Healthcare Finance, Health Insurance and Healthcare Administration for the Poor and Elderly People in India – Scope of Public-Private Partnership

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Abstract:

Health care in India is financed through out-of-pocket payments of individuals, central and state government tax revenues, payments from employers, external aid, private sector profits and other sources. National health accounts reveal that the government sector (central, state and local) together account for around 20% of the total health expenditures (representing around 1% of GDP – among the lowest in the world), external aid via voluntary sector for 2% and 78% take the form of out-of-pocket payments – one of the highest percentages of the world. In spite of a government owned free healthcare delivery chain, 64% of the poorest population in India is indebted every year to pay for the medical care. 92% of the Indian workforces working in the informal sector do not have any kind of insurance (Basu, 2011). The elderly population is mostly residing in the rural areas are poor, and if they are in workforce, most of them belong to the informal sector. Governments in the world are realizing that while publicly financed, universal healthcare is undoubtedly humane, it can be an enormous drain on national resources and extremely difficult to sustain in the long run. No government has been reckless enough to abandon healthcare entirely to free market forces. Therefore, a public-private mix of funding mechanisms exists in most countries and then governments are able to cut on the public share of healthcare expenditure. Policies designed to shift the burden of healthcare away from the public purse into the private pockets have been so effective that private spending now accounts for around three quarters of national health expenditure (Lim, 2004). The main objective of the present paper is to analyze the scope and prospects of public-private partnership (PPP) in healthcare finance and health insurance for the poor and elderly people of India.

Keywords: Health Care, Insurance, Public-Private Partnership, Poor Elderly People

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Introduction:

The Eleventh Plan recognized that “access to good quality health services is another critical element of the inclusiveness strategy”. Health is a basic human right and fundamental freedom. It is a birth right, an integral part of development and central to the concept of quality of life. Health is multidimensional. Health relates to the definition given by WHO which covers three specific dimensions – the physical, the mental and the social. Many more may be cited, namely spiritual, emotional, vocational, and political dimensions with the expansion of knowledge, it may be expanded. The Universal Declaration of Human Rights, set up a breakthrough in 1948, by laying down in Article 25 “everyone has the right to a standard of living adequately for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control”. Health and its maintenance is a major social investment. It is regarded as the responsibility of the State to ensure that healthcare facilities are made available to all its citizens. The government discharges this obligation by running hospitals and health centres which provide healthcare to its citizens. The structural snapshot of the healthcare system is given below:

Primary Care: The basic healthcare facilities for common and minor ailments and where prevention is most effective; Demand is the highest in the sector.

Secondary Care: Healthcare facilities that require constant medical attention including short period of hospitalization; Demand is moderate.

Tertiary Care: Conditions requiring care from specialized clinicians and facilities; Demand requirements are highly specialized and thus minimal. Inadequacy of financial and human resources and improper utilization of funds and inefficiencies in the public sector healthcare service have hampered efforts by the State to deliver appropriate health care and medical facilities to its citizens.

The key questions regarding healthcare systems are: (a) how to raise revenues to pay for healthcare; (b) how to pool risks and resources; and (c) how to organize and deliver healthcare in the most efficient and cost-effective manner. Whether the strategies adopted rely on public sources like taxes and social insurance, or private sources like private insurance and out-of-pocket payment, it will have a profound impact on health care costs, quality and access to healthcare amenities.
Public-Private Mix in healthcare provision and financing is given below.

<table>
<thead>
<tr>
<th>Finance</th>
<th>Provision</th>
<th>Public</th>
<th>Private</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public</td>
<td>Publicly financed</td>
<td>Publicly provided</td>
<td>Publicly provided</td>
</tr>
<tr>
<td></td>
<td>Publicly provided</td>
<td></td>
<td>Privately provided</td>
</tr>
<tr>
<td>Private</td>
<td>Privately financed</td>
<td>Publicly provided</td>
<td>Privately provided</td>
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</tbody>
</table>

In making the choice, technical efficiency is an important, but not the only consideration. Most health care systems in western industrialized countries assume a high degree of responsibility for personal health care because they are driven by values which lean heavily towards notions of equity, fairness and solidarity. There must be a tripartite regulatory framework among (a) patient, (b) provider and (c) regulator.

The three challenges highlighted – cost containment, developing a medical hub and ensuring quality and patient safety are interrelated. A focus on costs without a corresponding focus on quality and
patient safety is meaningful. Care that is cheap but of poor quality is not surely desirable. Neither will a reputation for expensive or inappropriate treatment propel us towards our goal as a medical hub. Both cost containment and quality of care are critical factors to success as a medical hub. The international market competition as with the domestic market competition will ultimately be decided on the basis of both price and quality. A first attempt towards achieving all of these goals is to create the right criteria for (i) competition, (ii) consumer choice, and (iii) provider cooperation. Governments face increasing pressure on public finances for the provision of public services, particularly healthcare. Healthcare spending presently exceeds $4 trillion worldwide (9% of GDP globally), though amounts range from less than $3 per person annually in some low-income countries in Africa, to $6,250 per person annually (18% of GDP) in USA. More than 30 countries spend less than $20 per person annually on healthcare. Many low-income countries lack the facilities necessary to provide basic healthcare services and products. Most countries also face shortage of trained medical personnel. At present, the trend in both developed and developing countries has been towards greater private sector involvement in healthcare provision and financing. The Public Private Partnership (PPP) can help in removing the problem of poor health services delivery at two levels: to improve delivery mechanisms and to increase mobilization of resources for healthcare. There are various types and models of PPP in healthcare sector in the world. Many governments are turning to private sector to respond to public healthcare needs. Among the types and models of partnership are contracting (contracting-out and contracting-in); franchising; social marketing; joint ventures; subsidies and tax incentives; vouchers or service purchase coupons; hospital autonomy; build, operate, and transfer; philanthropic contributions; health co-operatives; grant-in-aid; capacity-building; leasing; and social health insurance. The UNO and its agencies like WHO have been at the forefront of engaging with the private sector in an attempt to foster collaboration that would deliver more resources for healthcare. In India, the private sector is the most important source of healthcare services, providing about 80% of all services. During the last few years there have been many initiatives to improve the efficiency, effectiveness, and quality in provision of health services in the country. PPPs aim to harness the large pool of private sector healthcare resources and draw them into the process of nation building. PPPs for healthcare should be distinguished from privatization. (Mozika 2011, Biswas 2011).

The objectives of this paper is to discuss about (a) the comparison of national health expenditures, healthcare and health insurances of some countries of the world, (b) the objectives of the PPPs in

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healthcare and health insurance, (c) different practices of PPPs for healthcare and health insurance those have been adopted in India and reporting of their progresses, (d) healthcare and health insurance for senior citizens have been proposed and adopted in India.

The paper is organized into the following sections: I. Introduction, II. National health expenditure, healthcare and health insurance for some countries of the world and their comparisons, III. Objectives and benefits of PPPs in healthcare and health insurance, IV. Different practices of PPPs for healthcare and health insurance in India, V. Healthcare and health insurance for senior citizens in India, VI. Conclusions and recommendations.

I. NATIONAL HEALTH EXPENDITURE, HEALTHCARE AND HEALTH INSURANCE FOR SOME COUNTRIES OF THE WORLD AND THEIR COMPARISONS

Medical expenditure is high in the first few years of life and increases again in old age with the onset of chronic illness and disability. The Table below (Table 1) presenting relative per capita healthcare expenditure by age group, England and Wales, circa 1980 to 1990 provides some idea about pattern of medical expenditures at different age groups (Mayhew, 2000).

<table>
<thead>
<tr>
<th>Age group</th>
<th>Relative expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 4</td>
<td>1.00</td>
</tr>
<tr>
<td>5 - 14</td>
<td>0.40</td>
</tr>
<tr>
<td>15 - 44</td>
<td>0.53</td>
</tr>
<tr>
<td>45 - 64</td>
<td>0.82</td>
</tr>
<tr>
<td>65 - 84</td>
<td>3.20</td>
</tr>
<tr>
<td>85+</td>
<td>5.52</td>
</tr>
</tbody>
</table>

Source: Calculated on the basis of data from UK Department of Health
All governments spend a major portion of GDPs on healthcare. Singapore was the pioneer in designing policies to shift the burden of healthcare away from the public purse into private pockets which have been so effective that private spending now accounts for three quarters of national health expenditure. The Singapore model has attracted a fair amount of international attention and some mixed reactions. Admirers claim it holds useful lessons for others, while critics charge that it sacrifices equity in the name of efficiency. Singapore manages to tap the financial strengths of the public and private sectors while balancing efficiency and equity goals. Medisave in Singapore was introduced as an extension of a larger, national superannuation scheme called the Central Provident Fund (CPF). The latter is a compulsory, tax-exempt, interest-yielding savings scheme started in 1955 to provide financial protection for workers in their old age. Over the years the scheme has been modified and liberalized to allow for pre-retirement withdrawals to purchase homes, buy home mortgage insurance, and even invest in “blue chip” stocks and pay for children’s college expenses. Medisave represents 6-8 percentage of wages (depending on age) sequestered from the individual’s CPF account in anticipation of hospitalization and acute-care medical expenditures in later life (Lim, 2004). Table below (Table 2) provides the comparison of some national health expenditures: Singapore and selected OECD countries (ranked in order of public health expenditure as percentage of total health expenditure).

Table 2: Comparison of national health expenditure: Singapore and selected OECD countries (ranked in order of public health expenditure as percentage of total health expenditure)

<table>
<thead>
<tr>
<th>Country</th>
<th>Public health expenditure as % of total health expenditure</th>
<th>Private health expenditure as % of total health expenditure</th>
<th>Total health expenditure as % of GDP</th>
<th>Per capita expenditure in PPP $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sweden</td>
<td>84.3</td>
<td>15.7</td>
<td>8.1</td>
<td>2145</td>
</tr>
<tr>
<td>UK</td>
<td>83.7</td>
<td>16.3</td>
<td>6.7</td>
<td>1675</td>
</tr>
<tr>
<td>Japan</td>
<td>79.5</td>
<td>20.5</td>
<td>7.4</td>
<td>2243</td>
</tr>
<tr>
<td>France</td>
<td>77.7</td>
<td>22.3</td>
<td>9.4</td>
<td>2288</td>
</tr>
<tr>
<td>New Zealand</td>
<td>77.3</td>
<td>22.7</td>
<td>7.6</td>
<td>1163</td>
</tr>
<tr>
<td>Australia</td>
<td>68.3</td>
<td>31.7</td>
<td>10.5</td>
<td>2697</td>
</tr>
<tr>
<td>USA</td>
<td>45.5</td>
<td>54.5</td>
<td>8.4</td>
<td>1714</td>
</tr>
<tr>
<td>Singapore</td>
<td>25.6 (b)</td>
<td>74.4 (b)</td>
<td>3.0 (b)</td>
<td>678</td>
</tr>
</tbody>
</table>

Sources:

- WHO
- Ministry of Health Singapore (2000)
The United States spends more on healthcare than any other developed country - $2.4 trillion in FY 2008, increasing to $4.4 trillion in FY 2018. Medicare is the single largest player within this system, with expenditure in FY 2008 of $386 billion, rising to $797 billion by 2018. The growth in Medicare spending is unsustainable.

Again the following Tables (Tables 3 and 4) provide some information regarding (a) Percentage GDP spent on health (b) Percentage spread between government and private spending on health for some selected countries including India.

**Table 3: Percentage of GDP spent on Health for Some Countries Including India**

<table>
<thead>
<tr>
<th>Country</th>
<th>Percentage of GDP spent on Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>India</td>
<td>6.1</td>
</tr>
<tr>
<td>Brazil</td>
<td>6.6</td>
</tr>
<tr>
<td>Chile</td>
<td>3.7</td>
</tr>
<tr>
<td>Mexico</td>
<td>4.7</td>
</tr>
<tr>
<td>Argentina</td>
<td>5.9</td>
</tr>
<tr>
<td>Spain</td>
<td>8.7</td>
</tr>
<tr>
<td>Italy</td>
<td>8.3</td>
</tr>
<tr>
<td>USA</td>
<td>15.0</td>
</tr>
<tr>
<td>UK</td>
<td>8.0</td>
</tr>
<tr>
<td>Thailand</td>
<td>6.0</td>
</tr>
</tbody>
</table>

Table 4: Percentage Spread Between Government and Private spending for Some Countries Including India

<table>
<thead>
<tr>
<th>Country</th>
<th>Public health expenditure as % of total health expenditure</th>
<th>Private health expenditure as % of total health expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>UK</td>
<td>83</td>
<td>17</td>
</tr>
<tr>
<td>France</td>
<td>76</td>
<td>24</td>
</tr>
<tr>
<td>Germany</td>
<td>79</td>
<td>21</td>
</tr>
<tr>
<td>Netherlands</td>
<td>66</td>
<td>34</td>
</tr>
<tr>
<td>Spain</td>
<td>71</td>
<td>29</td>
</tr>
<tr>
<td>Singapore</td>
<td>31</td>
<td>69</td>
</tr>
<tr>
<td>Thailand</td>
<td>70</td>
<td>30</td>
</tr>
<tr>
<td>Japan</td>
<td>82</td>
<td>18</td>
</tr>
<tr>
<td>India</td>
<td>78.7</td>
<td>21.3</td>
</tr>
<tr>
<td>China</td>
<td>34</td>
<td>66</td>
</tr>
<tr>
<td>Poland</td>
<td>72</td>
<td>28</td>
</tr>
</tbody>
</table>


Only 15% Indians have health insurance coverage out of which 1.4% belongs to private health insurance. (Source: 1. Ellis Annual Report, 2. McKinsey Analysis)

II. OBJECTIVES AND BENEFITS OF PPPS IN HEALTHCARE AND HEALTH INSURANCE

PPPs allow governments to leverage the expertise of the private sector to improve the quality, accessibility and efficiency of public healthcare systems without burdening public finances. They also can complement public sector approaches to healthcare delivery.

Under a PPP, a government (or public health insurer) contracts with a private firm (for-profit or not-for-profit) to provide infrastructure and/or services to publicly-funded patients. PPPs can be tailored to meet specific needs, with the private operator’s role ranging from facility management and non-clinical services, to specialized clinical services, to full hospital management including all clinical services. The five areas where private sector contribution can prove very beneficial are:
1. Infrastructure Development - Development and strengthening of healthcare infrastructure that is evenly distributed geographically and at all levels of care

2. Management and Operations - Management and operation of healthcare facilities for technical efficiency, operational economy and quality

3. Capacity Building and Training - Capacity building for formal, informal and continuing education of professional, para-professional and ancillary staff engaged in the delivery of healthcare

4. Financing Mechanism - Creation of voluntary as well as mandated third-party financing mechanisms

5. IT Infrastructure - Establishment of national and regional IT backbones and health data repositories for ready access to clinical information

6. Materials Management - Development of a maintenance and supply chain for ready availability of serviceable equipments and appliances, and medical supplies and sundries at the point of care

In each of the above areas, there are different capabilities and drivers for the public and private sectors in a PPP arrangement. For example, the government is the largest provider of healthcare in the country especially at the primary and secondary care levels, and the government is also the largest buyer of healthcare services at the tertiary and quaternary care levels. The private sector investments in healthcare have been driven by free market economy, and the pricing of healthcare services has been largely influenced by investment cost. Consequently, these services have remained out-of-reach of a large majority of our population particularly poor people due to cost consideration. In order to make PPP as a sustainable common ground for both public and private sectors and to evolve successful PPP models, it is essential to have clarity of the public and private sector positions and develop unambiguous criteria for assessing PPP models. An evaluation framework proposed in this document brings out four key principles on which any PPP model must be assessed

1. Effectiveness or the ability to meet program objectives

2. Efficiency or the financial efficiency in transfer of ownership and associated risks

3. Equity or the ability to accrue the benefits of the program to the poor people

4. Financial Sustainability or financial viability of the model
The key advantages of PPPs are that they combine the different skills and resources of various partners in innovative ways and allow for the sharing of risks and responsibilities. This ensures governments benefit from the experience and expertise of the private sector, and allow them to focus instead on policy, planning and regulation by delegating administrative and day-to-day operations. The key to success in PPP initiatives lies in effective management of the public sector and private player interests across different stakeholder roles. PPP experience from different sectors indicate some key implementation aspects of PPP which need upfront clarity and have to be kept in mind by concerned parties before initiating PPP projects in healthcare.

1. Defining and differentiating scope of free services at PPP hospitals- Free service implies access to healthcare to the beneficiary free of charges particularly for the poor and elderly persons.

In order to establish clarity of objectives upfront in any PPP project, it is recommended that the MoUs define the complete scope of “Free Services” and include the following:

- Determination of “Free Services” to provided at the PPP hospital,
- Definition of the scope of “Free Services” to be provided at the PPP hospital,
- Definition of the eligibility of patients to avail the “Free Services”,
- The Quality charter of “Free Services”,
- Differentiation of facility’s infrastructure for “Free” & “Paid” Services.

2. Tariff Determination- It is essential that pricing strategies and service tariffs of the “Free Services” are determined on mutually agreeable platforms. The service tariffs should be determined on the basis of the following criterion while entering into the partnership agreement between government and private sector:

- Inflation (current & projected),
- Project Operational Expense,
- Project Capital Expense,
- Project Profitability,
- Public Sector partner’s obligation,
- Periodicity of tariff change,
- Agreeability by both partners

3. Role of advisors to the PPP- In most PPP initiatives, the public sector partner identifies the management and financial consultants to advice on the projects. It is important that the appointed advisors should develop the contractual clauses after discussion and in mutual agreement of both the public and private sector interests.

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4. Regulatory Role in a PPP setup - PPPs are looked upon as bringing the best of the both public and private sector practices and benefits together to provide better healthcare. A strong control mechanism is needed to ensure that the public and private sectors operate within defined roles. Some of the areas where the regulator could contribute are: a) consumer rights protection, b) litigation issues, c) ensure timely decisions, d) exit options for private providers.

III. DIFFERENT PRACTICES OF PPPs FOR HEALTHCARE AND HEALTH INSURANCE IN INDIA

A. Rashtriya Swasthya Bima Yojana (RSBY)

Rashtriya Swasthya Bima Yojana (launched by the Ministry of Labour and Employment, Government of India) is a pioneer in PPP in health insurance for the poor (below BPL) in India. It was introduced in April 2008. RSBY has several stakeholders – the central governments, the state governments, the insurance companies, the public/private healthcare providers, and BPL families – who will all benefit from the new scheme which is the first government social sector scheme to embrace a business model of profit. The new scheme is meant for the Indian workforce (about 300 million) working in the informal sector who do not have any kind of access to health protection benefits. The central and state governments jointly bear the premium of providing quality healthcare to the poor in all districts of India through RSBY. This is an IT enabled scheme and will provide for healthy competition among public and private healthcare providers leading to real improvements in health infrastructure particularly in rural areas. RSBY is considered as a successful PPP model in terms of outreach and sustainability and may become a precursor to other schemes in the social sector. The majority of the financing (about 75%) is provided by the Government of India (GOI). In the North-eastern states and J&K GOI’s contribution is 90%. The strength of the scheme lies in the fact that it is a social welfare scheme with the profit made by the various stakeholders acting as a catalyst. Cases of corruption and fraud can be tracked by the stakeholders themselves. RSBY provides the participating BPL households with freedom of choice between public and private hospitals and makes them potential clients (with Rs.30, 000/- on their card) worth attracting on account of the significant revenues that hospitals stand to earn through the scheme. If RSBY succeeds, this model of public private partnership in the social sector will become a precursor to other schemes.
B. Chiranjeevi Programme in Gujrat

Under this programme launched by the Gujarat government, the state government drew up a scheme to ensure institutional deliveries for the poor through the active engagement of the private sector. In a pilot project, obstetricians in five districts were offered a financial package nearly of Rs 1.75 lakh for every 100 deliveries they conducted. The state issues a service voucher worth about Rs 2,000 to each poor pregnant woman and ensures that the provider is reimbursed.

C. Vande Mataram Scheme

This scheme was launched by the union government in collaboration with the Federation of Obstetrician and Gynecologists Societies of India, which depended on obstetricians providing free services to the poor.

D. Yeshasvini Health Scheme in Karnataka

The Yeshasvini Co-operative Farmer’s Healthcare Scheme, initiated by Narayana Hrudayalaya, a super-specially heart hospital in Bangalore and by the Department of Co-operatives of the Government of Karnataka, is a health insurance scheme targeted for the benefits of the poor. The government provides Rs 2.50 of the monthly premium (Rs 10 per month) paid by the members of the Cooperative Societies. The incentive of getting treatment in a private hospital with the government paying half of the premium attracts more members to the scheme. The cardholders can access free treatment in 160 hospitals located in all districts of the state for any medical procedure costing up to Rs 2 lakhs.

E. Telemedicine Initiative by Narayan Hrudayalay in Karnataka

The Government of Karnataka, the Narayana Hrudayalaya Hospital in Bangalore and the ISRO initiated an experimental telemedicine project called ‘Karnataka Integrated Tele-medicine and Tele-health Project’ (KITTH) which is an online healthcare initiative in Karnataka. With connections by satellite, this project functions in the Coronary Care Units (CCU) of selected district hospitals which are linked with Narayana Hrudayalaya Hospital. Each CCU is connected to the main hospital to facilitate investigation by specialists after ordinary doctors have examined patients. If a patient requires an operation, she/he is referred to the main hospital in Bangalore otherwise she/he is admitted to a CCU. This scheme is very effective and will be more effective and efficient in near future throughout India because of its low cost and high scalability. But initially it requires high cost on installation, providing awareness and acceptability about its usefulness through training programmes. It was initiated and has been functioning in Karnataka because Karnataka is one of the pioneer states in IT in India.

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F. Some of the other schemes are

1. Arogya Raksha Scheme in Andhra Pradesh,
2. Contracting in Sawai Man Singh (SMS) Hospital, Jaipur,
3. The Uttaranchal Mobile Hospital and Research Center (UMHRC),
4. PHC’s in Gumballi and Sugganaballi, Karnataka,
5. Emergency Ambulance Services Scheme in Tamil Nadu,
6. Urban Slum Healthcare Project, Andhra Pradesh,
7. Rajib Ganghi Super-Specialty Hospital, Raichur, Karnataka,
8. Community Health Insurance Scheme in Karnataka,
9. 108 Emergency Response Service etc.

IV. HEALTHCARE AND HEALTH INSURANCE FOR SENIOR CITIZENS IN INDIA

The Committee on Health Insurance for senior citizens has asked the IRDA (Insurance Regulatory and Development Authority) to promote standalone health insurance companies as subsidiaries of insurance companies (life and non-life) and gives them separate treatment to ensure their viability. At least half the service tax on all health insurance premiums is to be credited to the insurance pool to be set up with the IRDA for dealing with high risk cases of senior citizens. Premium is to be fixed at a base price at the age of 50, which is to be adjusted with a loading for each year.

Health insurance products for senior citizens should be designed according to their capacity to pay; senior citizen beneficiaries of schemes like CGHS, ESIS etc., may be given the choice to opt out of the scheme and a suitable grant to buy health insurance, if the facilities under the schemes are not available at their post-retirement places of settlement. Insurance driven healthcare should have more inclusions than exclusions, since there is hardly anyone in this group without pre-existing disease. Many medical conditions are treatable and could be kept under control for a long time.

VI. CONCLUSIONS AND RECOMMENDATIONS

PPPs in healthcare and health insurance are a relatively new development. There is an air of optimism surrounding PPPs in India. Used judiciously and fitted to local circumstances, they clearly have the potential to drastically change the healthcare and health insurance landscape in India to an effective and efficient one. PPPs will survive only if the interests of all stakeholders are taken into account. This means detailing specific roles, rights and responsibilities, establishing clear standards, providing training for public sector managers, active dissemination of information, and constantly refining the process to make the system more efficient and effective. The public sector has to lead by example, and be willing to redefine itself and work

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with the private sector. The latter must be in turn willing to work with the public sector to improve mutual cooperation and understanding. In such a situation, the interests of the poor and underprivileged sections of the society, particularly the elderly people, need to be guarded by appropriate regulatory mechanisms so as to ensure that equity, efficiency, effectiveness, and affordability are maintained in the provisions of healthcare and health insurance.

The following measures may be undertaken to make the PPP model successful:

1. Developing awareness programme in use of IT like Web browsing, Chatting, Data transfer, E-mailing etc.;
2. Consideration of the healthcare and health insurance as part of social security;
3. Considering Universal Access to healthcare;
4. Raising of funds for the promotion of healthcare for the poor and elderly people;
5. Developing proper awareness about the benefits of PPP among the people, particularly poor, elderly people, people working in the informal sectors;
6. Just like the people of different sectors are brought under health insurance coverage, it should give necessary instructions to relevant bodies to design health insurance schemes so that they cover the differently abled people, particularly the elderly people.
REFERENCES


