

Public-private partnership in health care of India: A review of governance and stewardship issues

Somen Saha^{1,2}, Raj Panda¹, Kumar Gaurav¹

¹ Public Health Foundation of India, ² Indian Institute of Public Health Gandhinagar

Introduction

Indian health care is characterized by a mixed health system and different kinds of delivery structure. Mixed health systems can be defined as involving 'centrally planned government health services that operate side-by-side with private markets for similar or complementary products and services'.¹ Public health care delivery system includes teaching hospitals, secondary level hospitals (at district and subdivisional level), first-level referral hospitals (community health centres/rural hospitals), dispensaries, primary health centres, sub-centres and health posts. The private sector, both for-profit and not for profit, however, is the dominant sector and services range from 2-bed facilities to 1000+ bed hospitals.²

The private provisioning of health care has grown from a mere 5 to 10 percent during India's independence era to 82 percent of outpatient visit, 52 percent of inpatient expenditure, and 40 percent of births in institution.³ A report of the task force on Medical Education for the National Rural Health Mission in India determined that the private sector provides 58 percent of hospital buildings, 29 percent hospital beds, and 81 percent of the doctors in India.

Private sector in India can be classified into four types according to its status.⁴

- Formal, medically qualified, private for-profit providers (hospitals, individual and group practices of general practitioners and specialists)
- Formal, medically qualified not-for-profit sector (hospitals, outpatient facilities, community-based programs)
- Formal providers qualified in Indian and other, non-allopathic system of medicine (hospitals, outpatient providers who have received formal training and are licensed)

- Less than fully qualified practitioners (partially qualified and experienced practitioners of allopathic medicine and other practitioners with limited or no formal training delivering mainly acute outpatient treatment and drugs)

The high-level expert group (HLEG) on Universal Health Coverage (UHC) set up by the Planning Commission of India (now NITI Aayog) recognize the pre-dominant role of private sector in health care. The HLEG definition of UHC envisages government as the guarantor and enabler of health care, although not necessarily the only provider, of health and related services in India.⁵ It envisages the government to purchase essential health services for the entire population of the country. It is thus important to understand the existing structure of the health care system in India. With government assuming the role of purchasing agency, the bigger question is to define governance, stewardship, regulatory and contracting mechanism to implement UHC in India.

Through a review of evidence, this paper aims to assess the existing models of health purchasing in India and other low and middle income countries (LMICs) with a focus on the institutional architecture, management and governance mechanisms. Specific objectives are to:

- Describe the concepts of strategic purchasing, governance and stewardship;
- Lessons from LMICs; and
- Lessons from large PPP programs in India.

Concepts of strategic purchasing, governance, and stewardship

Strategic purchasing is a method devised under government's stewardship to translate health policy decision and health needs of the population into a reality by purchasing healthcare services in accordance with clearly specified policies that ensure a just and equitable distribution of

Corresponding author: Somen Saha,
Indian Institute of Public Health Gandhinagar, Gujarat, India, Email: ssaha@iiphg.org

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healthcare services across regions, caste and creed through payer-provider mechanisms like contracting- in and public private partnerships.⁶

The concept of governance is different from government. Governance refers to a system by which an organization or group is directed and managed, as against government that refers to a formal institution of nation-states.⁷ In health sector, governance refers to function of health systems and component of health sector organizations and development strategies.⁸ Governance is also defined as an arrangement linking the society and the state, where matters related to public affairs, efficient use and division of resources based on equity and policy measures required to serve the needs of a society are devised, explored and employed. This is done by empowering the actors of governance and defining their roles and priorities in setting up mechanisms that promote good governance in the medium and in the long run.⁹

Government guides the health system by setting rules that defines how the goals of health system are to be attained. This is termed as stewardship. Stewardship involves 'formulating strategic policy directions, ensuring good regulation and appropriate tools for implementing it, and fostering the necessary intelligence on the health system's performance to ensure accountability and transparency'.¹⁰ Health stewardship is usually executed through: creating legislation and collaborative decision making; creating adequate structure and regulation; financing activities of health system elements and services; and provision of formal and informal policy.

Effective health system governance (stewardship or leadership) requires a mix of regulation and encouragement, incentives, persuasion and involvement of informed patients and the public (civil society), with innovation as a central feature. Strengthening the function of governance and stewardship is one of the six 'building blocks' of the health system as part of health system strengthening.

Lessons from low and middle income countries

The private sector is large and complex in many developing

countries. In case of LMICs the distinction between state and non-state is blurred.¹¹ In South Asia, Sania Nishtar referred this as 'mixed health systems syndrome'.¹² The syndrome is characterized by:

- Insufficient state funding for health;
- A regulatory environment that allows the private sector to deliver social services without an appropriate regulatory framework; and
- Lack of transparency in governance.

The public-private mix varies greatly across countries, yet data to accurately quantify the mix are scarce. Many developing countries have traditionally followed a public provision of financing healthcare where ministries of health are responsible for hiring doctors, building hospitals, and paying for health care out of tax revenues. There are also concerns about efficiency of resources channeled through private sector to achieve health gains, which could be use more effectively in strengthening public system. Countries in the Asia and the Pacific region can be grouped into three broad categories according to the extent of private sector provision in their health system.

Private sector in these countries have the potential to fill some of the gaps in public sector delivery, however, without proper incentive for quality, equity, and affordability, and without adequate monitoring markets can produce poor outcome.¹⁴ Role of public stewardship in health system, hence play an important role in a mixed health system. Some of the limitations of stewardship in a mixed health system are dearth of necessary information, a lack of government capacity for stewardship functions, and a failure to set a high priority for the stewardship of whole health systems.

1. Limited information about private actors in health sector. In absence of comprehensive information about private sector, it is difficult to regulate them. The sector is highly fragmented, and there is incentive for private providers to operate informally to avoid taxation, costly compliance, or even time-consuming licensure processes.

Group	Private sector scale and role	Countries
1	Private sector provides more than half of all health services. Important for primary care services. Provides some to majority of secondary and tertiary (hospital) care. For-profit private sector much larger than NGOs.	Cambodia, Indonesia, Lao PDR, Malaysia, Myanmar, Philippines, Thailand, Vietnam
2	Private sector is small, providing less than half of health services. NGOs provide a significant proportion of private sector health care .	Fiji, Kiribati, Marshall Islands, Micronesia, Papua New Guinea, Solomon Islands, Timor-Leste, Tonga, Vanuatu
3	Private sector exists in specialty areas (e.g.: dental care) and within structural arrangements in which government is an active partner.	China, Mongolia

Source: Montague & Bloom, 2010¹³

2. Lack of government capacity. Public sector lacks the skills to regulate private sector. Ministries of health were structured to focus primarily on government managed health delivery system, rather than regulating competing or complementary private delivery system.¹⁵ The skills and resources to manage the direct delivery of care are different from those to regulate.
3. Lack of priority for stewardship. Harmful incentives exist in many government delivery systems, often manifested in informal payments to providers, absenteeism, leakage of supplies, or kickbacks from suppliers to government officials. The survey of countries about regulatory constraints found that the majority of countries surveyed self-report high concern about their own ability to apply regulatory measures for practitioner licensing, facility regulation, and facility accreditation.

The common regulatory challenges in LMICs relates to:¹⁷

- Weak enforcement of regulation. Failure to enforce regulations is attributed to lack of institutional capacity.
- Lack of institutional development and limited availability of resources result in limited institutional capacity in LMIC for regulation and enforcement. Regulation requires skilled human resources and dedicated departments or units that are associated with a cost. Regulatory reforms adopted at the right time can lead to avoiding or managing problems. As private sector grow, it is difficult to introduce regulation in the system.
- Predominance of medical professionals in design of health policy and healthcare regulation in LMIC makes regulation of medical profession difficult and generally requires self-regulation. The quality of education, training and continued professional development of doctors are poorly monitored and generally delegated to professional associations.

Lessons from large PPP programs in India

Over time several larger public-private partnership schemes were implemented in India. In the following section, we discuss three key initiatives, and the way government enter into a partnership with the private sector.

Janani Suraksha Yojana

In 2005, Government of India introduced the *Janani Suraksha Yojana* (JSY), a safe motherhood initiative under the umbrella of the National Rural Health Mission (NRHM). The objective of JSY is to reduce maternal and neonatal mortality by promoting institutional delivery. It provides cash incentive to poor pregnant women who either give birth in a public health facility or an accredited private health provider. Beneficiaries in high performing states receive Rs. 600 in urban areas and Rs. 700 in rural areas. In case of low performing states, the cash incentive to a beneficiary increases to Rs. 1000 in urban areas and Rs. 1400 in rural areas. As per 2010 estimates, the ratio of public and private sector for institutional deliveries

has increased from 37:63 in 2005-06, to 67:33 in 2009 . In terms of beneficiaries, JSY is one of the world's largest conditional cash transfer scheme.¹⁸⁻¹⁹

The scheme adopted a mechanism in which government contract-in EmOC specialists for conducting complicated deliveries.²⁰ District Nodal Officer holds an overall responsibility of planning and implementation of JSY in the district through constant monitoring. The scheme is monitored by district, state and national level committees at two levels – monthly meeting with Medical Officers at district level and monthly meeting of grassroots functionaries and ASHAs at PHC/CHC level. With an aim of increasing the reach of the scheme, district level authorities empanel accredited private health facilities. The empanelment process is done by district administrative authorities. The medical officer at the first referral unit holds the responsibility to connect these private EmOC specialists to the pregnant women in emergency situations.

In Maharashtra, a study on JSY reported the lack of ownership of the scheme among the administrators at the district and block level.²³ The administrators were reported quoting the scheme merely as a special accreditation and not a PPP initiative. Besides, government investments in such schemes to ensure maternal healthcare free of cost to poor women, beneficiaries still requires to pay out-of-pocket for many services that further discourages poor women from using the services.²⁴ Lack of documentation regarding specification of roles and responsibilities, incentives, penalties, etc. leads to confusion among key stakeholders. Agents from the private nursing homes tend to pay extra to ASHA resulting in diversion of the cases to private hospitals and centres. In terms of quality, most of the private centres lack basic infrastructure for treating emergency deliveries. Due to lack of facilities such as absence of blood storage and blood banking facilities, the complicated delivery cases tends to be transferred from private hospital to public hospitals.

Chiranjeevi Yojana

In 2005, the state of Gujarat launched *Chiranjeevi Yojana* (CY) that aims to reduce infant mortality and maternal mortality through public private partnerships. CY adopts a demand-side financing model that channels delivery care services to below poverty line (BPL) families who may otherwise struggle to access them. The benefit package of the scheme covers both direct and indirect out-of-pocket costs including free delivery, free medicines after delivery and transport reimbursement. Additionally, it also provides financial support to the accompanying person for loss of wages. The scheme works on the principle that it is more feasible and efficient to co-opt the skilled private providers by paying their marginal costs, than waiting for a provider to be posted to rural areas.²⁵ The scheme that started as a pilot project in five districts of Gujarat in 2005 was scaled state-wide and now covers all districts.

The scheme involved creating a panel of private care providers who would accept referrals by the families covered under the scheme. State government contract private gynaecologists for delivery related services by empanelling them in the network. District health officials are responsible for implementing the scheme and facilitating the involvement of private providers. More than 50% of the total number of private obstetricians in the state (~800) joined the program when it started in 2005.²⁶ The district health authorities are responsible for documentation and making payments to the empanelled obstetricians. The empanelled providers are reimbursed on capitation payment basis according to which they are reimbursed at a fixed rate for each delivery carried out by them.²⁷ *Anganwadi* workers, a front-line health worker, play a vital role and serve as the link to connect potential BPL beneficiaries with enrolled private providers. For quality assurance, Block Health Officers visit the field for random checks to ensure the delivery was truly 'cashless'. Weekly meetings were convened by all the district functionaries at various levels to discuss the progress and monthly reports were sent by the district to the state for review and feedback. However, apart from these random visits, no other monitoring mechanism has been developed.

Several challenges were faced in the CY scheme. Most of the enrolled providers belong to bigger towns of Gujarat.²⁸ Despite of the high level of participation, the providers have shared concerns that conducting deliveries through CY is not a part of their mainstream activity. Majorly two groups of professionals got enrolled – the beginners and the experience holders with intended benefits. On one hand, beginners considered it as a platform for gaining experience and reputation building, while on the other hand, experience holders who are at the end of their career and wanted to do some charitable service for the poor have joined this scheme.²⁹ Doctors also got enrolled in order to become licensed providers for abortion by gaining a Medical Termination of Pregnancy certificate. Around 50% of the providers have discontinued their participation from the scheme in past five years.³⁰ Private providers view the scheme to be less of a PPP initiative and thus they feel that the scheme is a form of a charitable activity only that aims to help poor groups. There were also incidence of breaking trust between BPL families and *anganwadi* workers as private providers' demands additional money from BPL patients for the treatment. Even though, the financial package offered to private providers does budget for pregnancy complication, they prefer "safe" cases of normal delivery and divert complicated cases to the public providers. Private providers claim that the cost of treating complicated pregnancies was much higher than what is being compensated under the package. Providers also reports disappointment when the scheme neither yield an increase in number of patients nor provide sufficient remuneration for complicated deliveries. These were also one of the major reasons for withdrawal of

the private providers from the scheme. Despite of the fact that nearly a million poor women have taken advantage of the scheme and a increase in rate of institutional delivery from 55% to 76%, the scheme is still questionable in terms of whether it was able to fulfil the objective of reducing maternal mortality.

Government sponsored health insurance schemes

Public financing for health in India is low, leaving households to rely heavily on out-of-pocket payments for health expenses. Recent data suggest that India spends about 1.04% of its GDP on health, which is among the lowest. The out of pocket expenditure is very high and accounts for 3.16% of GDP. Almost 72% expenses are on medicines. Only 3/4th of the population is able to access essential health services and rest find it difficult because of financial difficulties. Almost 60 million people suffered a huge financial loss due to high cost of treatment and it leads to 35% of people to move below the line of poverty.

In response, government resorted to scheme-based program address health-related financial distress of low-income population. Rashtriya Swasthya Bima Yojana (RSBY) or (National Health Insurance Programme) is a health insurance scheme, meant for poor and deprived people and is managed by Government of India. It provides a cashless Insurance for medical treatment in public as well as few private hospitals. Since its launch in the year 2008, the scheme has been implemented in 25 states of India. About 36 million households were registered under this scheme until February, 2014. The RSBY Scheme enables every person, who is below the line of poverty (BPL), to get benefit of cashless inpatient medical care upto Rs 30,000/- per year. This facility can be availed from any of the hospital registered under this scheme. A biometric enabled smart card is issued by paying a nominal registration fee of Rs 30 (US\$0.7).

Several state governments also have initiated their own social health protection schemes to protect low income households against tertiary care expenses: *Rajiv Aarogyasri* scheme in Andhra Pradesh, *Vajpayee Arogyashri* scheme in Karnataka, *Kalaingar* in Tamil Nadu, and the *Mukhyamantri Amrutum Yojana* in Gujarat. These schemes cover higher-end tertiary care for people living below the poverty line on a cashless basis.³¹ These schemes, together with private voluntary health insurance and central government insurance schemes for the formal sector employees (Central Government Health Scheme and Employees State Insurance System) covered an estimated 302 million people, or roughly one-fourth of India's population in 2010, from a low of 75 million in 2007.³² A World Bank report projects that more than 630 million persons, or **about half of the country's population, can be covered with health insurance by 2015.**³¹

The success and sustainability of these government sponsored health insurance schemes hinge on the development of strong governance arrangements,

management systems, monitoring and purchasing mechanisms, cost- containment tools, and quality-improvement instruments.³¹ Governance arrangements in social insurance schemes were inadequate in terms of accountabilities, incentives and information availability. A World Bank review observes the key to any good governance arrangement is to protect the schemes from political interference while making them accountable to major stakeholders such as government and beneficiaries. It recommends setting up a legal autonomous umbrella health insurance coordination agency to support, coordinate, monitor, and evaluate all social insurance schemes.

Discussion

A mixed market health system that India is, require an effective governance and regulatory system to ensure that the health markets are contributing to the achievement of key health and financial protection goals such as universal health coverage.

Over time Government of India has resorted to contracting as one of the dominant tools to engage with the private sector in provision of health services. Several state governments came out with its own policies to encourage partnership in health sector. However, policy pronouncement by government alone is not sufficient for public-private partnerships to succeed. Issues emerging from the case

studies indicate lack of ownership in the schemes, inadequate documentation regarding roles and responsibilities of stakeholders, lack of basic infrastructure by private providers, concentration of private providers in few big towns and cities, unclear vision and lack of information critically hampers realization of the scheme objectives. Other issues highlighted in literature are information asymmetry as a result of private bidder possessing information not available with government, informal network and collusion that can be abused to influence the bidding process, and conflict of interest on the part of public officials. Successful partnerships were often governed by individual motivated individual, either from government or private sector. For example the Yeshasvini scheme in Karnataka was led by Dr. Devi Shetty, founder-director of Narayana Hrudalaya. The Chiranjeevi Yojana in Gujarat was conceptualized and led by the then Health Commissioner of Gujarat, Dr. Amartjeet Singh. The adoption and management of government health centres in Karnataka and Gujarat were influenced by Dr. Sudarshan from Karuna Trust, and Dr. Haren Joshi in Gujarat, respectively. In other cases, huge hospitals were handed over to private players due to inability of state governments to manage those facilities. The post-earthquake Bhuj Civil Hospital in Bhuj, Gujarat was handed over to Adani group, while the Rajiv Gandhi super-speciality hospital in Raichur, Karnataka was handed over to the Apollo Hospitals for the above reason. Limited capacities of government to play an effective stewardship role were also highlighted in review of key LMICs.

Suvarna Arogya Suraksha Trust in Karnataka

The Government of Karnataka has established a separate governing agency for the VA scheme, the Suvarna Arogya Suraksha (SAS) Trust. It is an autonomous trust under the aegis of the Department of Health and Family Welfare (DOHFW). The trust manages several public-financed health assurance schemes of the state such as *Vajpayee Arogyashree* scheme for BPL families, *Rajiv Arogya Bhagya* Scheme for APL families, *Jyothi Sanjeevini* Scheme for State Government Employees and their Dependents, and *Mukhyamanthrigala Santhwana* Scheme for Road Accident Victims. The trust acts as a gate keeper wherein all approvals undergo a two tiered control mechanism to prevent fraud and misuse. The trust is responsible for all strategic decisions related to scheme design and implementation. For day-to-day functioning, the trust has contracted for a three year period an intermediary, a licensed third-party administrator, selected through a competitive bidding process. This TPA undertakes the empanelment of hospitals and manages preauthorization and claims processing activities on behalf of and in consultation with the trust. The TPA has hired field officials for the scheme, known as *arogyamithras*, who have been placed in each network hospital and are managed by district level coordinators. In addition to TPA fees, all costs of these field officials are borne by the trust.

The trust has an executive committee empowered to ratify and approve policy decisions concerning the scheme. Any changes in scheme design, guidelines, implementation, and internal controls are made with the prior concurrence of the executive committee. The CEO and executive director of the trust is a senior Indian Administrative Service (IAS) officer, who is supported by a small team of medical specialists and administrative staff.

Source : (La Forgia & Nagpal, 2012)³¹

Limited information about private actors in health sector, lack of governance capacity, lack of priority for stewardship, weak enforcement of regulation, predominance of medical professionals in design of health policy and healthcare regulation were key issues identified in LMIC. One key theme emerging from this analysis is the importance of public stewardship of the non-state sector. Effective government stewardship is crucial for achieving broader health objectives, given the reality that many countries already have large, complex markets for healthcare, presenting major challenges and significant opportunities.¹⁴ Lessons from India and other LMIC indicate limited capacity of government to play an effective stewardship role.

Conclusion

Lessons from literature and partnership schemes discussed here indicate need to develop capacity of public sector to handle complex public-private interactions. Capacity enhancement should be in the area of project management, managing robust system to monitor program, and generating information on program performance. Purchasing health services from private providers, such as through health insurance, require information on unit costs, volume, and market prices for the procedures in different geographical settings. For schemes that seek to empanel hospitals or providers, stakeholder consultation and mapping of providers are a key prerequisite for successful partnership. Managing complex partnership program require specific managerial capacities such as contract management, provider payment mechanism, project management, and financial management skills. Often regular health department officials are ill-equipped to handle partnership schemes. Experience shows creating an autonomous structure within the health department with adequate trained human resource supplement has been helpful in managing innovative partnership programs.

Partnership with private sector needs to build on lesson from past experiments. This would necessitate developing forums to facilitate cross-learning with members drawn from all the schemes to encourage collaboration and knowledge exchange. Regularly tabulating, analyzing, and sharing monitoring data would contribute to continual assessment of overall schemes' performance as well as the details of the schemes' financing, managerial, and delivery systems.

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