health where a restricted range of services was being provided by the private sector providers, for maternal health care, the problem was one of excess – the private providers were recommending more antenatal care visits than required, prescribing more laboratory investigations routinely than recommended, and the C-section rate was also far higher than expected assuming a normal patient distribution or even when compared to the obstetric complication rates quoted by the providers (Figure 2).

Figure 2 Association between C-section rate and obstetric complication rate



There is shortage of paediatricians; obstetricians and gynaecologists are the dominant IPD service providers. In addition to limited specialists to provide paediatric care, IPDs offering newborn and child care services had infrastructure deficiencies – of 41 such IPDs, only 10 had a Neonatal Intensive Care Unit and 26 had a Newborn Care Corner. Newborn care service providers lacked clarity on the timing of initiation of breastfeeding and/or the definition and duration of exclusive breastfeeding. Other elements of routine newborn care such as delaying bathing to prevent hypothermia, or administration of Vitamin K injections were not being practised by a significant proportion of the providers. The Government of India has recently released guidelines on kangaroo mother care (KMC) and antibiotic of choice for sepsis, based on latest global evidence. Private sector providers were unaware of these changes; hardly any could correctly define KMC and knew the birth weight cut-off at which it should be initiated. Most of them relied on cephalosporin group of drugs for treating sepsis opposed to the recommended combination of amoxicillin and gentamicin (Table 1).

Table 1 Management of neonatal sepsis and availability of paediatrician in the facility

	Facilities		
	With paediatrician	**Without paediatrician**	**Total**
Penicillin (Amoxicillin) along with Injection Gentamicin	3	2	5
Antibiotic(s) other than Penicillin or Gentamicin	22	3	25
No response	10	1	11
Total	**35**	**6**	**41**

Similarly, screening of newborns for birth defects was not being performed routinely by the providers, and even where it was being followed, the focus was on easily recognizable defects such as cleft lip or palate and Talipes (club foot) and not so much on others like congenital deafness or retinopathy which require the services of other specialists beyond a paediatrician, such as an Ear Nose Throat or ophthalmic surgeon.

Similar to newborn health, many providers were not following the recommended guidelines for treatment of common childhood illnesses like diarrhea and pneumonia. While many were not aware of the correct dose of zinc for diarrhea management, quite a few providers were prescribing higher order antibiotics like the cephalosporin group for treatment of pneumonia. Irrational use of antibiotics for treatment of neonatal sepsis was rampant even in presence of paediatricians.

Respondents from the community and health workers in the districts of Gumla and Haridwar offered insights to the factors influencing community to select private sector providers. Primarily Accredited Social Health Activists (ASHAs) and Anganwadi Workers referred maternal and newborn cases to private hospitals when doctors were not available in government hospitals (in Haridwar) or the government hospital had refused to handle the complicated cases (in both the districts). In some cases, the health workers were also urged by the family to refer cases to a private hospital due to its proximity. Families showed preference for private providers in case of a sick child or a woman whose case was poorly handled at government hospital. However, government providers were preferred for free delivery (vaginal as well as C-section). Almost all community members highlighted the ease of access as one of their top most reasons to prefer private sector, especially in case of emergency, and a misplaced belief that government services are only for those who cannot afford to pay. Beneficiaries opined private hospitals to be cleaner but received lesser services than in government hospitals. Many women recounted that they received counselling on birth preparedness, danger signs for mother and for newborns, early initiation and exclusive breastfeeding, post-partum contraception and KMC in government hospitals but not in private facilities, highlighting the gaps that good quality nursing care can fill in private sector. ASHA's were not perceived as having any role in managing childhood diseases.

Adherence to legal frameworks and quality improvement initiatives by private sector providers

Overall, only 37 of 87 IPDs had legal registration to provide medical services. In districts North West Delhi and Saraikela, compliance to Clinical Establishment Act or similar state specific Act was high, while only one of 17 IPDs in Gurdaspur and none of the 15 IPDs in Haridwar were registered under this Act (Table 2). Accreditation for 2nd trimester Medical Termination of Pregnancy (MTP) was not sought to avoid harassment under Pre-conception and Pre-natal Diagnostic Techniques (PCPNDT), Act.

Table 2 Compliance to mandatory legal regulations across seven districts

District (facilities)	Legal regulations		
	Establishment Act*	MTP Act	PCPNDT Act
Chamba (4)	2	2	1
Gumla (12)	7	2	4
Gurdaspur (17)	1	9	11
Haridwar (15)	0	6	6
Hisar (14)	3	9	8
North West Delhi (12)	12	6	6
Saraikela- Kharswan (13)	12	7	7

* Clinical Establishment Acts in Chamba, Gumla, Haridwar and Saraikela-Kharsawan; Punjab Shops and Establishment Act in Gurdaspur and Hisar, and Delhi Nursing Homes Act in North West Delhi.

Measures to indemnify private providers were largely missing exceptions being a legal cell under the IAP and the Private Medical Association in Gurdaspur that has hired legal advisors for representing doctors.

Patient safety in private sector is adversely affected due to non-adherence to standard guidelines for patient management. The assessment found that none of the facilities were providing all the 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 of the many reasons for this non-alignment with global and national guidelines were:

- Lack of input either from the government or their professional associations to newer guidelines;
- Not enough readiness to deviate from the knowledge and practices gained in medical schools they graduated from many years and in many cases decades ago;
- Inadequate time invested by private providers to upgrade themselves with newer information; and
- Absence of standard operating procedure in most of the facilities.

While the professional associations are expected to play an important role in developing treatment guidelines and in encouraging their members to adhere to it, the three associations covered in this assessment – IAP, National Neonatology Forum (NNF) and FOGSI - have only disseminated treatment guidelines to its members but not monitored and enforced adherence. This lack of focus on quality of services is also reflected in the providers' disinclination for accreditation. Very few facilities were accredited under the known systems like National Accreditation Board for Hospitals (NABH) and International Organisation for Standardization (ISO). There were also some facilities that were accredited in the past but have subsequently not renewed their accreditation, because of the intense efforts over protracted timeframe for the process along with perceived absence of any substantial benefits following accreditation.

Coordination mechanism to effectively engage stakeholders and maximize their strengths

The assessment revealed various initiatives to increase private sector involvement in improving reach of RMNCH+A services are ongoing; however, there is no common forum that links these initiatives and makes the PPP process seamless.

Government has introduced many partnership schemes such as the Rashtriya Swasthya Bima Yojana (RSBY) but private providers have inhibitions in empanelling for such schemes -cost of services does not cover actual costs incurred by private facilities and reimbursements are delayed. Contrastingly, government suspects private sector of unethical practices, inflated bills and wrongful claims.

Despite the perception of private sector being profit driven, almost all service providers claimed offering discounts or waiving fees for patients from more vulnerable households across the six states. These efforts usually go unnoticed by the government due to lack of a supportive supervision and feedback mechanism for private sector providers.

Reach of initiatives led by professional associations for improving quality standards needs to be improved.

- IAP is developing a protocol based treatment approach for private paediatric care providers.
- The NNF is designing an accreditation process aimed at expanding availability of neonatal care services through trained medical graduates and non-paediatric post-graduates in health facilities with basic infrastructure for newborn care services.
- FOGSI in partnership with the NABH and Jhpiego is launching an accreditation system for small maternity care hospitals and clinics in India.

Social entrepreneurs face triple challenge of product, price and perception. Products such as safe birth kits, pregnancy test kits, hypothermia bracelet among others are at various stages of independent assessment for compliance to quality standards and testing in field conditions. Some of the products are prescription based. As entrepreneurs are recruiting more providers to endorse their products, they are experiencing 'a perception challenge'- their products are relatively new and not adequately reviewed and/ or endorsed by professional associations. A few social enterprises selling products in open market have products priced high enough to be unaffordable in HPDs. With increased usage of their products or services, the enterprise will eventually be able to have more affordable pricing.

Readiness to engage in scaling-up high impact RMNCH interventions

Many private providers in the assessment had positive experience of extending services to poor and marginalized, when empanelled under RSBY – a government sponsored insurance scheme, where they were able to utilize their infrastructure and human resources capacities to the maximum. On the flip side, some providers had experienced inadequate compensation, delayed claims, non-adherence to the Memorandum of Understanding. The government officials at national, state and district levels had an equally positive outlook to engaging private sector hospitals.

The government officials opined that success of PPP depended on finding a common ground where both government's and private provider's interest met. The most common problems the government faced with private providers were presentation of inflated claims and of fudged records of services. The government officials at national, state and district levels were also guarded on lack of data from the private facilities, even when they are contract bound under the government schemes to do so.

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 were determined by competition and colleagues' recommendations.

Government as well as private providers stated that there are many risks in PPP. There are financial risks, performance and accountability risks, risk of confrontation between stakeholders and reputational risks for the private sector. The government felt that an intermediary organization, like a third party administrator for insurance agency, may be one of the options to facilitate administration of these interventions.

The responsibility of creating an enabling environment is not solely that of the government. There is an absence of a platform/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.

The assessment team found some district level initiatives that appeared to be working well for both the government and private providers. For example, the District Health Society in Gurdaspur has been selective in empanelling hospitals in those blocks where government was unable to effectively deliver services due to shortage of adequate human resources. Another example of the initiative taken by district officials to engage private sector is in Chamba (Himachal Pradesh) where, in absence of government obstetrician/ gynaecologist in the district, the Chief Medical Officer empanelled Swami Hari Giri Charitable Hospital in Kakira block to do institutional deliveries. As part of the agreement, obstetricians from the empanelled hospital would also conduct deliveries at the District Hospital whenever the government obstetrician is relocated to another district.

Way forward

Recommendations to develop strategic roadmap to engage private health sector

What policy makers can do?

Create an institutional mechanism at national and state level to design and manage PPP initiatives

There is a need for a decentralized institutional mechanism such as a PPP cell, to design, implement and monitor partnerships with private sector. There is inter and intra-state variation in the types of qualified private sector providers which need to be taken in cognizance in developing state-specific private sector engagement approaches.

Such an institutional mechanism should at state and sub-state levels:

- enforce existing regulations to achieve atleast minimum level of infrastructure and service quality requirements and make this a non-negotiable requirement for partnering under any government scheme
- engage experts to design private sector partnership approaches which bridge RMNCH service gaps and remain financially viable for the private sector health care provider
- 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
- embed monitoring and review of private sector engagement approaches in the design; felicitate good performers and identify champions for advocating private sector engagement approaches
- institutionalize grievance redressal for private health care providers empanelled under government schemes
- create environment for innovations in private sector engagement through dedicated budgets in annual plans, setting targets for such innovations and encourage cross-learning among states/ districts.

The operations of such an institutional mechanism should be reviewed atleast annually at national level through a PPP committee led by Joint Secretary, Ministry of Health and Family Welfare.

What professional associations can do?

As these agencies aim at professional enhancement, there are two sets of actions that require immediate attention to expand the services and products basket and improve the quality of RMNCH services available through private sector providers.

Increase access and functional knowledge of government endorsed treatment guidelines and standard operating procedures

- Awareness about existing government guidelines and protocols needs to be improved through incorporation of these in websites of professional associations, in print materials such as journals and newsletters and during continuing medical education.
- Create sample standard operating procedures for services that are not covered by current guidelines and make them available for private practitioners through e-forums, conferences etc. for ease of replication. A standard operating procedure for paediatric care is already under development by IAP.

Increase awareness about and adherence to quality improvement activities through accreditation

- Using success stories on increased revenues/ client load and patient satisfaction, promote accreditation of health facilities through NABH or ISO. Accreditation will ensure development of standard operating procedures and institutionalising processes to ensure compliance to the same.
- In addition to advocacy for accreditation, professional associations should employ a step-wise approach leading to accreditation. Starting with few pilot facilities and simpler quality improvement mechanisms, the capacity of these facilities could be increased to the level that is acceptable to an NABH or ISO accreditation over a year or two.

Both FOGSI and NNF are already in the process of testing such quality improvement mechanisms. The NABH, FOGSI and Jhpiego are launching an accreditation system for small maternity care hospitals and clinics wherein NABH will assess the systems and procedures of the private hospitals and clinics, FOGSI will evaluate the clinical

protocols and Jhpiego will be the capacity building partner. The accreditation is intended to standardize systems and protocols, improve quality of maternity care and reduce maternal and newborn mortality. The NNF's pilot on expanding availability of neonatal services through training of non-paediatric doctors will be particularly useful for IPDs which tend to have lesser neonatal and paediatric specialists but have general physicians.

The quality assurance mechanisms existing under the National Health Mission could be used to provide supportive supervision to willing private providers.

What VRIDDHI project and Development partners/ Donors can do?

Provide technical assistance to national and state governments on viable engagement with private providers through review of existing models and testing new models

- Funding implementation researches, documentation of successful models (both services and products) and advocacy for testing and scaling-up successful models.

Create a common interface for private sector RMNCH providers which can be managed through the existing associations

- In consultation with the professional bodies institutionalize process for joint technical updates and review of PPP initiatives. This could be in the form of biannual joint meetings of FOGSI, IAP and NNF.
- An independent web-based interface with support of commercial partners should be created to host database of private health care providers at state and sub-state level, function as a repository of guidelines and other technical updates and live chats for technical and legal counsel.
- Traditional financing for maternal and child health has typically been driven by the donor community. As we look towards more sustainable models, it will be important to consider how to channel resources in a way that spurs entrepreneurial activity and achieves desired health outcomes on a broad scale. Financial cooperatives, angel investor clubs, social venture capital funds, local development banks, credit guarantees, and other investment mechanisms are being used more widely, and specific tools can be adapted to healthy businesses at different stages of their evolution.

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