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Public Private Partnerships in Health:
Threat or Opportunity?

Why public-private partnerships?

The Government of India has been building a large and inclusive public health system to deliver comprehensive preventive and curative health care services in pursuance of its commitment to provide acceptable, affordable, and sustainable healthcare to all. These efforts have led to significant improvements in select health indicators, but rates of fertility, morbidity, and child and maternal mortality are still among the highest in the world. Disparities are stark, with the poorest 20% of Indians having more than double the mortality rates, malnutrition, and fertility of the richest quintile and public health subsidies disproportionately distributed in favour of the rich. In the most populous and poorest states, the public system does not reach even a quarter of the target population and analysis shows that the private sector in India more widely provides about 50% of all inpatient care and up to 80% of outpatient care. Other reviews have shown that the private sector caters to large numbers of both the rich as well as the poor.

In this landscape, collaboration with the private sector has emerged as an avenue to plug gaps of availability and accessibility of the public health system. Several Indian policy documents now speak of the need to co-opt the private sector to meet the commitments of the government on public health. The 11th Five Year Plan, the Report of the National Commission on Macroeconomics and Health, and the Mission Document of the NRHM propose that the government undertake judicious partnerships with the private sector to provide health care to those in need of it.

It is expected that since the government already has an extensive infrastructure in place, the private sector will be able to assist and complement it with the input of other resources to make the system deliver effectively and efficiently. The establishment of public private partnership (PPP) is seen as a mutually beneficial arrangement, wherein the public sector receives an infusion of capital and skilled human resource, and corporate houses and private foundations get government backing and consequently, credibility as a partner in national health programmes.

How does it work?

PPP leverages the synergies of the public and private sector (comprising of both not-for-profit and for-profit organizations involved in health care delivery) in meeting public health goals. Within its scope fall several arrangements of various sizes, forms and span at a global, regional or country level. At one end of the spectrum are transnational partnerships involving complex groupings; they may bring together several governments, local and international NGO, research institutions and UN agencies. At the other end, individual governments form partnerships with the for-profit private sector. There are also examples when a government partners with a (small) NGO with a particular technical strength or outreach capacity. PPP models can be described based on one or other characteristic of the arrangements reached between the public funder and the private provider such as institutional structures, reciprocal arrangements, payment mechanisms etc. Seen through an institutional lens, PPP can be described as follows:

Equity arrangements	Improving facility functioning by privatising existing facilities through a joint venture
Contracting in	Enhance delivery of services by contracting a private enterprise to carry out the service within a public facility
Contracting out	Improve services and product availability through contracting delivery at a facility of a private enterprise
Social franchising	Increase availability and access to services and products through exclusive arrangements at a franchisee facility
Social marketing	Use community marketing strategies to improve access and avaiability of health products in the population

PPP in practice: What is being done in India and other countries?

Although the earliest example of a PPP initiative in health can be traced to the 1960s with the social marketing of condoms, PPP began in real earnest in India about 10 years ago in national and state health programmes. Some of the current initiatives are delineated below:

State	Project	Key features
Uttar Pradesh	Health posts in remote/ unserved areas by NGO	NGO have been selected by IIM, Lucknow to support 195 health posts in 28 districts. This initiative has provided curative services to 1,40,000 clients i.e. 16% of project population & institutional delivery has reportedly increased 5 fold in these areas.
	Clinical RCH services through NGO	Ongoing with 20 partner NGO covering 72,00,000 population spread in 42 blocks across 12 districts. Key services: distribution of contraceptives, antenatal care & infant immunization. The project has trained 7494 ASHA.
	Social franchising in health	Supported by SIFPSA & implemented by HLFPPT as the franchisee, the project is responsible for developing, managing & sustaining the Merrygold health network in rural, semi urban, urban slum populations of the state which comprises Merrytarang, Merrysilver clinics & Merrygold hospitals. So far, 8 hospitals, 68 clinics & 967 Tarang partners have been franchised in 7 districts. The private partner provides routine health care, specialized health care, family planning, immunization, diagnostics, public health programmes (DOTS and ARV), chemist shops, health insurance & telemedicine.
	Saubhagyawati Scheme	Specifically directed at BPL families & funded through the NRHM, this scheme promotes institutional delivery under JSY. So far, 7 nursing homes have been accredited in 7 districts.
Gujarat	Chiranjeevi Yojana	Services of gynaecologists & anaesthetists from the private sector hired to conduct institutional deliveries in government facilities. The project has achieved significant success to fill the gaps due to insufficient availability of these specialists in government health centres.
West Bengal	Emergency medical services, diagnostic services, drugs, health centre management	Through German Financial Cooperation, a PPP was set up with a mandate to improve basic health services in 8 districts covering 4 components: provision of community based ambulance services for emergency transportation; provision of diagnostic services and Block PHC & Rural Hospitals; management of sub-optimally functional PHC by NGO; & procurement &supply of generic drugs increasing availability and accessibility of drugs
Orissa	Contracting out Primary Health Centres	Management & operations of some of the worst performing PHC have been handed over to private players. The government provides the building, equipment, furniture & supplies. So far, 3 PHC managed by an NGO and 1 PHC contracted out to a corporate agency. Additionally, 32 PHC in the process of being handed over to NGO.
	Contracting out Urban Health Centres	11 Urban Health Centres contracted out to NGO in Rourkela, Balasore, Bhubaneswar, Sambalpur and Cuttack. The NGO provide primary health services including outreach by their staff.
	Private agencies co-opted under the malaria control programme	Provision of outreach services, microscopy & treatment services, promotion of insecticide treated bed nets, larvivorous fish, & indoor residential spraying. Partnerships with 42 NGOs have been established in 6 districts
	Janani Express	Provides round-the-clock transportation to pregnant women for institutional deliveries & to sick infants. This scheme is being implemented in 124 blocks where the delivery load is 50 or more per month.
Delhi	Partnerships for diagnostic services	9 District Health Societies have partnered with private diagnostic centres & radiology units to provide diagnostic facilities at the PHC level to minimize referral to secondary level facilities & overcrowding of hospitals. Also envisages utilization of spare capacity available in the private sector to reduce out of pocket expenditure on health care.
Madhya Pradesh	Janani Express	Provides ambulances at door step on payment.
Andhra Pradesh	Emergency Medical Relief Programme	With provision of ambulances & human resources from public funds & Satyam Computers, the mandate if to provide 24x7 services free of any charge to provide emergency response services through well trained people; to provide first-aid services and pre-hospital care during emergency transportation. With 3195 field staff in position, the programme is attends an average of 4500 emergencies per day.
	Urban Slum Health Care Project	192 Urban Health Centres have been set up in 74 municipalities with the objective of providing primary health care to the urban poor in slums 192 NGO across the state to manage the Urban Health Centres.
	Janani Programme	An immunization booth has been set up in each habitation with the coordination of ANM, AWW, SHG and Sarpanch to strengthen the mother and child care programme.
	European Commission assisted Sector Investment Programme/Expanded Sukhibhava Scheme	Implemented to improve institutional deliveries, a cash incentive of Rs.300 is paid to the BPL women who deliver in certified private hospitals.

The success stories of PPP initiatives in developed countries are well documented; however, little documentation exists of such initiatives from developing countries. Two such initiatives are described below:

Bangladesh offers an example of how contracting with NGO and for-profit sector can be effectively improve service delivery in low income countries.

The World Bank financed Bangladesh Integrated Nutrition Project (BINP) has provided nutrition services to about 10 million in rural areas to improve nutrition practices. Implementation wwas carried out by an NGO through a large number of female Community Nutrition Promoters and provided management support in the field.

The Asian Development Bank financed Urban Primary Health Care project (UPHCP) is providing primary health care to a population of about 4 million in 4 large cities. Under the UPHCP, city corporations of Chittagong, Dhaka, Khulna, and Rajshahi contracted NGO to deliver urban PHC services. The experience of UPHCP demonstrated that competitive bidding based on both quality of technical proposals and price is feasible. This approach has resulted in low cost that is sustainable by government. The experience in Bangladesh has also highlighted that bidding procedures must be clear to all the stakeholders; that it should be done for clearly delineated packages; and that outside experts should be involved in the process of bid evaluation.

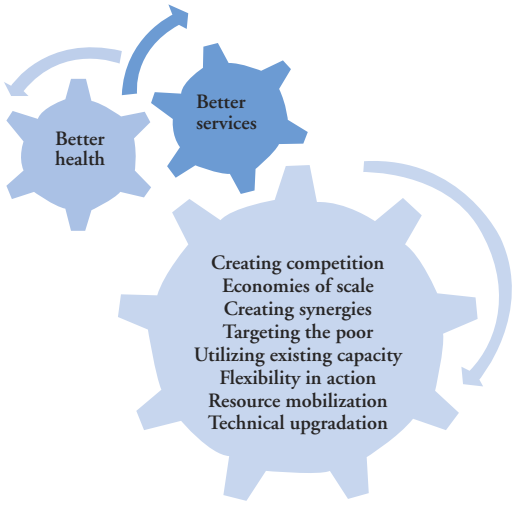
Successful PPP initiatives of developed countries

- Privatization of outpatient dialysis services, Romania
- Catering at the Charite Clinic, Germany
- Shared regional hospital sterilization service, Austria
- National E-Health Portal, Denmark
- Better IT for Better Health, Germany
- Holistic care centre Waldviertel, Austria
- Privatization of St. Gorgan's Hospital, Sweden
- Build Own and Operate PPP at Berlin-Buch Hospital, Germany
- Comprehensive PPP Programme, Portugal

Cambodia: A large-scale quasi-experiment in contracting with NGO to provide primary health care in 9 rural districts of Cambodia took place between 1999 and 2001. The contracts specified targets for maternal and child health service improvement. The programme increased the availability of 24-hour service, reduced provider absence, and increased supervisory visits. There is some evidence it improved health. The programme resulted in increased public health funding which was roughly offset by reductions in private expenditure as residents in treated districts switched from unlicensed drug sellers and traditional healers to government clinics.

What are the benefits and concerns relating to PPP?

There are divergent perceptions of the desirability and viability of PPP for health in India. While resource constraints make pooling of capabilities and resources necessary, the benefits of such initiatives also package complex ethical and process-related challenges. It is widely expected that public-private collaborations could improve efficiency of the health sector by ensuring availability of affordable health care to the community and provide several other benefits as described in the diagram.



On the other hand, concerns have been expressed by many regarding the ability of private partners to provide for public interests. Some key concerns are:

Equity: It is important for partnership arrangements to ensure that the profit motive alone does not guide the interest of the private sector and exacerbate health inequities. Thus, partnership guidelines should be in consonance with the profit motive of the private partners as well as treatment needs of the poor.

Full scope health delivery: In its natural state, the private sector focuses principally on curative care and diagnostic services while preventive and promotive care is left to the public sector to address. This can lead to gross inequities and moral hazard issues in full scope projects of contracting out

health facilities especially at the primary and secondary levels of the system.

M&E and social auditing: The interface to the private and public system is opaque and requires careful auditing to ensure adequate monitoring of both performance and results. It is necessary to evolve a mechanism for social auditing to ensure that equity and quality are not compromised.

Lack of a regulatory framework: In this evolving field, it is clear that much further work is needed to define systems to overcome challenges relating to fund flow, logistical management, mutual trust, transparency, and sustainability of PPP initiatives. Further, in light of the incentive system, regulating principles become imperative.

Dispute redressal mechanism: Effective dispute redressal mechanisms are necessary, particularly in view of the large disparity in size and influence of the public and private partners. Such disputes, if left unattended, would diminish the ability of the PPP initiative to deliver effectively and efficiently.

What are the main lessons that emerge?

Experience in the health sector has shown that the identification of a clear task including identification of the appropriate target population, the scope of partnership, selection of the right partners and appropriate model of PPP is crucial. Models should be framed on the basis of the desired outcome from the system. The main questions, therefore, would revolve around what is the most effective way to improve coverage, reach, quality of service and cost.

A key characteristic is the degree of aggregation of the payment unit. As the payment unit becomes more and more aggregated, the financial risk of the provider increases. This may lead to escalation of bid price and difficulties in ascertaining performance. Competition among providers tends to improve performance of payment mechanism.

In the absence of much hard evidence and lack of experience in developing and administering partnership instruments, there should be mechanisms to innovate and evaluate. The approach would have to be based on fewer directives with more emphasis on dialogue among partners.

The emphasis must be on partnership with clear delineation of roles so that the focus is on health care provision of assured quality. The public sector partner would have to ensure that its monitoring, regulating and enforcement roles are recognized and effectively undertaken. Skilled management and solid information systems are essential under any payment mechanism. Quality assurance of programmes is essential. A crucial parameter would be to ensure accountability of private providers and support of all the key stakeholders through IEC and advocacy.

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