

# 15 - PUBLIC/PRIVATE PARTNERSHIP IN HEALTH CARE SERVICES IN INDIA

\* Dr. A Venkat Raman

And

\*\* Prof. James Warner Björkman

## I. Background

*It is widely accepted that the deficiencies in public sector health system can only be overcome by significant reforms. The need for reforms in India's health sector has been emphasized by successive plan documents since the Eighth Five-Year Plan in 1992, by the 2002 national health policy and by international donor agencies. The World Bank (2001:12,14), which has been catalytic in initiating health sector reforms in many states, categorically emphasized: now is the time to carry out radical experiments in India's health sector, particularly since the status quo is leading to a dead end. . But it is evident that there is no single strategy that would be best option The proposed reforms are not cheap, but the cost of not reforming is even greater”.*

Health Sector Reform (HSR) is defined as *a sustained, purposeful change to improve the efficiency, equity and effectiveness of the health sector'* (Berman 1995). The World Health Organization (1997) defined health sector reform as *a sustained process of fundamental change in policy and institutional arrangements of the health sector, usually guided by the government. ..It is designed to improve the functioning and performance of the health sector and ultimately the health status of the people* . Reform strategies include (i) alternative financing (user-fees, health insurance, community financing, private sector investment); (ii) institutional management (autonomy to hospitals, monitoring and management by local government agencies, contracting); (iii) public sector reforms (civil service reforms, capacity building, productivity improvement); and (iv) collaboration with the private sector (public/private partnerships, joint ventures) (World Bank 1993; Thomason 2002; Abrantes 2003).

Partnership with the private sector has emerged as a new avenue of reforms, in part due to resource constraints in the public sector of governments across the world (Mitchell-Weaver and Manning 1992). There is growing realisation that, given their respective strengths and weaknesses, neither the public sector nor the private sector alone can operate in the best interest of the health system. There is also a growing belief that public and private sectors in health can potentially gain from one another (ADB 2000; Bloom et al. 2000; Agha et al. 2003). Involvement of the private sector is, in part, linked to the wider belief that public sector bureaucracies are inefficient and unresponsive and that market mechanisms will promote efficiency and ensure cost effective, good quality services (WHO 2001). Another perspective on this debate is linked to the notion that the public sector must reorient its dual role of financing and

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\* Institute of Social Studies, The Hague, The Netherlands, Email:bjorkman@iss.nl

\* Institute of Social Studies, The Hague, The Netherlands, Email:bjorkman@iss.nl

provision of services because of its increasing inability on both fronts (Mitchell 2000). Under partnerships, public and private sectors can play innovative roles in financing and providing health care services.

While reviewing the health sector in India, the World Bank (2001) and the National Commission on Macroeconomics in Health (2003, 2005) strongly advocated harnessing the private sector's energy and countering its failures by making both public and private sectors more accountable. The Tenth Five-Year Plan (2002-2007) envisioned in detail the need for private sector participation in the delivery of health services.

Collaborating with the private sector and fostering a partnership for providing health services to the underserved sections of the population are particularly critical in the Indian context. Due to the deficiencies in the public sector health systems, the poor in India are forced to seek services from the private sector, often borrowing to pay for them.

India has one of the world's highest levels of private out-of-pocket financing (87 percent estimated in World Bank 2001). Out-of-pocket expense at the point of service use is about 85 percent (Kulkarni 2003). Such a mode of financing imposes debilitating effects on the poor. Hospitalisation or chronic illnesses often lead to liquidation of assets or indebtedness. It is estimated that more than 40% of hospitalised people borrow money or sell assets to cover expenses, and 35% of hospitalised Indians fall below the poverty line because of hospital expenses. Out-of-pocket medical costs alone may push 2.2% of the population below poverty line in one year (Selvaraju and Annigeri 2001; Mahal et al. 2002). Approximately 29 percent of the Indian population (almost 300 million people) live below the poverty line and depend on free health services from the public sector. The inequities in the health system are further aggravated by the fact that public spending on health has remained stagnant at around one percent of GDP (0.9%) compared to the global average of 5.5%. Yet even the public subsidy on health does not automatically benefit the poor. The poorest quintile of the population uses only one-tenth of the public (state) subsidies on health care while the richest quintile accesses 34 percent of the subsidies (Mahal et al. 2002).

### **Private Sector in India**

Over the years the private health sector in India has grown remarkably (Baru 1999). At independence the private sector in India had only eight percent of health care facilities (World Bank 2004) but recent estimates indicate that 93% of all hospitals, 64% of beds, 85% of doctors, 80% of outpatients and 57% of inpatients are in the private sector (World Bank 2001). Contrary to commonly held views, private hospitals are relatively less urban-biased than the public hospitals. Given the overwhelming presence of the private sector in health, various state governments in India have been exploring the option of involving the private sector and creating partnerships with it in order to meet the growing health care needs of the population.

The private sector is not only India's most unregulated sector but also its most potent untapped sector. Although inequitable, expensive, over-indulgent in clinical procedures and without quality standards or public disclosure of practices, the private sector is perceived to be easily accessible, better managed and more efficient than its public counterpart. It is assumed that collaboration with the private sector in the form of

Public/Private Partnership would improve equity, efficiency, accountability, quality and accessibility of the entire health system. Advocates argue that the public and private sectors can potentially gain from one another in the form of resources, technology, knowledge and skills, management practices, cost efficiency and even a make-over of

their respective images (ADBI 2000). Partnerships are expected to ameliorate the resource constraints of the public sector by reducing investments in expensive tertiary care services.

## II. Public/Private Partnership

There are many ways of defining the terms public and private (Wang 2000). In general, however, the public sector includes organizations or institutions that are financed by state revenue and that function under government budgets or control. The private sector comprises those organizations and individuals working outside the direct control of the state (Bennet 1991). Broadly the private sector includes all non-state actors, some explicitly seeking profits (for-profit) and others operating on a not-for-profit (NFP) basis. The former are conventionally called private enterprise, the latter non-governmental organizations (NGOs). In the health sector, for-profit providers may include individual physicians, diagnostic centres, ambulance operators, blood banks, commercial contractors, polyclinics, nursing homes and hospitals of various capacities. They may also include community service extension of industrial establishments, co-operative societies and professional associations. The for-profit private health sector encompasses the most diverse group of practitioners and facilities. But likewise the character of not-for-profit organizations varies in terms of their size, expertise level and geographical spread. NFP services are clustered in charitable clinics or hospitals. Some are established on a financially sustainable basis and are funded from user-charges; most, however, require the support of grants or donations.

Although widely used, the term partnership is difficult to define. Some definitions in the literature are so ambiguous that they cover practically any type of interaction between public and private actors. Yet partnership is often used to describe a range of interorganizational relationships and collaborations. Some of the useful definitions of public/private partnership are:

- \* “.....,means to bring together a set of actors for the common goal of improving the health of a population based on the mutually agreed roles and principles (WHO 1999)
- \* “.....a variety of co-operative arrangements between the government and private sector in delivering public goods or services provides a vehicle for coordinating with non-governmental actor to undertake integrated, comprehensive efforts to meet community needs... to take advantage of the expertise of each partner, so that resources, risks and rewards can be allocated in a way that best meets clearly defined public needs (Axelsson, Bustreo and Harding 2003)
- \* “...a partnership means that both parties have agreed to work together in implementing a program, and that each party has a clear role and say in how that implementation happens (Blagescu and Young 2005)
- \* “.....a form of agreement [that] entails reciprocal obligations and mutual accountability, voluntary or contractual relationships, the sharing of investment and reputational risks, and joint responsibility for design and execution (World Economic Forum 2005)

Three fundamental themes emerge from these definitions. First, a *relative sense of equality* between the partners; second, there is *mutual commitment to agreed objectives*; and third, there is *mutual benefit* for the stakeholders involved in the partnership. Partnership is therefore a collaborative effort and reciprocal relationship between two or

more parties with clear terms and conditions, clearly defined partnership structures, and specified performance indicators for delivery of a set of health services in a stipulated time period. In other words, 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).

### **Challenges in Partnership**

While the health system as a whole has common objectives of equity, efficiency, quality and accessibility, public and private providers interpret the contents of these objectives differently. Generally, the motive of the government is to provide health services to all at minimum cost or free; it develops policies and programmes to provide equity of access to such services. From the public sector point of view, there are merits and demerits in collaborating with the private sector.

Not-for-profit organizations have special concern for reaching the poor and the disadvantaged but, in many states, they account for less than one percent of all health facilities (World Bank 2004). Their sustenance depends on philanthropic donations or external funding. As a result their interventions remain ad hoc, and their up-scalability remains doubtful. But they provide good quality care, need little regulation or oversight from government, are able to attract dedicated staff, and cater to the needs of those otherwise excluded from mainstream health care. Moreover, they are also willing to undertake health care challenges that the for-profit sector is unwilling or unable to take on. Given their non-profit motives and grass-root level presence, NGOs can play useful oversight roles in the system. Their size and flexibility allows them to achieve notable successes where governments have failed.

Opinion is divided on the motives of the (for-profit) private sector, ranging from outright distrust to strong support for close co-operation with it. One extreme view is that the private sector is primarily motivated by money and has no concern for equity or access.

Bennet et al. (1994) identified five main problems associated with private-for-profit provision of health services. They are related to the use of illegitimate or unethical means to maximise profit, less concern towards public health goals, lack of interest in sharing clinical information, creating brain drain among public sector health staff, and lack of regulatory control over their practices. Rosenthal (2000) cites similar concerns towards involving the private sector in delivering public health services. However, Bloom, Craig and Mitchell (2000) suggest that the private sector is neither so easy to characterise nor easy to neglect. Its strength is its innovativeness, efficiency and learning from competition. Management standards are generally higher in the private (for-profit) sector. The private sector can play an important role in transferring management skills and best practices to the public sector. In India, the formal for-profit sector has the most diverse group of facilities and practitioners. Since it accounts for the largest proportion of services and resources in the health sector, it is argued that future strategies to improve public health should take into account of the strengths of the private sector (World Bank 2004).

There are also a large number of non-qualified rural medical practitioners in the informal private sector in India. A conservative estimate puts the number of these practitioners at 1.25 million. The pros and cons of partnering with each subgroup in the private sector are identified in Table 1 below.

### **Table 1 : Pros and Cons of collaborating with the Private Sector in Health**

Subsector	Pros	Cons
Informal	Accessible Client-oriented	Poor quality care Difficult to mainstream Low cost Poorly educated
Not-for-Profit	High quality Targeted to the poor  community	Small coverage Lack of resources Low cost Involves the Cannot be scaled-up Ad hoc interventions
For profit	High quality (in select	Ad hoc interventions disciplines) Huge outreach /coverage Innovative Efficient High Cost Variable quality Clustered in cities

(Source: Adopted from World Bank 2004)

### Characteristics of Partnership

Despite these differences, the public and private sectors constantly interact with one another. While the government needs the private sector's support in order to attract more resources, expand coverage and provide diversity of services, the private sector has incentives to approach government in order to influence its policies in terms of tax exemptions, accreditation and fee setting (Wang 2000). Partnerships are more useful when the net benefits of partnership exceed those of independent activities, and when the joint efforts result in more efficient or effective services than independent action (Bazzoli et al. 1997).

The Ministry of Health and Family Welfare (MOHFW) in India presupposes that partnerships could help in ameliorating the problem of poor health services delivery at two levels: to improve delivery mechanisms and to increase mobilization of resources for health care (Government of India 2005). Other presumed benefits of partnerships are

improvements in quality of services, reduced cost of care either due to competition or through economies of scale, redirecting the public resources to other areas, reduction in the duplication of services, adoption of best practices, targeted services to the poor and better self-regulation and accountability.

It is often observed that partnerships are formed between organizations but succeed because of individuals who are strong leaders and who champion the partnership projects with vision, energy and enthusiasm. It is important to emphasize that partnerships are no substitute for good governance and that partnership requires governmental leadership. There is a danger that, wherever governance is weak, partnerships could be projected as an automatic choice rather than improving governance. Partnerships work typically with one providing the financing and the other providing the services (Paoletto 2000; ADBI 2000).

**ADBI (2000) identifies the enabling conditions for the success of a partnership as:**

- A clear understanding between the partners about mutual benefits

- A clear understanding of the responsibilities and obligations between the partners
- Strong community support
- Need for some catalyst to start the process of partnership (maybe an individual, a donor, a compelling vision or even a political or economic crisis)
- Stability of the political (government) and legal climate (laws)
- Regulatory framework that is followed and enforced
- 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.

In many countries, legal and political considerations create obstacles for any partnership with the private commercial sector. Partnership with the private sector could be misconstrued as an attempt at privatisation. Such fears about the private sector may have emerged from the perceived social image of the private sector as exploitative and having ulterior motives. It is also possible to presume that bureaucracy would be more willing to partner with the for-profit sector for administrative efficiency, whereas the political and popular sentiments may prevent any overt or enthusiastic collaboration. Though not-for-profit NGOs may be easier to engage as partners, concerns have been raised about the difficulties of NGOs working with the government (Mukhopadhyay 2000) and the financial (survival) motives of the NGOs (Ahmed 2000). In India concerns have been raised about the dubious nature of some NGOs that are often established by the political personalities to garner funds from the state. Other concerns about partnerships are the apparent difference between the public sector and the private sector in terms of resource commitment (long term commitment of the public sector compared to short term commitment by the private sector), differences in work culture and the notion of efficiency, perceptions about the quality of care, and type of patients seeking services.

### **Scope and types of partnership**

Based on research literature it is possible to identify varied types and models of public/private partnerships in health sector around the world. 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; grants-in-aid; capacity- building; leasing; and social health insurance. Of course, different models are useful under different circumstances. However, among all the partnership models, contracting has been the most common form. The research literature is replete with examples of contracting as a form of public/private partnership.

### **Contracting**

Contracting is one of the dominant tools for engaging the private sector in health sector reforms across all types of public health systems throughout the world. Under contracting, the financing and provision (delivery) of health services are clearly delineated between the provider and the purchaser (Ashton, Cummings and McLean 2004). The private providers receive a grant or budget amount from the government for

delivering certain services that the latter used to deliver itself. The relationship between the government and the private sector is specified in a written agreement. Bennett and Mills (1998) identified several stages in a contracting process viz., a) decision to contract and the services to contract, b) tendering and selection of the contractor, c) contract design, d) implementation, e) monitoring the performance, and g) evaluating the implications of contract on the public health system. Other critical issues relate to the objectives and scope of the services to be delivered, costing of the services, performance specifications including quality and expected health outcomes, payment for the services, supervision, access or special privileges to the poor and target population, and the relative capacity of the partners in managing the partnership contract.

Currently several private partnership initiatives are under implementation in the states of India. The scope of these initiatives span disease surveillance; purchase and distribution of drugs in bulk; contracting specialists for high risk pregnancies; national disease control programs; social marketing; adoption and management of primary health centers; colocation of private facilities (blood banks, pharmacy); subsidies and duty exemptions; joint ventures; contracting out; medical education and training; engaging private sector consultants; pay clinics; discount vouchers; self- regulation; R&D investments; telemedicine; health cooperatives; and accreditation.

### **III. The Study**

While the forms of partnerships vary, there is little evidence to indicate the relative merits of one form of private partnership over the others. Little is known about the scope and coverage of the services under partnership with the private sector and less is known about the institutional capacity of government agencies to design, negotiate, implement and monitor such partnerships. Information is required about subsidies, performance and quality of services under partnership arrangements, operational constraints, effect on the public health system, and the stakeholders perspectives on this policy option. There is no consensus on the appropriate private sector involvement in health care or an appropriate public policy towards private sector.

At the policy level, some issues that need careful analysis are the relative efficiency of one mode of partnership over other. How partnership deals could be specifically designed to target and benefit the poor? What is the institutional capacity of the government or the private partner to manage a partnership? At the operational level, questions that merit indepth analysis include the conditions for successful partnership; how to ensure that the poor actually benefit from services; mutual responsibilities and commitments of partners; incentives and disincentives; performance indicators; and monitoring the functioning of the partnership.

A wide range of health services is spanned by case studies recently conducted by the authors for the Indo-Dutch Program for Alternatives in Development (IDPAD). Located in rural and urban areas, the health services studied include clinical care services as well as non-clinical support services and stationary establishments as well as mobile services. They specifically include diagnostic services, general curative care, maternal & child health services, community health financing activities, health promotion activities and ICT-based health service provision.

After careful review of various partnership models in different states, the study compiled sixteen cases in nine states of India in order to reflect and assess different models of public-private partnership. The study critically reviewed, in depth, the cases through contract documents, government orders, memoranda of understanding and other documents. The study also compiled the feedback from different stakeholders, including the patients, public and the private partner officials. Operational issues in the management and functioning of schemes were carefully compiled.

The appendix provides a brief overview of the sixteen case studies. Partnership initiatives ranged from super-specialty tertiary-care hospitals (Apollo Hospital, Raichur; SMS hospital, Jaipur) to primary care (Karuna Trust in Karnataka) to slum communities (Arpana Swasthya Kendra, Delhi; urban slum care in the district town of Adilabad, Andhra Pradesh). Community health insurance initiatives in two states were also documented (Arogya Raksha scheme in Andhra Pradesh; Yeshasvini scheme in Karnataka). In Tamil Nadu, Uttaranchal, and West Bengal the study examined mobile health services: the first case provides emergency ambulance, the second case provides diagnostic and general health care and the third case combines features of the previous two. Other partnership initiatives studied include telemedicine and tele-health project in (Karnataka and contracting-out cleaning, kitchen and laundry services in West Bengal. Rogi Kalyan Samiti, or hospital autonomy in a decentralised context by local self government in the city of Bhopal (Madhya Pradesh), was taken up to understand how a public/public partnership fits within the public/private partnership framework.

Although a detailed analysis is not possible here, some critical issues are highlighted and debated in this paper.

#### **IV. Analysis and Discussion**

The case studies are analysed under two broad frameworks: operational issues in the management of the partnership, and policy perspectives on public-private partnerships. Beyond the appendix, a brief overview of the case studies is provided before the specific analyses.

##### **Overview of the Case Studies**

Though contracting (contracting out and contracting in ) is the predominant model of private partnership, our research also studied other forms of partnerships. The private sector was represented in the form of individual physicians, commercial contractors, large private and corporate super-speciality hospitals and not-for-profit agencies (NGOs). Out of the sixteen case studies and nineteen partnership agreements, only eight partners were NGOs. Some partnerships dealt with simple contracts (diet, laundry, cleaning) whereas other more complex contracts involved many stakeholders (Yeshasvini is a community-based self-financed health insurance scheme). In almost all partnerships, the principal public partner is the department of health and family welfare, either directly or through health facility level committees. In terms of monetary value, the least valued contract provided dietary services at a rate of Rs 27 per meal for about 30 meals in a day (Bhagajatin Hospital, Kolkata); the most expensive engaged a corporate hospital to run a government-built super-speciality hospital in Raichur, Karnataka (over Rs 600 million). The oldest partnership (since 1996) is the Karuna Trust that adopted and manages primary health centres in Karnataka whereas the Chiranjeevi scheme that engages private doctors for deliveries in Gujarat is the most recent initiative (since December 2005). Except in one case (Birla Institute in Uttaranchal s Mobile Health Clinic), all other private partners have had prior experience in the health sector. In terms of the scope of services, three partnerships provide super-speciality tertiary-care services, twelve partnerships provide community care and support services, and the remaining few provide non-clinical support services. Of the sixteen partnership projects, five are based in urban areas but most projects are in rural and tribal regions. Although most projects are specific to a geographical region, some partnerships benefit people in the entire state (Yeshasvini scheme in Karnataka and Arogya Raksha scheme in Andhra Pradesh).

##### **Enabling Conditions**

Policy pronouncements by government are not sufficient for a public/private partnership to succeed. Except in three partnerships where the government resorted to open-tender bidding, most of the partnerships revealed that the government and the private partner chose to consult each other, formally or informally, before venturing into partnership agreements. In such partnerships, charismatic leadership and vision of the personalities, both from the private sector and the public sector, played a critical role. There were also compelling circumstances and relationships based on trust that were critical in triggering partnership initiatives. For example, in the case of Arpana Swasthya Kendra, the Municipal Corporation of Delhi (MCD) had built a maternity health centre through funds from the World Bank's India Population Project-VIII but the building was not operational due to non-deployment of staff. An NGO that had been working in the slum community approached the IPP-VIII project director in MCD with a request to let the NGO manage the health centre. The project director worked hard to convince the political leaders and administrative heads of the corporation, eventually obtaining their approval for a proposal to transfer the health centre to the NGO under a fixed-term agreement.

In the case of the Yeshasvini scheme, Dr Devi Shetty, founder-director of Narayana Hrudayalaya and already a highly popular figure in the country for his pioneering work on low-cost cardiac surgeries and charity, was invited to endorse a milk product at a function held by the Karnataka Milk Federation (KMF), a co-operative with more than two million members. During the function Dr Shetty offered to provide services to all KMF members if each paid a monthly fee of five rupees per person. Dr Shetty made a proposal to Karnataka's then Chief Minister and to the Secretary of the Cooperatives Department. The proposal was formally approved by the state government that, in turn, contributed half of the subscription for each member of the scheme. Dr Shetty and his staff conducted most of the planning, initial implementation and supervision before an independent trust undertook the responsibility. To make the services available for the beneficiaries all over state, Dr Shetty used his personal contacts and his persuasive skills to attract more private hospitals all over the state to become part of the scheme. Similarly Dr Shetty played a critical role in the setting up the Karnataka Integrated Telemedicine and Tele-health project. There are, of course, other personalities involved in the project.

In the case of adoption and management of the primary health centres (PHCs) in Karnataka, the role of Dr Sudharshan from the Karuna Trust was crucial. At his suggestion, the Government of Karnataka mooted a proposal for NGOs to manage the PHCs. Dr Sudharshan undertook the task of managing two PHCs as model centres for primary care. The success of this experiment led the government to issue a formal policy on public-private partnership in 2000. Similar initiatives of people like retired Colonel CS Pant (Uttaranchal mobile health clinic), Dr KJR Murthy (Mahavir Trust Hospital in Hyderabad), Mr MA Wohab (boat-based mobile health services in the Sunderbans of West Bengal), and Dr Haren Joshi (Shamlaji Hospital in Gujarat) have inspired partnership initiatives.

Circumstances that lead to private sector involvement are critical for the success or failure of a partnership. The Rajiv Gandhi super-speciality hospital in Raichur Karnataka, was built at a cost of Rs 600 million. This economically backward region of the state has no modern health facilities so people are forced to travel long distances to seek specialist medical care. As government was unable either to deploy or retain specialist doctors, the hospital was lying unused. Apollo Hospitals Ltd, a corporate hospital chain, was seeking to establish its own hospitals in the region, but it was not sure about building a super speciality hospital. The respective dilemmas of the Government of Karnataka and Apollo Hospitals Ltd were highly conducive for establishing this partnership for mutual benefit. Through this partnership, the Government is able to

provide free services to the poor, and Apollo Hospitals Ltd is able to establish its business operations without having to invest in constructing physical infrastructure. The corporate hospital is able to pay well for its staff so it could retain the desired manpower. Similarly Chamarajanagar, a predominantly tribal district, had only primary care facilities at its district hospital. For any superspeciality care, people had to travel far. Bangalore's Narayana Hrudayalaya came forward to set up telemedicine services in collaboration with the state government and the Indian Space Research Organization (ISRO). Geographical and topographical limitations in accessing health services by the people in Uttaranchal and in the Sundarbans prompted innovative health delivery mechanisms by local private agencies.

Operational constraints also prompted some partnership initiatives. In Jaipur's SMS hospital, the hospital administration could not properly maintain its radiological equipment. Instead of purchasing and maintaining expensive equipment (CT scan and MRI), the government invited a private contractor to operate his own machine on the hospital premises, with special concessions and even free services for the poor (an example of purchasing services on behalf of the poor rather than provisioning). Similarly the Life Line Fluid Store in the same hospital is able to negotiate cheaper rates for drugs and supplies and maintain better inventory management of the drug store. Contracting out dietary, laundry and cleaning services in Kolkata's Bhagajatin Hospital is another typical example of private partnership for improving hospital efficiency.

Partnerships with the private sector tend to be more successful if the policy is built around the lessons from prior experiments, although contracting-out non-clinical support services seems to be an exception to this principle. For example, in Karnataka and West Bengal, state-level policy on public-private partnership was framed after launching a few pilot projects. In Tamil Nadu, Rajasthan and Gujarat, state policy toward public/private partnerships seems to have been introduced without any prior experimentation. Tamil Nadu is one state where private sector involvement in health services had long been encouraged, especially by industrial houses. Yet it would be fair to say that, as of now, the policy is ineffective. The state of Andhra Pradesh, which had a positive engagement in health sector reforms, does not currently have any private sector partnership initiatives of significance.

### **Equity and Accessibility**

Partnership with the private sector presupposes that equity, accessibility and quality of care would be ensured to the targeted beneficiaries, i.e. the poor and deprived sections of the population. However, verification of the authenticity of the poor patients is one of the operational difficulties faced by field managers. Each partnership project profiled here gave special privileges to the poor under various contract clauses. Such services ranged from direct provision of clinical care to providing services via insurance, vouchers, etc. In some projects, upper limits have been placed on the utilisation of services. For example in Yeshasvini scheme, the patients are not allowed to avail any medical treatment (inpatient admission) that does not lead to surgery; and only two unmarried children plus a spouse of a co-operative society member are allowed to avail benefits under the scheme. In the Arogya Raksha scheme in Andhra Pradesh, beneficiaries are eligible for free hospital treatment only if sterilisation had been carried out in a government hospital.

There are relatively few partnership projects that are exclusively meant for the patients from below poverty line (BPL) families (Urban slum health project, Arogya Raksha and Chiranjeevi schemes). There are no uniform procedures adopted for the identification and verification of authentic BPL beneficiaries. Decisions about who qualifies as BPL patients are left to the interpretation of hospital managers. As a result,

complaints often lead to confrontation between patients and hospital management. An observation by one staff member at Raichur s Rajiv Gandhi hospital sums up the difficulty in verifying the antecedents of BPL patients: People drive in to the hospital by a *Honda City* car and claim that they are BPL patients . Some projects have better systems to verify the antecedents of the BPL patients. For example, in the cases of Chiranjeevi scheme beneficiaries in Gujarat and sterilisation in the Arogya Raksha scheme in Andhra Pradesh, the patients were required to get a citation from the local government hospital for an ante-natal check-up. In most of the partnership projects user charges are not permitted. In those projects where a user-fee is allowed, the quantum of collection is too meagre to meet the operational expenses. How the user-fee is to be accounted for during the grant allocation by the government is not made clear in the partnership agreements.

### **Private partner selection and obligations of the Partners**

Based on our analysis, it is possible to suggest that a competitive process of selecting the private sector partner is less effective than an invited or negotiated partnership. A possible explanation may be that, while competing to win a contract, the private partner's primary concern is to showcase a low cost that would clinch the bid. The public sector managers, on the other hand, are more concerned about satisfying procedural requirements (for internal regulatory systems) than meeting the beneficiaries needs. The tendering process in government invariably chooses the lowest bid. While seemingly economical for the government in the short run, after some time the contractor would expect an upward revision of the tariffs or incentives. In the absence of these, the contractor is unlikely to deliver services in the same level of quality or effectiveness as at the beginning of the contract. Governments may resort to a transparent and competitive process of selecting the private agency to withstand administrative and legal scrutiny. This approach of contracting may be useful in commercial projects but not in the social sector where competitive pricing of services is not the priority; rather, reaching the poor is. Some of the successful partnership projects documented here point to the importance of prior negotiations with the potential partners. In some cases the eligibility conditions were tailor-made or else the prior experience of the agency was used as a basis for choosing the private partner.

Among the core components of any partnership are mutual responsibilities and commitments. In all the partnerships, the public sector is committed to providing the physical infrastructure in the form of building premises, equipment, drugs and supplies, electricity, water connection and in some cases fuel for the ambulance or an equivalent budget item. Otherwise the public sector commits resources by reimbursing expenses incurred or providing grants-in-aid. The responsibilities of the private partners are clearly stated in most of the projects. A common theme of responsibility is to provide uninterrupted services to the target beneficiaries (BPL patients), employment of qualified staff, maintenance and upkeep of physical infrastructure, payment of rents and taxes, and submission of periodic accounts and reports. Some partnership projects prescribe additional responsibilities for the private partners under certain contingencies. For example, the Rajiv Gandhi super-speciality hospital should be ready to provide free services during natural calamities; Shamlaji hospital should cater to medico legal cases and treat accident and trauma cases. All the partnership projects are expected to provide services under national programmes, including immunization and family planning. Private partners are allowed to extend the services beyond the scope of the partnership agreement.

### **Performance Specifications**

While all the partnership agreements have clear operational guidelines for the private partners, specific performance indicators are conspicuously absent in all projects except Delhi's Arpana Swasthya Kendra, Andhra Pradesh's urban health scheme and West Bengal's mobile health scheme in the Sunderbans. In the AP urban slum project, the performance parameters are explicitly based on a formula that has a weighted score of 200 points. Most of the indicators include health outcomes indices. In the Sunderbans mobile health scheme, the performance indicators are measured by mortality and morbidity indicators. Some partnerships agreements mandate the private sector to submit periodic reports but most indicate a monitoring mechanism without specific details. It is widely believed that, in government contracts, there is a tendency to pay less attention to the performance indicators. This is based on a premise that the public sector itself does not function efficiently and therefore would not be able to identify performance standards and specifications. Another premise is that if those who are in-charge can use contracts to obtain performance from the private contractors, they should use their influence to get required performance from their own workforce.

### **Resource implications**

Private provision of health services instantly evokes the image of user-charges. However, in the partnership projects reviewed in our study, there are no uniform policies about user-charges (see Table 2). No mention is made either on the basis of fixing the rates of user-charges or on how the revenue from the user-charges will be used. Some charges are in the form of direct fees paid by patients; others are in the form of insurance premiums. The funds received by the private agency are either in the form of grants-in-aid or global budgets. Case analysis indicates that government grants under private partnerships are

invariably directed toward primary care services. This finding repudiates the claim in some quarters that partnership with the private sector would divert government resources toward specialist care services. Even in primary care services, the argument that private partnership is a route towards privatisation does not hold much water since, without government grants, the private sector cannot sustain the operations at these locations.

Table 2: (ref book on page 71)

Therefore government responsibilities have become more indispensable under public/private partnerships.

One of the critical issues in public-private partnerships throughout the world is the timely release of grants or reimbursements to the private partner. At the core of this issue are the procedural requirements to get funds released. Timely release of funds is inevitably tied to the efficiency of the bureaucracy. In some states the release of funds is timely whereas there are inordinate delays in others. In at least one instance, a state government did not release a grant to an NGO for nearly 13 months. Since the NGO is large and had been long functioning, the agency could withstand the delay. For most agencies, however, such delay would cause closure of the project. The entire issue of timely release of payment appears to be a sensitive one, and the private partners underplayed their difficulties. In the existing partnership agreement there is no mention of the timely release of payments or, in the event of non-release of payments, the consequences thereof. In some projects (Mahavir Trust Hospital in Hyderabad, Emergency Ambulance in Theni), no financial transaction occurs between the government and the private agency.

Another critical issue is related to the difference between the private-for-profit agencies and not-for-profit agencies in terms of the quantum of the grant or budgetary

support. While the for-profit agencies receive full grants or reimbursement, the not-for-profit agencies (NGOs) are not given full budgetary resources. For NGOs, grants from the government are in fact sustenance for their existence. Interestingly, the government on the one hand is circumspect about granting incentives to the non-profit private sector whereas on the other hand there have been excessive concessions to the private-for-profit sector. It would be interesting to examine whether this is due to better negotiating skills in the private sector or due to a philosophical approach towards not-for-profit agencies by the government. There is also a widespread perception that it is acceptable for a for-profit agency to negotiate financial details and profit margins whereas a similar approach by a not-for-profit agency would be spurned. Such distinct differences could be seen from the manner in which the government of Karnataka supports Raichur s Rajiv Gandhi Hospital and the Karuna Trust to run the PHCs. While Karuna Trust is given a maximum of only 90% of the salary costs of staff and other material support, the Rajiv Gandhi hospital gets full reimbursement of all expenses plus a service fee. There are no explicit incentives stated or agreed in any of the partnership agreements. A positive incentive for private partners is that their experience of working with government may help them in securing more contracts in the future.

### **Autonomy**

One of the cornerstones of partnership is the relative autonomy enjoyed by both the partners on day-to-day operations as well as in the overall management of the partnership. Autonomy is seen as non-intrusiveness by the public sector and the freedom of the private agency to take operational decisions without having to resort to cumbersome bureaucratic approvals or being constantly told about do s and don ts . In the partnership projects analysed here, the autonomy of the private agency has not been compromised in the majority of the cases. However, the partnership agreement does provide the government agencies with enormous scope for an active (interventionist) role. Possibly the government agencies lack either technical skills or willingness to take an active oversight role. If the government officials would take a more active role in monitoring and supervising the partnership projects, then an ensuing question could be: what prevents these officials taking similar interest in monitoring the functioning of the government hospitals and its functionaries? In most of the projects the private partners are free to decide what additional services to offer, free to generate additional resources except through user-fees, and free to appoint staff and determine their service conditions. In fact, in Karnataka and West Bengal, the private sector has been influential in shaping the government policy towards the private sector. Given the degree of autonomy of the private sector, the often expressed fear about loss of autonomy by private organisations if they work with the government is misplaced, at least in this context.

### **Technical and managerial capacity**

Public/Private Partnership as a formal policy instrument is at a nascent stage. Many state governments are still organising themselves to engage the private sector effectively. Many continue to experiment with the partnership concept. In states where health sector reform projects had been initiated through funding from the World Bank (e.g. West Bengal, Karnataka, Andhra Pradesh, Gujarat), the states have separate health sector reform cells. Officials in these cells are highly trained in the public/private partnership concepts and systems. But efforts of these officers must be complemented by modifications in the legal and administrative systems in the health departments, which is not easy. Despite these limitations the officers are able to design systems such

as tenders, policy guidelines, requisite forms for financial transactions, performance monitoring, etc. But often officers trained in health sector reforms are transferred out of the department, and the new officials are unable to understand or appreciate the systems developed by their predecessors. Furthermore, lower-level functionaries are either unaware or unskilled in handling the private sector agencies. Similarly the private agency may not be able to understand the more formal and complex rules that bind the bureaucratic system. Bureaucracy requires a great deal of documentation and procedural details that the private sector, especially non-profit NGOs, are unable (or unwilling) to understand. Similarly the NGOs may not be able to calculate the unit cost of their own services or to follow accounting systems as detailed as the government agency would prefer.

### **Quality of services**

One of the major gaps in partnership agreements has been a lack of specific conditions related to the quality of services to be delivered to the beneficiaries. In most of the projects, the importance of delivering quality services is stated, but not in specific terms. Only the SMS hospital mentions that the private agency is responsible for improper contrasts in the CT/MRI images. Although most partnership projects concern primary health care services, specific quality parameters have not been taken into account.

### **Risk-sharing**

Another critical issue in public/private partnerships is the risk vulnerability of the partners. Perception of risk depends on two factors. First, the rule-bound behaviour of the partners with strict disincentives for deviance; the second relates to the notion of trust between the partners. The risks vary at different levels of health functionaries and are also based on the scope of services. At the policy level, the risks are rather political in nature. Popular sentiment (media, political parties, health action groups, staff unions, etc) may forestall the government from making overt gestures towards the private sector, especially the for-profit sector. This constraint is evident in the assumption that the private sector is primarily interested in making profits. Among the poor, the cognitive image of the private sector is that of an exploiter. In the current economic context of liberalisation, where public sector commercial activities are slowly divested from the government control through disinvestment or privatisation, there is a strong suspicion that the government may resort to similar steps in the health sector too.

This suspicion is strengthened by the fact that the government has not been effective in regulating the asymmetrical growth of the private sector in health care and its misdeeds. It is suspected that why a commercial private health sector organization would be interested in delivering health services to the poor without any motive? Private sector, in turn, has shown enormous enthusiasm to collaborate with the government in providing tertiary care services and in medical education (setting up medical colleges). This proclivity again reinforces the image that the private (for profit) sector would collaborate with the government only if there are monetary benefits without having to face any risk. The not-for-profit organisations, on the other hand, are popularly perceived as givers and therefore this image is advantageous for them.

At the operational level, the risks for both the partners are on many dimensions. There are financial risks, performance and accountability risks, risk of confrontation between stakeholders and reputational risks for the private sector. While the for-profit private sector may well be capable of withstanding any financial risks in the implementation of the project, any error by a not-for-profit agency could close down the organization. Accounting systems in not-for-profit agencies are usually not sophisticated so errors lead to administrative strictures or unforeseen complications. The government

agency may have to delay the release of funds until the error is rectified. A crisis of funds at this stage could lead to stoppage of services to the beneficiaries, further complicating the issue. Also, an administrative stricture may lead to audit inspections by the government agencies, thereby denting the reputation of the agency and depriving it from bidding on projects in the future. Another problem is accountability for service delivery for the government is ultimately responsible for the delivery of health services. If any deficiencies are committed by the private sector, responsibility for dereliction of services falls on the government health functionaries.

Coordination between the stakeholders is another area of potential conflict. Differences in personalities and their respective styles could jeopardise the functioning of the partnership. And once the contract expires, would another contractor with similar terms and conditions be ready for such partnership? In Raichur's Rajiv Gandhi hospital, if Apollo Hospitals Ltd does not function effectively, the alternatives available to the government are not evident. At the same time, if the partnership is successful, it is unknown if the government would be willing to extend such a partnership to other places in the state. In the event of the project being unsuccessful, there could be a sense of discomfort that is to say, if Apollo could not, who else could?

Another notion of risk is whether the partnership is based on rule-bound behaviour or on trust. A relevant hypothesis is whether partnership projects run higher risks if the partners are chosen through competitive tendering or through selectively negotiated agreements? Competitive processes cannot easily distinguish those who can perform better or more effectively from those who cannot. The partnership is then based purely on the terms and conditions that were agreed by the partner agencies, and therefore there is no prior intimacy between the partners. On the other hand, selecting partners on the basis of their prior track-records could help in determining the effectiveness of the partners and in making a more judicious selection. Whether non-profit private agencies prefer trust-based partnerships with government or whether the for-profit private sector prefers competitive selection processes requires careful analysis. In the projects documented in this study, many partnerships were generated by relationships. Except in the Andhra Pradesh urban health scheme, almost all not-for-profit partnerships have been based on prior familiarity and trust-oriented selection.

### **Stakeholder Perspectives**

Beneficiaries in all the partnership project sites viewed the services received by them in a positive manner, though often they were not aware of any partnership. In general, feedback from the beneficiaries has been that the services are better now than in the past. Very few patients have been turned away from receiving services. Despite an overall positive feedback from the beneficiaries, some concerns require attention from the authorities. Though most of the concerns are project specific, a common complaint has been about the insufficient availability of drugs, thus forcing patients to buy these from the market. Another concern expressed by beneficiaries as well as private agencies is a lack of clarity about who should pay user-fees and who is exempt.

The main concern of the staff working under the private partners has been that of high workload, long hours of work, lower pay, job insecurity, political interference and staff turnover. The public health staff are not kind in their comments about the private partnership projects, although they are willing to work with them. It has been reported that health services are among the most corrupt civic services in India. However, there were no reports of bribery or corruption in any of the projects.

### **V. Summary and Conclusion**

The research study compiled sixteen case studies that spanned diverse forms of public/private partnerships in the health sector of nine states in India. The case studies represent a wide spectrum in terms of rural-urban mix, for-profit and not-for-profit partners, primary care versus speciality care services, clinical services to insurance schemes, laundry to telemedicine, etc. These case studies provide insights about the manner in which public/private partnerships function in many parts of India.

There is no pattern to indicate whether the public/private partnership as a policy option was guided by donor agencies or due to compulsions of resource constraints or due to competitive bureaucracy. However, public/private partnership seems to have been prompted by visionary personalities from the bureaucracy and from civil society. Our analysis suggests that states that experimented with partnership ideas before formalising a policy seem to be more successful compared to those that promulgated a formal policy without experimentation. Policy pronouncements by government alone are not sufficient for public/private partnerships to succeed. Visionary leadership, social entrepreneurship and relationships based on trust between the stakeholders are equally important for successful partnerships.

There is no uniform pattern to suggest which type of services are to be provided through partnership and what type of services should be off-limits to the private sector. Our analysis suggests that some of the most successful partnerships have been with private non-profit organizations. Lack of success in partnerships was often due to insufficient consultations with facility-level managers. Contracting is the predominant form of partnership, although other forms of partnerships are beginning to attract greater attention. Pre-negotiated partnerships seem to be more effective than competitive bidding. Apparently wherever the partnerships initiatives have been made by the bureaucracy, the success seem to be limited compared to partnerships initiated by the private sector. Poor patients have benefited from public-private partnership. Revenue generated through user-fees is negligible so there is a need to redesign the services towards more acceptable user-fee or else to abolish them.

Capacity of private partners and public sector officials towards managing the partnerships is yet to be fully developed. Public sector managers may perceive the new initiative as a burdensome task, requiring them not only to placate their subordinates but also to seek better performance from their private partners. This is a daunting task. Private partners, who are known for their informal and flexible systems and organizational processes, are uncomfortable with the rigid organizational and managerial processes and procedures of the public sector. Bureaucracy is yet to become conversant in the principles of New Public Management.

Designing partnership (contract) agreements requires sufficient capacity-building measures but central government leadership may not be ideal for achieving this aim. States could create regional resource centres to develop these capacities locally. The approach towards pricing of tariffs for services (both in block grants or in case-based reimbursements) is based only on competitive tendering process rather than on a standard calculation of competitive rates. Similarly the payment system is mired in red tape that impedes successful partnerships.

Policy innovations such as public/private partnerships are, of course, highly contextual. Partnership with the private sector is not a substitute for the provision of health services by the public sector. Also, public-private partnership initiatives cannot be uniform across all the regions or suitable under all kinds of political and administrative dispensations. While private partnership is an administrative decision, an obvious but important point is that it must enjoy political and community support. In states where the private sector is prevalent, partnership initiatives could be an alternative, not necessarily

because of competitive efficiency but to prevent further immiseration of the poor and the deprived sections of society. There has to be a clear rationale for partnering with the private sector. It is important to understand not only what services are to be provided under private partnership but also to understand the basis on which such decisions are made.

Any policy initiatives to strengthen the flagging public sector health services in India would be welcome. But a government that fails to deliver quality social services due to lack of basic administrative capacity would not be able to contract either clinical or nonclinical services. The first step must be to improve basic administrative systems.

## VI. References

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17. Factors that Frustrate Growth of the Private Sector Health Insurance in India – C V Ramana Reddy
18. Health Financing – Need for Regulated Development: Current Experience in India – Ajit Sharan
19. Reform Born in Private Sector with Globalization – Jonathan Lewis
20. Health Insurance in India: Prognosis and Prospects – Randall P Ellis, Moneer Alam, Indrani Gupta.
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