

Are Arrangements for Public Private Partnerships for Emergency Obstetric Care Services Adequate under JSY?

A Study in Ahmednagar District, Maharashtra

5 CHAPTER

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INTRODUCTION

Maternal mortality remains one of the most daunting public health problems in resource-poor settings, and reductions in maternal mortality have been identified as a prominent component of the Millennium Development Goals. The World Health Organization estimates that 515,000 women die each year from pregnancy-related causes, and almost all of these deaths occur in developing countries, particularly in rural settings.¹

The maternal mortality ratio for India is 254 per 100,000 live births,² compared to eight to 12 per 100,000 live births in North America. India contributes about 20 percent of maternal deaths globally. This situation is particularly tragic because no new technologies or drugs are needed to radically lessen maternal mortality. Eighty percent of the maternal deaths are due to five obstetric complications — obstructed labour, haemorrhage, sepsis, eclampsia and unsafe abortion, which can be well managed by provision of emergency obstetric care (EmOC).³ Significant declines in maternal mortality in Sri Lanka and Malaysia over the past 50 to 60 years provide evidence that the implementation of maternal health interventions in developing countries

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is feasible. Increased access to skilled birth attendance accompanied by the development of EmOC and other complementary health services were key contributors to the reductions achieved in these countries.⁴

The Government of India launched the National Rural Health Mission (NRHM) in April 2005 to address the country's health issues. Janani Suraksha Yojana (JSY) is a safe motherhood intervention under NRHM, being implemented with the objective of reducing maternal and neonatal mortality by promoting institutional delivery among the poor pregnant women. The Yojana, launched on 12 April 2005, by the Hon'ble Prime Minister, is being implemented in all states and Union Territories (UTs), with special focus on low-performing states. The JSY is a 100 percent centrally sponsored scheme and it integrates cash assistance with delivery and post-delivery care.⁵

Over the years, the private health sector in India has grown remarkably.⁶ At the time of independence, the private sector in India had only 8 percent of healthcare facilities but today it is estimated that 93 percent of all hospitals, 64 percent of beds, 80–85 percent of doctors, 80 percent of outpatients and 57 percent of inpatients are in the private sector.⁷ Therefore, today one is unable to ignore the role of private sector in healthcare service delivery. India has a rich experience of Public Private Partnership (PPP) over the past five decades, but these were ad hoc and not organized or policy-driven.

Appropriately trained personnel and the provision of necessary supplies and equipment are critical to the development and implementation of effective EmOC services and the serious inadequacies in the public sector in this regard have long been identified. The Mission, therefore in its expectation to address the gaps in the provision of effective healthcare to the rural population, aims at fostering public-private partnerships in its supplementary strategies. Adjuvant to this strategy, the JSY has a provision

of subsidizing cost of caesarean section deliveries or management of obstetric complications through partnership with the private sector.

PPPs are collaborative efforts, between public and private sectors, with clearly identified partnership structures, shared objectives, and specified performance indicators for delivery of a set of health services in a stipulated time period.

The core elements of a viable partnership are beneficence (joint gains), autonomy (of each partner), joint-ness (shared decision-making and accountability) and equity (fair returns in proportion to investment and effort). A PPP is termed a successful one when the net benefits of the partnership exceed those of independent activities, and when joint efforts result in more efficient or effective services than independent actions.⁸ Some authors believe that PPPs have been associated with malpractices and private sector gains at public expenses — like subsidies to the pharma industry, to medical education and trust hospitals.⁹ Such outcomes may have resulted from inadequate mechanisms to regulate the private sector.

Research literature identifies varied types and models of PPPs in the health sector like: contracting (contracting out and contracting in), franchising, social marketing, joint ventures, subsidies and tax incentives, vouchers or service purchase coupons, hospital autonomy, BOT (build, operate and transfer), philanthropic contributions, health cooperatives, grants-in-aid, capacity building, leasing and social health insurance. Amongst all the models, contracting has been the most common form of PPP. These models existed in the country much before the NRHM was launched, but were never viewed as partnerships, rather regarded as subsidies or incentives, and it is under the NRHM that a more organized effort is being made to institutionalize PPPs.

The following paragraph, from JSY document elaborates the PPP initiative:

Subsidizing Cost of Caesarean Section or Management of Obstetric Complications

Generally, PHCs/FRUs/CHCs etc., would provide emergency obstetric services free of cost. Where government specialists are not available in the government health institution to manage complications or for caesarean section, assistance up to Rs.1,500 per delivery could be utilized by the health institution for hiring services of specialists from the private sector. If a specialist is not available or that the list of empanelled specialists is very few, specialist doctors working in the other government set-ups may even be empanelled, provided his/her services are spare and he/she is willing. In such a situation, the cash subsidy can be utilized to pay honorarium or for meeting transport cost to bring the specialist to the health centre. It may however be remembered that a panel of such doctors from private or government institutions need to be prepared beforehand in all such health institutions where such facility would be provided and the pregnant women are informed of this facility, at time of micro-birth planning.

Source: Section 4.12: of The Janani Suraksha Yojana, The National Rural Health Mission document
Ministry of Health and Family Welfare, Government of India, www.mohfw.in/nrhm.

The Context

The JSY is implemented in all states and UTs of the country with a special focus on the low-performing states. Maharashtra is categorized as a high-performing state where the JSY is applicable to only those women either living below the poverty line (BPL), or to women from the Scheduled Caste (SC) or Scheduled Tribe (ST) families, and who are above 19 years of age, for the first two live births. The JSY for rural Maharashtra provides women a cash assistance of Rs.700 in case of institutional deliveries and Rs.500 in case of home deliveries. JSY also provides assistance of Rs.1,500 to manage obstetric complications or caesarean section through public-private partnership. Some state governments have added to the Rs.1,500 from the centre or have innovatively utilized the provision and have evolved different models of PPPs for EmOC provision; for

example, the Chiranjeevi scheme in Gujarat and the Ayushmati model in West Bengal.

The study was conducted in the Ahmednagar district of Maharashtra state in western India. The district has 14 blocks. The public health system in the district functions through 96 Primary Health Centres (PHCs) and 23 Community Health Centres (CHCs) that are the secondary care centres and a district general hospital at the district headquarters in Ahmednagar city. The private medical sector has a significant presence in the district with multiple speciality centres available at the block headquarters as well as in Ahmednagar city.

The socio-demographic profile of the district is summarized in Table 1.

TABLE 1: Socio-demographic profile

Indicator	Ahmednagar	Maharashtra	India
Population (millions)	4	96.9	1028.6
SC (%)	12	10.2	16.2
ST (%)	7.5	8.9	8.2
BPL (%)	30	30.7	27.5
Birth rate	22.3	19	23
Death rate	5.2	6.7	7.6
MMR/1000 live births	<2	<2	3

Since EmoC provision through PPPs is perceived as an immediate solution to the inadequacies in the public sector, it was felt essential to understand the mechanisms followed for the design and implementation of the same and how these affect the availability of EmoC services to women.

THE OBJECTIVES

The overall goal of the study was to collect and collate experiences of women, providers and administrators with regards to the PPP scheme for EmoC provision in selected blocks in Ahmednagar district in Maharashtra state of India.

Specific Objectives

- To investigate whether the PPP for EmOC under JSY is implemented as per the NRHM guidelines.
- To determine the sufficiency of monetary assistance provided under the scheme.
- To understand the difficulties in referral mechanisms and in proving eligibility for availing benefit, if any.
- To understand the views and perceptions of different stakeholders (implementers, service providers, women who had obstetric complications) about the PPP scheme for EmOC provision.
- To find out the reasons for not availing the benefit of the scheme.

METHODOLOGY

A cross-sectional study was conducted using the Rapid Assessment of Health Programmes Approach. The study duration extended from June 2008 to June 2009.

Sample Selection

Five blocks in the district were chosen for the study randomly using the lottery system. A list of the names of PHCs in the selected blocks was used to randomly select two in each block. One staffer, either medical officer or an ANM, was interviewed from each of the selected PHCs to participate as a public health provider. One private provider of EmOC services in a block from three of the five study blocks was selected for interview as a private health provider. Block medical officers in three blocks and the district health officer were also interviewed as administrators of the scheme.

Data from the block medical officers of the selected blocks was used to identify women who had delivered

between June 2007 and October 2008, and were beneficiaries of the EmOC provision under the JSY. Two women in each block were randomly chosen from these lists. The anganwadi worker in these locations was used as a link to reach these women, henceforth referred to as beneficiaries.

A list of women who had availed emergency obstetric care from the private providers and was eligible for the benefit of the JSY was obtained from the private practitioners at the block headquarters.¹⁰ Also names of women who had a complicated delivery were obtained from the anganwadis in the selected PHC areas. Of these, two women in a block were randomly chosen to participate in the study. Eligibility of these chosen participants for availing the benefit of the JSY was confirmed on meeting them. Women who had not received the benefit of JSY for management of obstetric complications or caesarean section were enrolled as participants in the non-beneficiary group. In case of unavailability of a chosen participant the next randomly chosen person from the particular study category was approached.

Data Collection

Qualitative methods were used to elicit information and data. These included semi-structured interviews (SSI) and focus group discussions. Semi-structured interviews were conducted with these participants at their homes using pilot tested interview guides. Semi-structured interviews were conducted with providers at their workplace.

Focus group discussions were carried out to complement the information received in the interviews and to add new perspectives. Two focus groups consisting of seven and six participants respectively, drawn from the ANMs working in sub-centres of the PHCs in chosen blocks, were held. Three key informant interviews were conducted, one each with a senior administrator in the district health unit, a block medical officer and an ANM working in a PHC.

TABLE 2: Overview of Methodology

	Implementer of Sscheme	Beneficiaries of Scheme	Non-Beneficiaries of Scheme	Private Health Service Providers
Respondents	District level: DHO Block level: THO MI. S. at CHCs PHC/SC level: ANMs, MOs	Women who have benefited from scheme for management of obstetric emergencies under the JSY.	Women eligible for but not benefited from scheme for management of obstetric emergencies under the JSY.	Obstetricians in private hospitals having facility for EmOC services.
Recruitment process	DHO and one block level respondent from 5 selected blocks were chosen. 1 respondent from each of the 2 PHCs in 5 selected blocks were chosen.	List of beneficiaries obtained from TMO & MO. 2 women in each block were randomly chosen from these lists	Names and addresses of women who undergone CS in private hospitals were collected from Pvt. hospitals and anganwadis in 5 blocks. Of these, two women in a block were randomly chosen to participate in the study.	One private provider in a block from five study blocks was invited to participate in the study.
Data collection method	SSI & FGD	SSI	SSI	SSI
Main areas of investigation	Implementation process, Hassles in implementation, Referral mechanisms for EmOC, Views, perceptions and suggestions about the scheme.	Mode of benefit, Difficulties in availing benefit, Sufficiency of benefit, Awareness about the scheme, Cost and consequences of obstetric complications.	Barriers in availing benefit of scheme, Awareness about the scheme, Cost and consequences of obstetric complications.	Awareness about PPP for EmOC. Initiatives from public system for partnership. Experiences of / willingness for PPP, Views, perceptions and suggestions about the scheme
No. of respondent	District level - 1, Block level - 5 PHC/SC level - 10	10	8	3

Table 2 summarizes the respondent categories, number of respondents in each, the recruitment process and areas of investigation.

Data Analysis

Interviews and other information were all recorded in the local language, Marathi and audio taped and transcribed verbatim for analysis into English. The transcripts were read and re-read several times to allow the researchers to become increasingly familiar with the participants' experiences and meanings and to allow a more accurate and genuine depiction of the process. Field notes and reflections supported this. Themes emerging from the transcripts were assigned colour codes which were then used to assign quotes to particular themes. The data for each code were compiled in excel spreadsheets. These were then summarized to arrive at the results.

Ethical approval to proceed with the study was received from the Institutional Ethics Committee of the Foundation for Research in Community Health (FRCH). All respondents had the purpose of the study explained to them and their consent was sought. In case of non-literate participants, oral consent was taken.

Limitations

The findings of this study must be considered in light of its limitations as well. This study uses rapid assessment approach. Rapid assessments are, by design if not by definition, studies which opt for timely, focused and qualitative information at the expense of generalization of results through probability sampling. Although this study gives important insights into the operations of the scheme, the findings cannot be generalized to a population as a whole. The subjectivity resulting from the data collection methods

is another challenge. This study has been conducted as a part of training on rapid assessment methods with prevailing time and finance constraints.

FINDINGS

Implementation

The basis of PPP for EmOC service provision in Maharashtra state differs from NRHM guidelines. While guidelines from the centre recommend the scheme for management of obstetric complications and caesarean section (CS), the state guidelines mention only caesarean section. Those who required EmOC but not a CS are not considered eligible for the benefit. This was mentioned by all of the providers interviewed except a block administrator who mentioned of being unsure of the guideline in this regard.

The scheme is limited to cash assistance rather than service provision. The study found that not a single facility in the public health system of the district has entered into a PPP to provide EmOC under JSY. There is no accreditation of private facilities in the district. The guidelines issued by the Maharashtra State Public Health Department mention providing Rs.1,500 to the doctor conducting the caesarean operation in a private institute while rest of the hospital charges are to be paid by the patient. Thus, the institutional set-up ensures that the monetary assistance of Rs.1,500 provided for hiring specialists from the private or other public institutions is utilized as a subsidy after a caesarean operation.

There are variations in implementation; for instance, the study found that payments are being made to the private specialists in certain blocks, to the woman in others or to either in some. A medical officer (PHC, MO) said that he follows the norm of giving it to the woman if she comes with a receipt of the payment made for the surgery or else it is given to the private doctor who conducted the operation.

This is dependent on the interpretation of the guideline by the respective block medical officers. A cheque in the private doctors' name handed to the woman is another practice followed in some areas. In some blocks, a patient accessing care from the district general hospital or municipality hospitals, where it is provided free of cost, is considered eligible to receive the Rs.1,500 benefit while in others she is not. One public provider mentioned that registration of pregnancy before 12 weeks of gestation is mandatory to avail the benefit of the scheme. Table 3 presents a picture of JSY implementation from the District Programme Management Unit for a 6 month period during April to September 2008.

None of the public providers have any list of accredited facilities for maternal health in the area, in contravention to the NRHM guidelines. A medical officer noted that accreditation is expected but not mandatory for the doctors whose services are being covered under the scheme. Certain providers mentioned of denying the benefit in case of the hospital being non-accredited. Private doctors (obstetricians

TABLE 3: HMIS data for Ahmednagar district: April -September 2008

INDICATORS	SC	ST	BPL	Total
Estimated no. of JSY beneficiaries	2489	2886	2319	7694
No. of JSY beneficiaries registered	2252	1434	1923	5609
No. of JSY beneficiaries delivered at institutions	1534	945	1435	3914
No. of JSY beneficiaries delivered at home	128	88	108	324
No of JSY beneficiaries provided financial support (Rs.700 or 500)	1822	1982	1692	5496
No. of JSY beneficiaries paid Rs.1500/- for LSCS	61	50	86	197 (2.5% of eligible women)

Source: District Programme Management Unit, Ahmednagar

and gynaecologists), on the other hand, mentioned that patients' relatives, who come after a caesarean section to ask for doctors' signatures, gave them an idea of a subsidy being provided to such patients. However, none of them was approached for a partnership.

Though JSY is a referral based scheme, no documents about the referral of the patient are required, nor is any rationale required to be given for the CS being done.

With regard to the eligibility of poverty classifications and caste, some documents were found to be necessary. Accepted proof of a woman's caste is her caste certificate or a school leaving certificate. A block medical officer however contradicts this by claiming that they do not ask for the caste certificate, and will take the ANM's word for the same. One block medical officer said that he had issued guidelines for the BPL listing based on the 2002 demographic survey but pointed to lack of clarity on this aspect. Providers said that the woman is not required to provide a proof of her age as her word is accepted.

A senior administrator found the PPP scheme useful for urban areas, as he perceived patients from rural areas being apprehensive of delays in arrival of specialists from towns. He elaborated: "...Calling a doctor from the town is equally good as taking the patient to the town. There are transport facilities now. If you tell a patient that a surgeon would come from the town, ...they request discharge and want to go to a higher facility, ...I do not feel that anyone bothers about money at that time... This arrangement of a surgeon coming from outside is feasible only in the cities... (District Official)

Monetary Assistance

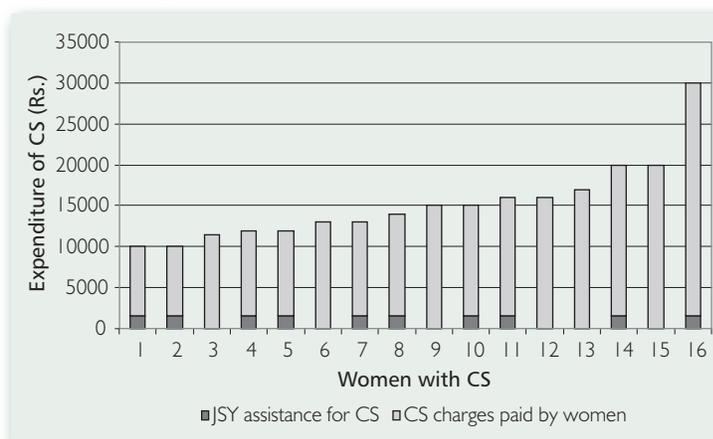
The overall opinion of providers and beneficiaries is that the amount of Rs.1,500 is not a sufficient amount. From the implementers' point of view, the amount is not always enough to attract private doctors. Speaking about the

possibility of the scheme being implemented as originally designed — providing free of cost care in public facilities by hiring specialists from outside, an MO opined about the lack of motivated doctors who would come to the rural hospital for just Rs.1,500. This is so because the prevailing rates for hiring a surgeon are Rs.3,100 and that for the anaesthetist Rs.2,200 for a Caesarean section.

A member of the Rogi Kalyan Samiti (RKS) of a sub-district hospital pointed out an experience of hiring a specialist from the private sector: “Dr..., a private gynecologist who is usually appointed on an on call basis in the hospital, is unwilling to come here, because of his interests in his own private hospital. The doctor feels that if he comes to the sub-district hospital, all his patients will not go to his own hospital. Who will want to spoil their own practice?”

Beneficiaries have pointed out that they have spent about ten times the JSY benefit amount. They said that the amount is not sufficient even for tablets and medications that were required during CS. Figure 1 shows the proportion of JSY assistance to CS charges paid by women to private

FIGURE 1: Proportion of JSY assistance to CS charges women paid to private hospitals



hospitals. It is evident that the Rs.1,500 received through the JSY did not significantly alter the expenses borne by families for CS in private facilities.

Amongst the beneficiaries of JSY PPP, with the exception of one participant who had her CS in the district general hospital, all have availed services from the private practitioners. The cost of hospital care ranged from a low of Rs.10,000 to a high of Rs.30,000, the average approximating Rs.15,000. This excluded transport and incidental costs, which come to about Rs.600 on average. The one participant who sought care from the district hospital spent Rs.2,500 for the suture materials and drugs that she was asked to buy from outside.

Thus, one can see that the cost of CS is a major burden to the families. Participants mentioned mortgaging belongings of her natal home to arrange for hospital bills. One participant recollected: "...We had to take a loan for paying the bill. My parents (not in-laws) are very poor, they took a loan at 5 percent interest a month. They have already repaid over Rs.8,000, for the Rs.5,000 they had taken for my caesarean..."

Besides the amount of JSY benefit, the mode of payment also created difficulties for women. The JSY amount is paid to woman by cheque in most places to reduce corruption associated with cash payment. As one ANM expressed: "Women do not even know what a cheque means. I have to accompany them to the bank, but this is possible for me because the bank here is nearby, but what about those working in sub-centres? The woman then has to give the cheque to her husband, and in most instances the money does not reach the woman."

An administrator also said that the bearer cheque given within 7 days of delivery is inconvenient. "How can a recently delivered woman go to the bank?" She is in a different mindset that time, she gives off the cheque to someone, and then you know what happens to the money."

All the participants emphasized on the need to increase the amount of benefit paid. Most feel Rs.5,000 would be reasonable amount, with the exceptions of a woman who suggests it should be 50 percent and an ANM who suggests it be 75 percent of the hospital bill.

Referral Chains

To access services from a private facility, the woman in need of CS is expected to carry a referral slip from the ANM or medical officer and also a proof of her being either SC/ST or BPL as per JSY guidelines. In case of emergencies, when the CS is not pre-planned, and a referral slip for the CS operation is not available with the patient, the implementers are expected to verify the patient's address and her being from SC/ST or BPL community. The guideline also mentions that the private facilities when demanding the honorarium (Rs.1,500) should produce a proof to the Block Medical Officer of having operated on the beneficiary. The study found neither the practice of referral slip nor the demand from private facilities.

Instead the study found that almost all cases are direct self-referrals to the private specialists, or via smaller private centres. The medical officers and ANMs at the PHCs have no specific referral chains, they prefer to leave it to the patient to choose a higher centre. There is no accreditation of centres done for this scheme; hence, there exist no measures to ensure the continuum of care and minimize delays.

One ANM mentioned of having referred and accompanied two EmOC cases to a sub-district hospital. However, they were diverted to the private hospital of the consultant appointed on call in the sub-district hospital. Public providers from all the study blocks revealed that CHCs in their block do not have EmOC services and thus were forced to refer poor patients to nearby charity hospitals.

Transport System

The JSY guidelines talk of provision of free transport for EmOC. Differences in norms regarding provision of transport for EmOC were noticed. The amount is upto Rs.250 for a patient according to some implementer while others mentioned it to be Rs.500. A block administrator mentioned of wall paintings displaying phone numbers of vehicle owners whom the patient can contact in need of emergency transport and use the vehicle without payment, which are directly made to the transporter by the PHC later. In another PHC, the understanding is that the patient has to spend for the transport first and it can be reimbursed later from the Village Health and Sanitation Committee or from the Rogi Kalyan Samiti money if the medical officer feels the need to do so. In a few places the norm is to spend for transport from the money available for sub-centre strengthening. However, this study found no participant who benefited from transport provided from the PHC or reimbursement for the same. Transport facilities used by women were private vehicles hired at high rates.

Availability of Funds

In all the blocks, the officials at the block office feel the funds are adequate for implementing the scheme, though grassroots workers in two blocks mentioned shortages. ANMs reported they many times do not get the amount of Rs.5,000 that they are supposed to get. In one block, a delay of 6 months was reported. Road blocks in processing payments like the case of a Block Medical Officer who withheld payment to those women who delivered before he joined in July 2008 posed a significant problem.

Barriers in Claiming Benefits

Service area constraints pose a particular constraint. Traditionally, in Maharashtra, as in most parts of the country, women

go to their maternal homes for delivery, usually in the 7th month of pregnancy and return about 6–8 weeks after the delivery. This creates problems while claiming JSY benefits. The women eligible for JSY are expected to carry their JSY card when they go for delivery. ANMs in the maternal homes, (whenever they come to know of the delivery — sometimes at the time of child’s immunization), consider her to be from out of their service area and direct her to avail benefit in her usual residence area. This is because some feel that it would not help in their work profile if they help women from other area in availing JSY benefits. There is also some fear among implementers who feel that if a woman is given benefit at her natal home where she has gone for delivery and has not got her JSY cards, might again claim benefit using JSY card when she returns to her marital home.

A common problem women face while availing JSY benefit, is the time limit of 7 days given to claim the benefit. This study could not identify a single participant who received the benefit within the stipulated period of 7 days after delivery. This period varied from a low of 10 days for a participant to 5 months for another, the average being 3 months after delivery.

A participant who had her delivery by Caesarean section in her mother’s place tried to avail Rs.1,500 when she returned to her marital home mentions of the inconvenience in collecting the documents required as “...we have spent about Rs.500 just for this, it costs us each time at least Rs.100 to go and come... how many times we have done that?... Once she would give the white paper, then the yellow one, then she asked the doctors signature, then my school certificate, one at a time.....”

While in another case, a woman in the study, in accordance to the JSY rules, produced her JSY card in a government hospital near her natal home, four days after her caesarean operation, was denied the benefit, as according to the officials she could avail it only in her residence area.

When she attempted to seek benefit in her area, on her return, after she was discharged on the 12th day of her delivery, she was denied the benefit there as it was past 7 days of delivery.

Quite a few implementers noted that JSY benefits are not provided to the migrant populations as the pregnancy is not registered. Women are expected to produce their JSY card for availing the benefit, but it is often the case that women are missing their cards. One medical officer said that the norm being followed is that a woman coming for delivery from outside the PHC's service area has to produce a certificate from the PHC of that area, that she has not availed the benefit there.

Stakeholders Perceptions

A grassroots implementer sees the scheme as a good initiative to help the poor whereas one medical officer feels that it is a wastage of government money as many better off SC/ST families avail the benefit who are not really needy.

Performance based Pay Structure to Implementers

One block administrator was very positive of the initiative and felt that even PHCs should be allowed to hire specialists and provide caesarean section facility and that success of the scheme depended on the goodwill of the practicing medical officers. According to him, there was a need to change the attitude and behaviour of government doctors towards their patients which could be possible only with a performance-based pay structure.

A participant woman reiterated the need for provision of EmOC facilities in government healthcare facilities at village level and preferred it over any cash assistance. She says, "The facilities should be made available in the sarkari davakhana so that we do not need to go to the private. They should

provide the facility instead of the money... we poor do not have the money at that time to pay for the hospital, what if the government gives us the aid later on.....”

Other suggestions include:

- Clarity of guidelines.
- Changes in the criteria for eligibility to benefit from the scheme, viz., the poor not having BPL cards and who are not from SC/ST should be included.
- Relaxation of the two-child norm, especially for EmOC.
- Replacement of the caste criteria with income criteria.
- Timely supply of JSY cards to PHCs.
- No shortage of funds at grassroots level.
- Use of information technology so that update is available to any provider about payments made by other institutes. This would do away with the need to confirm non-receipt in other areas before disbursement of money which causes delays.
- Private providers of EmOC suggested that the scheme should be displayed in their hospital premises and that private practitioners could inform the public health system of the eligible patients availing EmOC services from them with the expectation of payments of the subsidy to them before the patient. In this way, the poor patient will have to pay less.

Non-Utilization of the Scheme and Denials

The bottlenecks in availing the scheme that this study identifies are lack of information and awareness of the scheme, difficulties in producing the required documents within 7 days of delivery and delay in registration of pregnancy.

The information is disseminated through household visits by ANMs, anganwadi workers, the gram sabha (village meeting) and wall advertisement in some public

places. There were wide variations of information level of the JSY scheme among potential beneficiaries. The study found women who had received the JSY cards, but were not aware of what it was and assumed it to be an immunization card. As women were not made aware of the potential benefit of the JSY card, they therefore forget to take the card with them during delivery, though they take other relevant documents with them like their laboratory and ultrasound reports.

The scheme expects the ANMs, when they register the pregnancy and conduct antenatal checkups, to ensure that the eligible women keep their BPL/caste certificates ready. This however is found to be missing.

The guideline to provide the benefit within 7 days of delivery, though intended to ensure assistance soon or at the time of expenditure, has however resulted in denials. The practical difficulties in producing the required documents in this period of time due to lack of prenatal preparations for the same is found to be highly prevalent.

The JSY is a conditional cash transfer scheme. Three ANC checkups with early registration of pregnancy (before twelve weeks of pregnancy) are important conditions for cash assistance. In one of the PHC areas visited, we found registration beyond 12 weeks as a reason for denial of benefit of the scheme whereas this condition is not strictly followed in other PHCs in the block and the district. Women held the ANM responsible for delay in registration and even mistakes in noting the pregnancy period that resulted in denial of benefit to them.

DISCUSSION

Scope of the JSY Scheme

Emergency obstetric care provision includes treatment of obstetric complications — anti-convulsants for eclampsia, blood transfusion for haemorrhage, antibiotics for sepsis,

caesarean section for obstructed labour and safe abortion facilities.

Nationally, 15 percent of all deliveries are expected to be complicated ones requiring EmOC and a minimum of 5 percent need caesarean section operation. The Maharashtra state JSY guidelines provide assistance of Rs.1,500 to women who will have a CS done, and not for other EmOC treatment, in violation of national JSY guidelines. Thus, by avoiding the term obstetric complications in the state guidelines, two-third of women in need of EmOC have been barred from the eligibility to the JSY benefit. The major causes of maternal mortality according to 2001–2003 SRS survey are shown in Figure 2. Distribution of causes of maternal mortality in the figure clearly shows that catering only to CS need, which handles obstructed labour, is a very inadequate measure in view of the goal of reducing maternal mortality.

In the district studied, as is evident from Table 4, the estimated number of JSY beneficiaries (as per central norms) is 7694, of these 1154 women are expected to need EmOC and 385 would need a CS. The change in the guideline at state level has resulted in excluding 769 eligible women

FIGURE 2: Causes of maternal deaths in India (SRS 2001-2003)

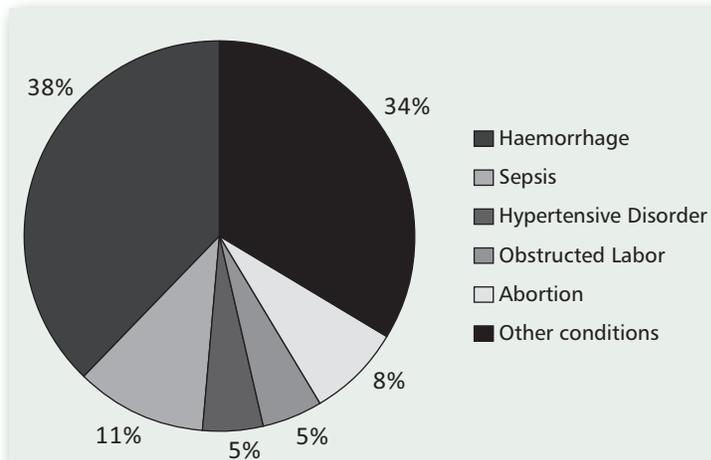


TABLE 4: Analysis of JSY Data for Ahmednagar District — April to September 2008

Indicators	SC	ST	BPL	TOTAL
Expected complicated deliveries (eligible for assistance – Gol)	373	433	348	1154 (15% of estimated benef)
Expected minimum no. of LSCS (eligible for assistance – MH)	125	144	116	385 (5% of estimated benef)
Missed out by MS norms				769 (66%)
Eligible women but assistance not reached (Gol norms)				83%
Eligible women but assistance not reached (MS norms)				49%

(66%) from the scheme, those who need EmOC but not a CS. The district has provided Rs.1,500 to 197 women. If one would apply the Central norms, 1,154 women would be eligible for the benefit which makes evident that the benefit has reached a mere 17 percent of the estimated, 83 percent being left unreached. Even if one restricts to the state norms, 385 women would be eligible for the benefit that has reached 197 women, leaving out 49 percent women eligible for JSY benefit.

Preference to Cost Subsidization over Contracting in

The provision of Rs.1,500 is for a PPP, i.e., for hiring specialist from the private sector, is a PPP by contracting in services. Contracting in services would mean contracting in specialist obstetric services from the private sector to the public facility. This implies utilization of the public infrastructure and drugs and supplies and hence free care to the patient. Thus, this form of PPP would provide cashless services to patients to improve access, as financial barriers are important reasons to defer treatment. This strategy could strengthen the public health system by filling the gap of skilled personnel. Monitoring the quality of care is comparatively easier in a

public facility than in the private sector which is well known to be unregulated.

However, implementers also have the option of cost subsidization where services from the private facilities are utilized and a certain amount of reimbursement given. This study finds that the second option was the one most preferred by all the implementers. The subsidy option, i.e., which is currently practiced, has no formal mechanisms, such as a formal contract, accreditation, quality control, accounting or information system. This is in a sense getting rid of the responsibility of EmOC provision. A senior district official responsible for empanelment of private providers believes this empanelment to be the responsibility of the civil surgeon. This points to lack of role clarity and specification of job tasks, the prerequisites for effective PPPs.

Subsidization of the cost of services is by payment of Rs.1,500 to specialists conducting CS in private facilities. This amount being far below the cost incurred in a private facility, the guideline clarifies that rest of the hospital charges are to be borne by the patient. This defeats the purpose of the scheme to increase easy access to EmOC services (only CS in this case). The family having to pay the entire hospital bill before discharge, is thus unaffected by the scheme at the time of payment, which questions the utility of the scheme. Though the guidelines strictly state disbursement of money within 7 days of delivery, but as the information of the delivery occurring reaches the system much later, as found by this study, the 7 day norm becomes irrelevant. The delay in reimbursement and small amount received as compared to money spent in CS, significantly do not help a poor woman's family to avail safe and quality delivery care services. Knowing the fact that a single hospitalization can push a quarter of the hospitalized Indians below the poverty line,¹¹ the subsidization option becomes a very limited effort to increase access to EmOC for preventing maternal deaths.

This situation is linked to the feasibility of contracting in. Contracting in specialists assumes adequate infrastructure and supplies availability in the public health system. Maharashtra stands better in comparison to the rest of India in this regard, and the Ahmednagar district scores comparatively better in the state. However, this seemingly better system is not equipped enough to provide EmOC just by hiring the specialists. The district and block administrators who did attempt the contracting in option find it unfeasible in view of lacking infrastructure especially blood storage facility, crucial to any EmOC centre. With long hours of power cuts in rural areas, 8–12 hours a day, providing electric backups to the available blood storage facilities has itself become a major difficulty. With the prevailing high rates of CSs and also the doubt whether a private specialist would risk losing clients by contracting in his/her services, it is doubtful that a private specialist would offer services for a meager Rs.1,500 provided by this scheme.

Implementation

The process of micro-birth planning is the essential pillar for successful operation of the JSY scheme, which this study hardly found in the practice. This has resulted in multiple operational failures of the scheme. Additional accounting and managerial personnel that the NRHM provides through district programme management units, to smoothen the implementation, do not seem to work as the study found that the flow of funds from the district to the block and then to ANM and beneficiaries is not happening properly.

The mode of payment by cheques, assumed to bring transparency, is however found to be acting as another barrier, as travel to and dealing with the banks is unfamiliar to rural women, and more so to those from the beneficiary communities.

The experience of JSY however raises a much larger issue — institutionalizing PPP, if successful to provide EmOC and reduce maternal deaths does not however address the root cause. The issue of lack of specialists in the public sector remains unaddressed. India has more than 20,000 obstetricians, of whom, only 780 work in the public health system at sub-district level in rural areas.¹² Hiring specialists from the private sector can only be an interim measure, the long-awaited changes in human resource policies need to be brought about to make the public sector capable enough to attract and retain specialists.

The present study raises serious concerns about the following enabling conditions for successful PPPs:

- Capacity and expertise of the government at different levels in designing and managing contracts (partnership).
- Appropriate organizational and management systems for partnerships.
- Strong management information system.
- Clarity on incentives and penalties.

CONCLUSION AND RECOMMENDATIONS

The study had made the following recommendations with regard to PPP participation in EmOC:

- Provision of free EmOC services in the public facilities is crucial. The public health system should be strengthened in terms of infrastructure and supplies as well to deliver EmOC services.
- The guidelines for implementing the PPP initiative in JSY should be inclusive, allowing eligibility and thus access to maximum women at risk of maternal death. The scheme should cover all life-threatening complications of pregnancy irrespective of whether they are antenatal, intranatal or postnatal.

- A systematic effort to identify centres where contracting in services could be feasible and a commensurate strategy rather than ad hoc guidelines needs to be developed.
- The capacity of the administrators to design and manage PPPs needs to be developed. Adequate systems for monitoring the PPPs are important.
- The cash assistance provided for hiring specialists should not be restricted to Rs.1,500. Approach towards pricing of tariffs for services should be based on competitive process rather than any standard calculation.
- Awareness of the scheme must be increased to generate demand from the beneficiaries immediately on need of EmOC service. The practices to ensure birth preparedness and complication readiness need to be emphasized.
- Availability of transport facilities to women in need of EmOC must be smoothened.
- The private sector being prohibitively costly and impoverishing there need to be mechanisms to ensure that the poor can access the services from the private partner.
- There need to be mechanisms to regulate the private health sector to ensure quality of care. A PPP should be able to guarantee a basic minimum quality of care. Mechanisms should also be conducive to create an environment such as the best of the private sector, in terms of fair play and social responsibility are encouraged to partner, rather than get harassed by the processes involved. Partner-friendly policies for accreditation, monitoring and accounting need to be followed.
- The government needs to ensure that the partnership brings private investment to public health system and not a mere transfer of public funds to the private corpus given the possibility of vested interests in a PPP. These options are minimized in the contracting in model, but performance indicators need to be instituted.

- Further research is needed to assess the effect of PPPs in reducing the risk of maternal deaths.

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