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REVIEW ARTICLE

Role of Public–Private Partnerships in delivering Health Care Services in India

[1]Ruchi Tanwar, [2]Rakshita Ojha, [3]Medhavi Agarwal, [4]Arun Singh, [5]Hari S Joshi

ABSTRACT

A public–private partnership (PPP) is a contractual arrangement between a private sector and a government sector. Through this agreement, the skills and assets of each other are shared in delivering a service or facility for use of general public. In recent years, there have been many initiatives to improve the efficiency, effectiveness, and equity in provision of health care services in the country. Public–private partnership is one such initiative. Public–private partnership is the first step toward the health care services to improve quality, efficiency, accessibility, availability, acceptability, and equity of the services. It strengthens the existing health system by improving management of health within the government infrastructure and mobilizes the additional resources. Private sector is the most important source of health care services in India, providing maximum health services to the population. In absence of effective public health system, majority of household seek health care from nongovernment sectors. Various partnerships are being pursued under the existing program of ministry, especially RCH-2, independently by the state under their own resources.

Keywords: Contracting in, Contracting out, Public–Private partnership.

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INTRODUCTION

The public–private partnership (PPP) is a main initiative to improve efficiency, effectiveness, and equity in the provision of health care services. This review article comments on the lessons that should be learned from some examples of such partnerships in various Indian states.

In India, the private sector is the first most important source of health care services providing nearly 80% of all services, according to the government's own computation. A related fact is that majority of health-related expenses are out of pocket and occur at the point of service delivery.[1]

Before considering emerging PPPs in health in India, it may be worth recalling that health care has historically (even in developed nations) been a private sector activity. There is a recent initiative by the government that emphasizes on its responsibility for providing or supporting health care services for the entire population. World look up to the National Health Service in the United Kingdom as the model for delivering universal and comprehensive health care services, which was established only in 1948, after World War II.

In India, starting from the Bhore Committee report in 1946, there has been an increasing emphasis on the state providing health care services through a three-tiered approach. However, despite these efforts and despite many health care and family welfare plans and programs made since then, health outcomes in India have remained closer to those in sub-Saharan Africa than in industrialized nations among which India would like to be counted. The aim of PPP is to harness the large pool of private sector health care resources and draw them into the process of nation building.

A major difference in the PPP approach in India today and earlier such initiatives around the world is that those were implemented in times of economic crisis when state funding for the health sector needed to be reduced. India, on the contrary, is experiencing unprecedented economic growth and there has been an explicit commitment to increasing state funding on health from 0.9% to 2 or 3% of the gross domestic product.[2] Thus, the first and main reason to encourage private participation does not appear to be a lack of funds but a lack of managerial and technical ability.

It is too early to say whether these experiments have achieved the expected results of efficiency, effectiveness, and equity. However, it may be useful to look at examples of PPPs in different Indian states to learn some lessons before it is too late.

Bihar was one of the earliest state governments to start PPPs since the National Rural Health Mission (NRHM) was announced. At some places this was introduced to provide pathology and diagnostic services, operate ambulances services in the state, and run additional primary health centers. The ambulance contract got suspended

[1,2]Postgraduate Student (1st Year), [3]Assistant Professor [4]Professor, [5]Professor and Head

[1-5]Department of Community Medicine, Rohilkhand Medical College and Hospital, Bareilly, Uttar Pradesh, India

Corresponding Author: Rakshita Ojha, Postgraduate Student (1st Year), Department of Community Medicine, Rohilkhand Medical College and Hospital, Bareilly, Uttar Pradesh, India Phone: +919997987457, e-mail: rakshitaojha5may@gmail.com

as it ran into trouble right at the outset. The pathology laboratory started contracting out the work.

Yet another story relates to partnerships to run additional primary health centers. In 2006, 30 to 35 such clinics were handed over to nongovernmental organizations (NGOs). Some complaints were heard that the government did not release money on time, or that the funds being given to NGOs were much less than what being spent in a similar government institution. Later it was realized that these contracts were not renewed.

The most noticed PPP in the country today is the Chiranjeevi Program launched by the Gujarat government. Gujarat is one of the most industrialized states in the country and a major hub of the pharmaceutical industry. Field experience tells us that, despite official figures to the irreconcilable, the state's maternal mortality ratio is high, reflecting poor access to health care.

Contracting is the predominant model of PPP in India. Under this system, states are trying contract in and contract out, outsourcing, management of hospital facilities by leading NGOs, hiring staff, service delivery including family planning services, medical termination of pregnancy, treatment of sexually transmitted infection/reproductive tract infection, etc. Franchising and social marketing of contraceptives are already built into the family welfare programs.[3]

Few important examples of use of PPP models in health sector are[3]:

- The immunization and polio eradication program effectively make use of World Health Organization (WHO), UNICEF, the rotary international, NGOs, etc.
- Under Janani Suraksha Yojana (JSY), private facilities have been accredited for institutional deliveries.
- The disease control program (tuberculosis, leprosy, blindness, cancer, HIV, AIDS, etc.) make use of NGOs in a big way.
- The professional bodies like FOGSI, IMA, IAPSM, IAPH, and IAP have been involved in building awareness, advocacy, training programs, and mass campaign.
- The growth of private hospitals not for profit centers and diagnostic centers was also encouraged by central and state governments by offering tax exemptions and lands on concessional rates, in return for provision of free treatment for a poor as a certain proportion of outpatients and inpatients.
- Apart from subsidies, private corporate hospitals receive huge amount of public funds in the form of reimbursements from public sector undertaking, the central and the state governments for treating their employee.
- The NRHM attempts to provide people-friendly regulation framework that promotes ethical practice in the nongovernment sectors.

Such efforts involve system of:

- Accreditation
- Standard treatment protocol
- Training and upgradation of skills of nongovernmental providers.

Overall, these efforts increase the quality of life.

There is also a great disparity between districts in access to health care. The state government introduces an ambitious scheme to ensure institutional deliveries for the poor through the active engagement of the private sector. In a pilot study, obstetricians in five districts were offered a financial package of roughly ₹ 1.75 lakh for every 80 to 100 deliveries they conducted. This amount was arrived at by proportional costing of a vaginal delivery, an assisted delivery, and one with a lower segment cesarean section intervention. The first year of the program has been completed and it is now running all over the state.[4]

The scheme sounds remarkably simple in its conceptualization and delivery and also typifies what may be called a win–win situation. The state issues a service voucher worth about ₹ 2,000 to each poor pregnant woman and ensures that the provider is reimbursed: It is something like a prepaid taxi service, but you do not have to pay for the receipt. But some negative effects have started coming in, and certain design elements may be of greater significance, such as the process of appointing obstetricians does not include any quality parameters. In other words, though we know that the majority of maternal deaths take place in the postpartum period, no quality criteria had been laid down for postpartum institutional care that would be mandatory for normal, assisted, or cesarean delivery.[4]

The financial dimensions of this arrangement are also worth examining. Assuming a population of 10 lakh for an average district and a poverty level of 33%, one can expect around 8,000 childbirths among the poor in the district each year. Under the Chiranjeevi Program, a total of up to ₹ 1.5 crore will be provided as cash vouchers to ensure institutional delivery for all poor women.[4] This reasonably large amount to be shared by 100 obstetricians practicing in the district is effectively taken away from strengthening services at the primary health center and community health center services that would have provided services for diarrhea, tuberculosis, malaria, hepatitis, chikungunya, and a host of other health conditions – besides ensuring safe deliveries. But then, as we mentioned earlier, this is a time of economic prosperity and it is possible that this additional sum will not take away from what is necessary to strengthen the system.

It has been reported from Gujarat that government centers are referring easy cases to private practitioners; private practitioners refer difficult cases to district hospitals. Government centers were not willing to operate

outside fixed hours (and deliveries take place when least expected) and obstetricians under the government contract do not want to handle complications.

Another scheme, the VandeMataram scheme, launched with much fanfare by the then Union Health Minister in collaboration with the Federation of Obstetrician and Gynecologists Societies of India, died an unsung death because it depended on obstetricians providing free services to the poor on one designated day of the week.

As the bulk of poor Indians seeking care visit the private sector, efforts to include the private sector within a formal planning and monitoring system for health care service delivery through the PPP approach should be welcome. However, current efforts are not up to mark on many counts and the problems must be addressed if a robust, accountable, and quality PPP mechanism has to be developed. Some parameters that need to be introduced are:

- Setting up a collaboration of technical and ethical parameters and standards for service delivery common to different levels of health care system. A start has been made with the Indian Public Health Standards and these should be applicable to both the public and the private sectors.
- There must be new regulatory parameters for the health care system, including the pharmaceutical industry which is among the least regulated in India.
- The value of health care should be regulated just as other consumer products are, through a system of maximum prices.
- A well-to-do monitoring and enforceable system should be introduced of penalties for breach of regulations and standards.

The WHO aims in establishing partnerships through partnership. The WHO seeks to:[5]

- Encourage industry to abide by the health-for-all principles
- Facilitate universal access to essential drugs and health services
- Accelerate research and development in the fields of vaccines, diagnostics, and drugs for neglected diseases
- Prevent premature mortality, morbidity, and disability by giving special attention to policies and behavioral change
- Encourage industry to develop products in ways that are less harmful to workers and the environment
- Acquire knowledge and expertise from the commercial sector
- Enhance WHO's image among typically hostile constituencies.

One hopes that the poor will then receive the services they need and at a cost they can afford, and providers will receive a fair compensation for their services.

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