# Public Private Partnership in the provision of Homoeopathic services in the city of Delhi, India

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***ABSTRACT***

*Homeopathy is among the popular medical systems in India. Over the years, government has been attempting to mainstream homeopathy, in the public health system. But most of the service providers are in the private sector. Therefore augmenting their capabilities to improve quality and accessibility to all sections of the population, under public-private partnership, is seen a viable policy option. In Delhi, 90% of the homeopathy service providers are in the private sector, including charitable trusts. Most of them provide services in urban slums among low income population. They receive significant number of patients.*

***Methodology:*** *In 2003, government of Delhi launched a scheme involving the private sector to provide homeopathic services in underserved areas of the city. The scheme provided financial support to the private agencies to run homeopathic clinics. This paper provides an over view of the scheme, and lessons from the scheme through in-depth case studies of six NGOs who participated in the scheme. The paper also highlights expectations of the private providers- through a survey of 31 agencies- and provides specific recommendations for wider private sector participation.*

***Results:*** *Major findings from the study are: i) the budget required to run a clinic through private partnership is only about 30% of budget needed to run a government clinic; ii) marginal increase in funding in the scheme would make the PPP clinics self sustaining; iii) cost of care per patient is 25% cheaper in partnership clinics; iv) a need to develop managerial capacity to design, implement and monitor partnership scheme; v) delay in release of payments is the primary bottleneck; vi) private partners are keen to participate, if the scheme could be redesigned from a grant-in-aid mode to contracting based partnership model. Private partnership promises enormous potential to mainstream indigenous systems of medical care.*

**Background: T**raditional systems of medicine - collectively recognized as AYUSH (Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homeopathy) [1], are widely accepted in Indian society and enjoy government patronage. Government expects AYUSH to play a vital role in health care[2,3,4,5,6,7,8]. Since private sector is a predominant provider of services, working with the private sector in the form of Public-Private Partnership (PPP) is advocated as a policy option[9].

Homeopathic system is not indigenous but is among most popular medical systems in India[1,10]. Under this system, there are currently 234 hospitals and 5,910 dispensaries with 10,933 beds, 217,860 registered practitioners, and 186 colleges (35 govt.) in the country. It is estimated that in 2010, the size of Homeopathic market in India is about Rs. 26 billions, as the demand for the system grow at 25-30% (ASSOCHAM 2007)[11].

**Homeopathy Services in Delhi:** Out of an estimated 5,000 homeopathy practitioners in the city of Delhi, 90% are considered to be in the private sector. There are 142 government dispensaries and about 600 charitable dispensaries in the city. Anecdotal evidence suggests that most of the dispensaries are run by single practitioners who charge nominal fee. It is alleged that they even employ self taught, unqualified, unregistered practitioners. It is argued that involvement of such private providers will improve the quality of homeopathy services, strengthen public health system, wean away people from quacks, improve access to health care at a relatively low cost, help mainstream the homeopathy system, and avoid malpractices. With these objectives, a scheme was launched in 2003 to establish ten such dispensaries in partnership with private sector[12]. By January 2003, five such Homeopathic dispensaries under PPP were established and in 2006, another five NGOs were given the contract. This paper is based on a study conducted to evaluate the performance of these dispensaries, with the objectives of strengthening future partnerships.

**Objectives of the study:** The overall objective is to evaluate the performance of the Homeopathic dispensaries under private partnerships, and identify strategies for enhanced and effective partnerships in future. The study also examined some specific issues and questions.

**Study design:** The study was conducted using in-depth case studies. Case studies of six NGOs with mixed performance level- two each from successful, partially successful and unsuccessful. Primary data was gathered through interviews from doctors, paramedics, patients and the management. Data was also collected from official records, and reports submitted by the NGOs.

**Case Analysis:** Highlights of the case studies are given below:.

**Case 1 (G. P. J.):** Registered in 1980, and located in an upper class urban area, yet services are mostly availed by domestic servants, daily wagers, and migrant labour from nearby slum cluster. Clinic was open for two hours daily and an average of 15 patients each day. With meagre honorarium (<70 US Dollars per month), it was difficult to retain any doctor or hire a new one. As a result the dispensary was dysfunctional and the trust was funding the losses. After the partnership in Feb., 2003, it augmented the services to six hours in two shifts. More space was provided for the clinic, with a doctor chamber, dispensing chamber and waiting area. Two Homeopathic doctors were employed through a newspaper advertisement. One pharmacist and one helper were also appointed. During the proceeding five years, the trust received financial support from the government. A total of 53, 072 patients attended the clinic during these five years at an average of 10,600 patients per annum (an average of 35 patients per day in 300 days clinic per year). The partnership has definitely resulted in increased patient volume, better accessibility through increased service hours, and ensured availability of sufficient human resources. The cost of care per patient works out to be Rs. 21.30 (or 50cents) and the government subsidy is only about 30%. Specific concerns are related to delayed release of payments, delayed audit report by the government, and lack of capacity of the NGO to optimally utilise the funds. Management expressed dissatisfaction on several fronts. Staffs were still concerned about low wages. Patients rated services even better than the nearest public dispensary and many private clinics.

**Case 2: (S. N. M.)** Registered in 1948 as a religious trust, it runs educational institutions and medical facilities. A Homeopathic dispensary was established by the trust in 1994, adjacent to an Allopathic hospital in a semi urban area. The dispensary caters to people who attend religious ceremonies or rural migrants. Prior to government partnership, the dispensary was open only for two hours and was attracting only about 20 patients each day. In April 2006, the trust adopted the government scheme and the response was overwhelming. The clinic which treated 5, 091 patients annually, witnessed five fold increase (25,998) in the first year of partnership, and continued to increase in the second and third year of operation. Although department has audited the accounts but is yet to release the grant. Data also suggest the average cost of treating per patient to be low (Rs. 9.15 or <20 cents) and the government subsidy close to 60%. The cause for concern remains to be delayed release of funds, and the inability to audit the performance of the dispensary in time. One of the suggestions was that government could create one-time corpus grant.

**Case 3 (M. D. D.): R**egistered in 1997 the NGO is engaged in community based literacy activities, in slum community. However, under the scheme, the society set up a dispensary in 2003. Daughter of the trustee- a homeopathic doctor- was appointed as the doctor in the dispensary. Patients predominantly belonged to the slum community.

The dispensary functioned for only three hours in the morning. Approximately 15 patients attend the dispensary each day. However the number has been declining during the past two years. One of the key lessons from this dispensary is that, an agency could run a homeopathy dispensary with no additional cost if the government could increase the budgetary allocation only marginally. The average cost per patient is at Rs. 24. 61 (about 60 cents), and the government subsidy is about 55%. Though the performance of the dispensary in terms of patient load is not appreciable, the financial aspects provide valuable lesson in the redesign of the scheme. Apart from the delayed release of payment, non-availability of an additional doctor due to low honorarium, and inadequate training of doctors by the government are indicated as cause for concern.
Management was specially critical about deduction of unspent balance and low wages, Patients expressed dissatisfaction due to non availability of doctor in evening hours.

**Case 4 (H. N.I.W):** Registered in 1990, this NGO undertakes social and cultural activities among industrial labourers. NGO did not have any experience in the health sector but were willing to work with the government to open a new dispensary. The NGO started its Homeopathic dispensary in February, 2003. The average patient load per day was 20 to 25 in the first three years and declined to less than 10 in the last year. The dispensary functioned only for three hours everyday in the morning. The NGO does not seem to be able to sustain the dispensary, as it had to meet an additional expense from its own funds. The average cost per patient is calculated to be Rs. 19. 56 (40 cents) with government subsidy at 50%. Performance of the dispensary in terms of patient load has deteriorated due to the inability of the management to maintain the services. NGO had also shown some unspent grant. This created delay in further fund flows in to the dispensary.

**Case 5 (V. C. A**.): Run by a religious organisation, this NGO established Homoeopathic dispensary in the premises of a temple in February 2003. The doctor himself a trustee, was reportedly irregular, therefore patient load was always sub optimal. Since the dispensary was located in a far flung area, it was not visited by Government authority regularly. It could not collect enough user charges from the patients and the dispensary was under deficit. It was found that doctor was contributing deficit out of his own remuneration. The cost per patient was Rs 36.5 (80 cents), and government subsidy was 80%. The partnership could barely work for two years.

**Case 6: (C. S. M.):** Established in 1992, CSM is a registered trust, which provides vocational training including computer skills to children from low income groups. The trust had prior experience in organising AIDS awareness camps, drug de-addiction rallies. In January 2003, the trust established a Homeopathic dispensary under the government scheme. However, during a review meeting in March 2003, the society claimed that it started the dispensary in September 2002 itself and that the funds released (1st instalment) in January 2003, had been utilized already. Further it was informed that a theft had taken place in the dispensary and all the furniture, drugs, etc

had been stolen. They also claimed that a dispute had developed with the owner of the house, which was on lease agreement to run the dispensary. A copy of the complaint filed with the police and other agencies was produced as evidence. The NGO insisted that they were already in deficit and therefore the remaining balance of the 1st instalment should be released immediately to enable it to run the dispensary at a newly rented place. A departmental enquiry revealed that, no Homeopathy dispensary ever functioned at the original premises approved. The new address for the dispensary was the residence of president of NGO, in a locality that is not underserved. Even at the new site, during inspection, outdated –expired- drugs were kept; drug inventory book, patient register and furniture were not available. The NGO claimed that the miscreants destroyed all the records during theft. Audit report found that the NGO did not maintain any cash book; receipts were on loose sheets without signatures; vouchers were without serial numbers; there was no stock entry for furniture, drugs and medicines and consumables; and no register of honorarium. Apparently the NGO was trying to mislead the Government. The government then directed the police to investigate the case. No breakthrough has been reported by the investigating authority even after 5 years.

**Key Lessons:** The key findings and lessons from the case studies are analysed with reference to the performance, outcomes and lessons from the partnership scheme.

**Selection of private agencies:** Prior consultation, thorough background verification, proven track record, and selection by a panel of eminent citizens could be most appropriate methods in selecting partners. Prior experience in health services delivery, particularly running a dispensary seem to be critical for the success. Several NGOs who are already providing Homeopathic services had not participated in the scheme. The reasons for their lack of enthusiasm need to be identified.

**Provision for rent:** The scheme did not have provision for the renovation or maintenance of building which may have affected the quality of services.

**Patient load:** According to the year wise patient load in the selected dispensaries, it was found that the patient load had increased consistently in successful partnerships. Patient load is clearly dependent on factors like availability of doctor, quality of care, and support from the management. In the unsuccessful agencies, either the doctors were irregular or unavailable. It could be inferred that for a moderately successful dispensary, the minimum patient load should be around 650-700 patients per month. Availability of more than one competent doctor is also essential for increasing patient volume and subsequent success of the dispensary. Performance of the staff will be unhindered if they are not appointed on the basis of any nepotism or favouritism.

**Financial sustainability:** Due to problems in the identification of poor patients only 5-10% was being treated free instead of 25% according to the contract. The user fee collected by each agency reveals that initial collections through user fees were not sustained beyond two to three years in partially successful and unsuccessful cases. The user fee was not found to be sufficient. Even the most successful NGO stated that there was a need for regular donations or Government grants to sustain services. It appears that the existing policy of reducing grants and total withdrawal of grants after five years is not viable and regular grants beyond this period is essential for the maintenance of the services. To maintain uninterrupted service delivery, the NGOs should be able to deliver services, even if funds are not released in time. It may be important for the scheme to add a clause that the agency must deposit a sum equivalent to 6 months of operational expenses needed to run the dispensary. The contract must also add a condition in which, the NGO shall be compensated, if payments are delayed for more than 6 months.

**Cost effectiveness of the scheme:** Data with respect to the cost per patient reveal that the government is able to reach the beneficiaries in a more cost-effective manner. Our analysis is based only on the data of four reliable NGOs. Data indicate wide variation in the costs suggest scope for further cost control and optimisation through increased patient volume. The average cost per patient in the government dispensary works out to be as high as Rs. 41.60 (95 cents). In addition there are administrative expenses, capital costs and recurring expenses which are not included in the analysis. Therefore it is safer to conclude that cost of treatment in a private partnership dispensary is more cost effective compared to the cost at government run dispensary. The net cost per patient for the government goes down even further in NGO dispensaries funded by the government. Cost per patient could come down if the demand for Homeopathic services increases. However net cost per patient in government run dispensaries is likely to increase further due to the implementation 6th pay commission report.

**Delayed release of payment:** Release of payments is generally delayed in all the cases due to delays in auditing by the government agencies, which leads to late clearance of payments. Small NGOs are highly dependent on funding from such schemes or donations. Any delay in cash flows even for few months could lead to disruption in services and the patients seek services from alternative sources. Possibility of a time bound, single window clearance system should be explored.

**Technical and Managerial Capacity:** Audit reports reveal that most NGOs did not have knowledge about codal formalities, maintenance of accounts and cash flows, inventory and stock register, etc. As a result some of them had unspent balance which was adjusted in subsequent payments. This resulted in financial hardship and ultimate closure of one dispensary. Even the successful NGOs could

not get full grant due to unspent balance. NGOs require proper training about the utilization of the grants. The government needs to provide supportive supervision during the initial phase of the contract.

**Risks:** Working with private sector, especially NGOs have an element of financial risk for both the government and the private agency. Since funds are released by the government there are distinct possibilities of collusion with the government staff, corruption and misappropriation of funds. If the dispensary does not attract sufficient volume of patients, it would be difficult for the NGOs to contribute matching funds which may lead to the dispensary being unsustainable**.** Another risk is in the appointment of (incompetent) staff from among the relatives and office bearers of the society, whose performance is not guaranteed. There is a need to build in safeguards, like MIS based performance monitoring and accounting for more transparency in the system and reduce such risks.

**Monitoring and Reporting:** Functioning of the NGOs is inadequately monitored by the government agencies. As a result any downfall in the performance is not addressed immediately. Submission of monthly reports is routine and these reports are not scrutinised for their authenticity. Inspections are carried out only once in a year, whereas it should have been quarterly.

## RE-DESIGNING THE SCHEME: Key Considerations

Based on the experience and lessons from the existing scheme, following suggestions are made for redesigning the scheme:

**Selection of Private Partners:** Identify underserved areas in Delhi; then identify the private providers / NGOs already operational in that area through a detailed field survey. A letter detailing the scheme could be sent to the private provider / NGO, along with an invitation to participate in the scheme.

**Type of organizations working in the field:** They need to be registered for their health service component. That would mean capacity building and supportive supervision. Over a period those meeting minimum standards in homeopathic services could be accredited.

**Building, Rent and Maintenance Charges: T**o have a wider choice of partners, provision of the payment of rent should be considered. For those operating from their own premises, some fixed sum could be paid for their electricity and water, whereas those operating from rental premise a fixed sum (slightly higher sum) could be given as rental and maintenance. Certain proportion or a fixed sum could be allocated as annual maintenance grant.

**Quantum of annual Funding and management of funds: D**ecreasing proportion of funding for five years does not lead to any meaningful engagement with the private providers. These norms need to be revised. The entire focus should be to provide quality services to the beneficiaries rather than on cost saving. The private partner should be given flexibility to re-allocate unspent balance of funds depending on the needs of the dispensary.

**Release of Funds:** Release of payments is always delayed due to belated audit and bureaucratic approach of the government officials. A mechanism should be worked out for the timely release of funds.

**Capacity Building:** Government should provide orientation training on some of the administrative formalities and systems such as accounting, stock register, inventory, reporting, etc. The doctors and paramedics should be encouraged to participate in CME programme.

**Reporting & Monitoring:** While redesigning the scheme a system of e–monitoring should be developed. The relevant data should be uploaded on daily basis through web enabled software. Feedback from stakeholders should be collected periodically by placing forms in the dispensary and a suggestion box.

**Mainstreaming Homeopathic system:** Involve homeopathic dispensaries in health promotions programmes such as immunization, IEC, BCC in MCH, birth control, nutrition, disease control, RNTCP, and other programmes.

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