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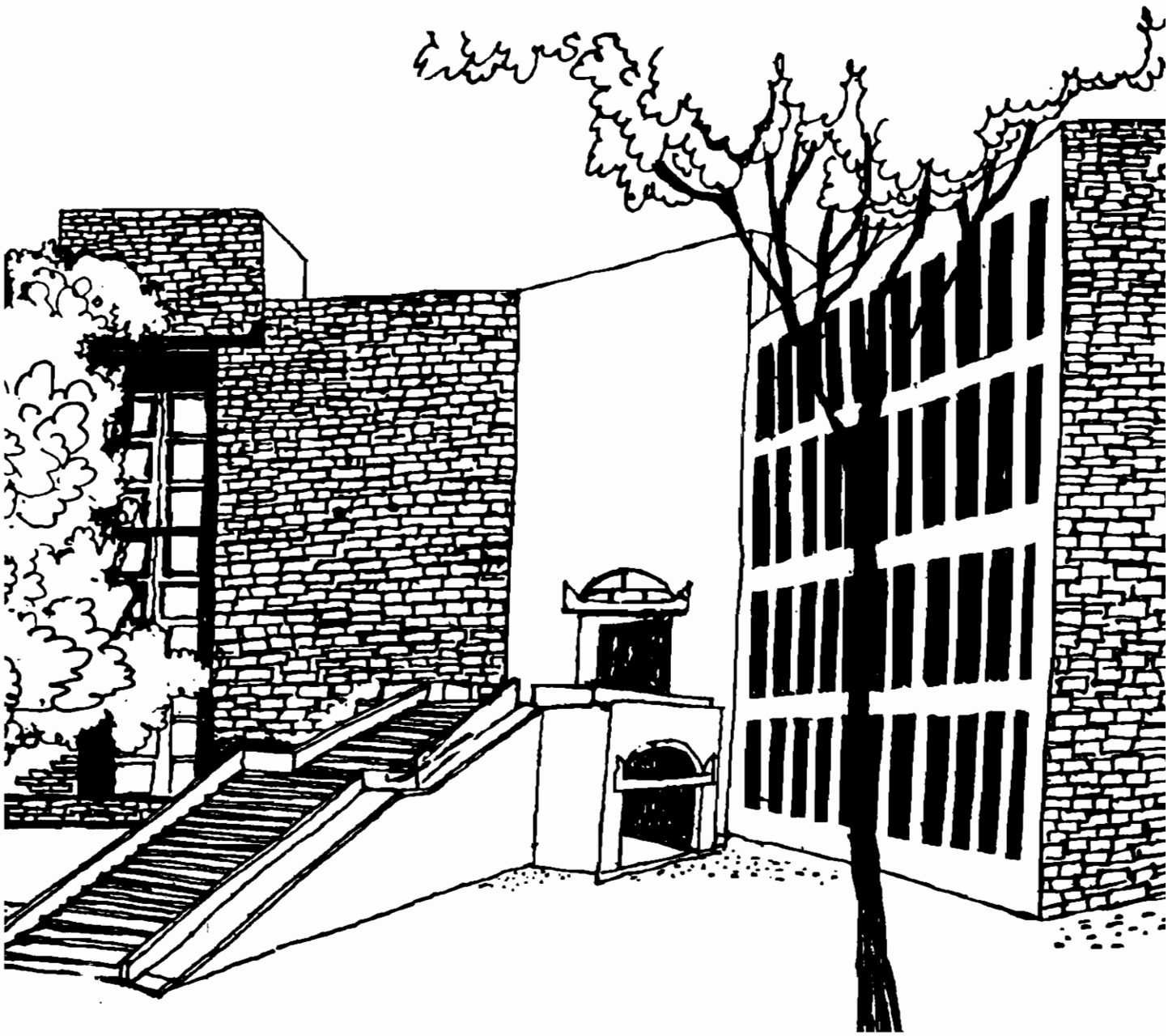

PUBLIC-PRIVATE PARTNERSHIPS IN HEALTH SECTOR: ISSUES AND PROSPECTS

By

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Abstract

The paper discusses selected cases of private-public partnerships, which have recently been initiated by several state governments in India. The analysis of these initiatives suggests inadequacies of proper institutional mechanisms to implement the private initiative policies effectively. The discussion brings out number of policy and management issues in developing and implementing these options. It has been argued that there is need to have "public policy towards private sector" and this policy framework should have sector-wide (addressing both public and private sector roles together) focus. The policy, *inter alia*, should address the question of public-private mix in health sector, scope of private-public partnerships, role of subsidies and incentives in promoting these partnerships, addressing issue of protecting the public sector from any reduction in budgetary allocations. Further, the paper points out that the success of any private initiatives critically hinges upon number of factors. There is need to have explicit, transparent and adequate mechanisms which ensure: involvement of all stakeholders in the process; co-ordination across various departments within the government and various implementing agencies; ensuring availability of critical resource such as qualified manpower; appropriate monitoring and governance system; provision of adequate information to all participants; institutionalisation of appropriate management structure to handle new tasks; and strengthening public systems. These are considered necessary pre-requisites for evolving effective public-private partnerships. The role of regulatory mechanisms to ensure proper standards of care is also considered important. All these suggest the need for a number of policy measures.

1 Introduction

With the shrinking budgetary support and fiscal problems, most of the state governments are finding it difficult to expand their public facilities to cater to the growing health care needs of their population. In terms of resource allocation, the most affected areas are the secondary and tertiary care. The difficulties experienced in providing health care specifically in these areas have compelled many state governments to explore alternative options. Having experienced significant growth in private sector at curative primary and secondary care, some of the state governments are exploring the options of promoting the public-private partnerships (PPPs) in health sector. Most of these options are being explored in the areas of curative and tertiary care, and provision of medical services in remote places.

The objective of this paper is to discuss and analyse the policy initiatives of selected state governments and MoHFW, GoI in India in developing these partnerships. The next section of the paper describes the policy context and discusses health financing scenario in India. Following this, in section 3 of paper, various initiatives of state and central governments have been described in brief. The cases discussed in this paper do not constitute exhaustive list of all PPPs. The cases selected for the analysis are based on the availability of data and have been used to describe broad nature of the PPPs initiated by the government agencies. Last section discusses the implications and summarises important issues and prospects of developing such public-private partnerships in India.

2 Policy context

In 1993-94 health expenditure as per cent of GSDP of fourteen major states in India has been around 1.1 per cent (World Bank, 1998). No doubt that the government budgetary allocations to health are low. Health delivery system having components of primary, secondary and tertiary levels need significant resources to maintain an appropriate balance at various levels to meet the health care needs of population. The budgetary allocations to

health have not kept pace with the growing requirements of the health sector. With the intensification of technological developments, the low budgetary allocations in the recent times have created serious imbalances at various levels in public health care delivery system. The areas of health care delivery system which have been seriously affected are curative and super-speciality care. The growing complexity of health sector programmes has also given rise to need for more resources. For example, the ability of government facilities to provide basic health care facilities in remote areas remains less than satisfactory. One of the important aspects missed in planning the curative health delivery system has been ensuring appropriate geographic spread of various types of health facilities within each state. Most of the curative health facilities are concentrated in urban centres. Therefore, there is wide gulf in the availability of curative health facilities in urban and rural areas. Most of the tertiary health facilities provided by the government are extremely limited and they have remained concentrated in the state capitals.

The epidemiological transition and changing health needs of the community are becoming major concerns and these are putting considerable pressure on the public system to meet the growing challenges. India is going through health transition. The non-communicable diseases are becoming a major threat. The health infrastructure at present is not geared to handle the load emerging from this changing disease pattern. The gains made in controlling the communicable diseases are likely to be completely offset by this change (Reddy, 1993). With these developments, there are considerable demands on the government to expand and up-grade their facilities to meet the health care requirements of population in curative and tertiary areas. Initiatives with the loan from World Bank are under way in four states to strengthen the secondary care system. Private sector is also becoming major provider of services in almost all states in India. However, it is increasingly being felt that because of the negative consequences of private sector growth and the absence of regulation to monitor their costs and quality, the other options need to be explored. Moreover, the unintended consequences of private sector growth are becoming quite evident, as many people from lower income strata are not in position to avail these facilities or those who avail are doing at catastrophic financial costs. The

exiting medical insurance mechanisms are too expensive to have wide acceptance and willingness to pay. The existing insurance policies are more in the form of reimbursement schemes and do not guarantee the availability of services when one is in need. Therefore, these initiatives have very limited coverage. The private sector infrastructure is also not geared to handle to new demands arising out of development of insurance mechanisms. There is pressure on many state governments to consider having some protection mechanisms in place for groups of population belonging to lower income strata. For example, the states of Goa and Maharashtra have already initiated schemes to protect population from lower income groups (Whyatt and Bhat 1997). In other states such as in West Bengal, government is considering using State Sickness Fund to protect the poor from catastrophic financial burdens arising out of illness. However, the process of implementing these schemes has remained less satisfactory. What are other options?

The expansion of tertiary and modern curative facilities needs considerable amount of resources. Most of the State Governments' budget experiences suggest that a major component of budgetary allocations is bare minimum to meet the recurrent expense requirements. In most states the salary and wages account for about 70 per cent of the total health budget. Emanating from financial crunch and fiscal problems, many states also experience a reduction in allocation of resources to the health sector. The overall effect of this has been the reductions in non-salary component of health expenditures, also salary crowding out other uses and growing arrears. The financial and fiscal pressures have also put considerable amount of pressure on capital expenditure. This is evidenced by the fact that the growth rate of capital expenditure of government on social sectors overall has shown a declining trend during the recent periods. For example, during the period 1986-87 and 1990-91 this rate has been -3.5 per cent (Rao and Sen, 1993). Whereas during the same period, the revenue expenditure has exhibited positive growth of 5.4 per cent. The share of capital expenditure in total health budget has remained very low and the data suggest a declining trend during the recent years. Analysis of two states Punjab and Rajasthan indicate that the average capital expenditure on health respectively has been around 5.5 and 2.5 per cent of the health sector budget (see Table 1). The overall impact

of these financial constraints is that quality as well as quantity of curative health care has suffered. Most states in India are under pressure to find alternative mechanisms to provide better curative services to their populations and to develop mechanisms to reach to the poor in remote areas.

There have been attempts to augment the resources of health facilities through the introduction of user fees. These attempts have not produced any significant result. The figures on all-India basis suggest that during 1992-93 the average hospital receipts amounted to about 1.4 per cent of the total hospital expenditure incurred by the hospitals (NIPFP, 1995). For 15 major states in India the average cost recovery has been about 3.8 per cent. Punjab tops the list with cost recovery of 7.7 per cent and Rajasthan averages at 2.8 per cent (World Bank 1997). In most cases, the state government treasury rules do permit the facilities to retain the user fees. This defeats the main purpose of implementing the user fees policy in public facilities as the policy does not facilitate the use of these funds to improve the quality standards of health facility. There are also various other management issues such as lack of proper guidelines; lack of appropriate management systems such as accounting, reporting, monitoring; effective exemption policy etc., in implementing the user fee policy (Bhat and Sharma, 1997).

The involvement of private sector in health sector is another option, which is being explored by number of states in India to mitigate the problems of adequate resources in curative and tertiary care. The role of private sector to augment the supply of necessary services in remote areas is also one of the policy initiatives being implemented in number of areas. The severity of financial crunch in health facilities particularly in super-speciality care was recognised in 1982 in the National Health Policy (NHP) of the Government of India. The policy recognized that the State and Central governments responsible for maintaining public health face many financial constraints in their objective of providing effective and efficient health care services to their population. To mitigate the problem of resource crunch, the policy document had recommended that the States should design processes which encourage the establishment of practice by private medical professional and investment by non-government agencies in

establishing curative centers. The policy statement had also recommended the following: *"...planned attention would also require to be devoted to the establishment of centers equipped to provide specialty and super-specialty services, through a well dispersed network of centers, to ensure that the present and future requirements of specialist treatment are adequately available within the country."* The policy document of the GoI had also suggested to reduce the government expenditures involved in the establishment of such centers and had proposed a planned effort to be made to encourage private investments in such fields so that the majority of such centers, within government set-up, can provide adequate care.

Towards implementing this policy, the government in the beginning evolved an instrument of providing duty exemption on imports of medical equipments. One of the major problems in expanding the super-specialties care in early eighties was almost non-existing manufacturing base of producing such technologies that were used in super-specialty care. A large number of equipments and machines were imported. The duties for importing such equipments were significantly high in the range of 150 to 300 per cent. To promote the growth on investment in health and super-speciality care, the Government of India provided duty exemption for the import of medical technology to the health care institutions in non-government sector having status of charitable institution. This policy initiative of the government has gone through number of changes over the period. For example, the overall duty structure has been substantially reduced in recent budget announcements. This has been in line with the liberalisation programme of the Government of India since 1991. By middle of nineties the domestic industry for medical technologies had also grown. For example, in 1994-95 budget, the following policy change was made regarding the import of medical equipments *"...the present import duty structure for medical equipments is complex and involves in some cases time consuming administrative procedure. The domestic industry is also not able to compete with imported equipment because it is now available duty-free to hospitals on production of certificates by designated authorities."* The budget then proposed abolishing the system of certification for charitable hospitals and allowed import of specified medical equipments at 15 per cent. Import facilities at zero-rate for government hospitals and for all specified life saving equipments, however, continued to exist. Overall, the import duty on various other medical

equipments, which was 85 per cent, was reduced to 40 per cent. Components for their manufacture were allowed to be imported at 15 per cent customs duty.

Over the period, the private health sector growth has been considerable in both provision and financing side. The recent health financing pattern suggest that out-of-pocket cost on health accounts for about 78 per cent of the total expenditure on health in the country (World Bank 1997). The private health expenditure in India is estimated to be about 4.25 per cent of the GDP. Insurance coverage mechanisms are negligible and most of this expenditure is out-of-pocket. The private health care expenditure in India has grown at the rate of 12.5 per cent per annum. For each one percent increase in per capital income the private health care expenditure has increased by about 1.47 per cent (Bhat, 1996). The share of private sector in health infrastructure is also quite significant. About 57 per cent of hospitals and 32 per cent of hospital-beds are in the private sector. The share of private sector investment in health infrastructure e.g., hospitals, investment in medical equipments and technology etc. is also quite significant. Most qualified doctors work in private sector. The data suggest that at present about 80 per cent of 390,000 qualified allopathic doctors registered with medical councils in India and 650,000 providers from other systems of medicine are working in the private sector. The dependence on private sector is, therefore, considerable. Utilisation studies also show that 1/3rd of in-patient cases and 3/4th of out-patients utilise the private health care facilities (Duggal and Amin, 1989; Yesudian, 1990; Visaria and Gumber 1994).

Given the role of private sector in health, various State governments are exploring the options of involving private sector in meeting growing health care needs in various areas. Private-public partnerships have emerged as one of the options to influence the growth of private sector with public goals in mind. For example, some of the policy initiatives such as developing incentives system to influence the desired geographic distribution of health facilities and in specified areas; and involving qualified providers through contract mechanisms in rural areas to improve the health delivery care system are some of the

options being explored. In general, the focus of various private-public collaborations has been on:

- Developing strategies to utilise untapped resources and strength of private sector with public goal in mind
- Enhance the capacity to meet growing health needs
- Reduce financial burden of government expenditure on speciality and super-speciality care
- Reduce regional and geographic disparity in health care provision and ensuring access
- Reaching to remote areas or targeting specific groups of population
- Improving efficiency through evolving new management structures

The next section examines some of these initiatives.

3 Public-private partnership initiatives

This section describes various initiatives in developing public-private partnerships in health sector. Table 2 summarises the characteristics of three important policy initiatives of state governments of Punjab, Rajasthan and Delhi in developing these partnerships. The other initiatives discussed are the involvement of NGOs and industry in managing public health facilities and involving qualified doctors in provision of health care in rural areas. Some of these initiatives also describe the reasons for initiating such private-public partnerships.

3.1 Offer of sites for specialised/super-speciality hospitals in Punjab

Government of Punjab evolved an initiative in public-private partnership by offering subsidised land to private sector to set up tertiary and super-speciality health facilities. Punjab Urban Development Authority (PUDA) through advertisement in November 1995 invited bids for the allotment of sites for setting-up specialised hospitals in urban estate of SAS Nagar (adjoining area to the capital city Chandigadh). The bids were invited for six locations having land area of 5 acres and 10 acres. The medical degree qualification or having requisite experience in the filed of health care was set as main eligibility criterion. Financial capability in setting up a hospital was also included as one of the important

requirements. In response to their advertisement, PUDA received bids from 20 respondents out of which 12 were short-listed. The short-listing was made with view to hold further discussion. Large corporate houses and a well know pharmaceutical companies were among the applicants.

This initiative did not result into any workable arrangement or collaboration with the private sector. The preference for a particular location by all bidding institutions was cited as the reason for non-acceptance of offers. The government also experienced that number of short-listed organisations did not have adequate experience in health and therefore the government was reluctant to offer land at subsidised prices to these organisations. In a few selected cases, land was allotted, but the offer was cancelled later.

In 1997, the Government revived the proposal and issued another advertisement for inviting applications for super-speciality hospitals in five specified urban locations in the state (these locations were Ludhiana, Jalandhar, Amritsar, Bhatinda and Patiala). This time the previous locations were not included in the list. Most of these locations were in areas earmarked for institutional purposes. However, PUDA this time did not provide detailed information on these locations. In previous offer, information about the exact location, number and size of available land areas was made available. The department considered that providing this information had created problems in implementing the previous initiative and, therefore, this time steps were taken not to provide this information. No detailed policy document was available on the present initiative. The offer was made through an advertisement, which had suggested that final allotment of land area would be based on applicant's requirements and preferences.

The revived initiative specified thirteen super-speciality services for which the private participation was invited from institutions in India or non-resident Indians. The total capital costs were envisaged to be about Rs. 500 million or more. This did not include the cost of land. The conditions for applying this time were made quite stringent. Only those having relevant experience in super-speciality areas could set-up the facility. The

government this time also laid down a condition of having at least 10 years of experience in the relevant field and required that the applicant should have established super-speciality/multi super-speciality hospital of international repute. The offer provided the scope for collaborations suggesting that any applicant interested in setting up health facility but not having past experience in health could have collaboration or have affiliation with a recognised medical centre or hospital.

The government agreed to offer land for this project at rates ranging from Rs. 1350 to Rs. 2060 per square yard depending on the urban estate. This involved subsidies ranging from 40 to 60 per cent. The cost of land was to be paid either in lump-sum or instalments.

Proposals to consider setting-up super-speciality by having joint venture with the government also featured one of the options in collaboration. Under this option the cost of land was proposed to form government's contribution towards equity capital in the proposed joint venture. The other conditions for these collaborations included setting-up of proposed super-speciality centre within three years period and use of land for only providing medical services.

The response to this initiative was very poor. Only five applicants this time showed interest in setting-up medical facilities. A high minimum investment requirement was considered the reason for poor response to this initiative. This time 2 responses were from non-resident Indian doctors who formed separate consortiums abroad and submitted bid application. The other applicants were big business houses, one of them proposing collaboration with well-known Apollo group having hospital chain in the country.

The department, however, did not issue any guidelines to interested institutions describing the process and did not provide any opportunity to clarify any questions arising in the process of submitting the bids. While implementing the private participation policy, it was not clear from the advertisement whether PUDA did involve other departments such as Finance, Health, Punjab Health Systems Corporation and Ministry of Urban Development

etc. The advertisement did not describe the process of short-listing of the institutions and criteria for allotting the land sites.

None of the organisation, which had participated in previous bid, responded to the revived initiative of the government. Besides the stringent conditions of the department for bidding under the new proposed arrangement, respondents to previous advertisement did not find any major perceptible shift in the policy and process of implementing the proposed initiative. The experience also suggests that earlier invitation had attracted more of local institutions having specific preference for a particular region. The entire process of revived initiative has taken more than two years and the selection has yet to be finalised.

3.2. Private Sector Investment in Health Sector: Government of Delhi

With a view to attract private investment in health sector, Directorate of Health Services (DHS), Government of Delhi in May 1997 proposed setting-up 10 hospitals as joint ventures on some of the sites available with the government. Out of these, seven locations already had government hospitals in place. These hospitals were proposed to be acquired from Municipal Corporation of Delhi. Others were earmarked sites of Delhi Masterplan. Most of these facilities were at commercial and busy locations.

In the proposed joint venture, government's contribution was to come in the from of cost of land and it was expected to constitute as part of equity capital of the proposed organisation. The proposal indicated that government's contribution in any case would not exceed 26 per cent of total share capital. In cases where the cost of land was expected to be less than 26 per cent of total share capital, the government had proposed to contribute additional resources to meet the requirement of minimum capital contribution from government. In forming these joint ventures, the government also made it a condition that up to 1/3rd of the board nominees will be from government.

The applicants were given the option for either setting-up of a general hospital or super-speciality facility. Each facility was expected to offer free care to a certain percentage of

OPD and IPD patients. The bidding institutions were required to specify the percentage of free OPD and IPD care they propose to provide. No specific guidelines were provided for identifying the poor patients but the government retained the right to refer the eligible patients for free care. Each facility was expected to participate in public health programmes of the government.

Contrary to the Punjab initiative, the government in Delhi provided a set of general guidelines for participating in these collaborations. As per instructions provided, applicants had to submit two separate bids: one technical and other financial. Very broad details were provided about the process of selection. The response to the offer was positive and more than 30 applications were received by the DHS in response to their advertisement.

The location of proposed facilities being at prime commercial and busy places attracted considerable amount of attention from public and others. Public litigation case on social security grounds was filed in the High Court of Delhi and stay order was issued halting the entire process of forming joint ventures. Many other applicants proposing to participate in these collaborations who could submit their application on time also filed number of cases on the ground that sufficient time was not provided for submitting bids.

3.3 Private investment in medical institutions: Government of Rajasthan

The policy document of Rajasthan government is the most comprehensive policy statements on the private-public partnerships (PPPs) of any state government's in India. In order to encourage the private investment in hospitals, diagnostic centres and nursing homes, Medical and Health Department of Government of Rajasthan (GoR) came out with a detailed policy in 1996. The state has 218 hospitals having a bed capacity of 35665. Out of these, only six hospitals provide speciality care in areas such as cardiology, neurology, nephrology, gastro-entrology etc. Justifying the reason of PPPs, the policy document indicates that given the difficult terrain of the state where the government is focusing more on increasing the access to primary care, the growing incidence of chronic diseases have

made it imperative to develop an effective secondary and tertiary care system. The policy statement acknowledges that the ability of the government to expand in these areas was significantly constrained by the funds availability. The policy also emphasises the need to increase the access to and quality of services and better clientele relationship as the reason for involving private sector in providing health services.

In order to attract investment from private providers in speciality services and curative care, GoR categorised bidding institutions into four categories. These were:

- *Category A*: Charitable medical institutions (non-profit organisation) willing to set-up at least one advanced diagnostic or curative services by acquiring medical equipments from approved list of state government or offer speciality services as per the plan approved by the state government.
- *Category B*: Charitable medical institutions having their own plan to set-up health facilities.
- *Category C*: Institutions (registered firms, societies, trusts) interested in setting-up speciality hospital in specialities approved by the state government and in particular geographic region.
- *Category D*: For-profit organisations (nursing homes providing maternity and child care facilities having at least 10 beds and OPD facilities, hospitals having at least 50 beds and OPD facilities, diagnostic centres).

One of the areas to facilitate the setting-up of private facility was subsidising initial set-up costs of establishing health care facility. As seen in previous two cases the governments have used "subsidising land" as one of the mechanisms to attract private sector. These subsidies are generally provided by offering land at reduced prices. Other forms of subsidy constitute the cost of medical equipments by lower or zero duties and exemption from various fiscal requirements or arranging to provide finances at subsidised rates.

The policy instrument of the GoR included providing land at subsidised rates and provision of other fiscal benefits to institutions interested in setting-up health facility. The subsidy was not uniform across all organisations but varied according to categorisation as defined

above and whether the facility was to be set-up in rural or urban area. The details of subsidy on account of concessions in land prices are provided in Exhibit 1.

Exhibit 1
Basis of arriving at cost of land to different category of providers

Category of Institutions	Rural area based on Market Price of Agriculture Land (MPAL)	Urban area (square yards) based on Reserve Residential Price (RRP)	
Category A	25% of MPAL (no ceiling on area)	Up to 2000 sq yds: Above 2000 sq yds:	50% of RRP 25% of RRP
Category B	25% of MPAL (no ceiling on area)	Up to 1000 sq yds: Above 2000 sq yds: 1000 to 2000 sq yds:	50% of RRP RRP Twice of RRP
Category C	50% of MPAL (no ceiling on area)	Up to 200 sq yds: Above 200 sq yds:	RRP Twice of RRP
Category D	MPAL	Up to 100 sq yds: 100 to 2000 sq yds:	Thrice of RRP Twice of RRP
RRP is the price set by the Urban Development Ministry.			

Further to this, GoR also provided fiscal incentives on all purchases of medical equipments, plants and machinery provided they are from approved list of DoHFW and facilities are set-up before 31 March 1999. These incentives were as follows:

- exemption from payment of sales tax on purchases of medical equipment, plant and machinery;
- exemption from payment of octroi on medical equipments, plants and machinery whether imported from abroad or other state.
- other fiscal benefits from state level and other financial institutions as per the provisions of those institutions.

A specific time frame of two years from the date of allotment was laid for the use of allotted land.

The government constituted a broad-based empowered committee responsible for screening all bidding proposals, short-listing and final selection of institutions. Most of the related department secretaries were members of this committee (for example, secretaries

from the department of finance, health, industry, revenue, urban development and housing and bureau of industrial promotion were members of this committee).

The response to the policy initiative of GoR was reasonable. In all 14 proposals were received. Each bidding institution was required to submit an application along with project feasibility report and proof for the sources of funding to set-up the project.

Despite having a comprehensive policy on private participation, the final clearances and allotment decisions have faced number of procedural difficulty. Since no locations were identified before the start of the process, the implementation of policy had to work out the details of available locations. For this purpose, the preferences from each bidding institution were collated first. The Committee forwarded this information to respective development authority or to Municipal Corporation. Since the number of development authorities and municipalities involved were too many, it became difficult to co-ordinate the whole process. Each agency was required to come up with detailed information about the possible sites of the required sizes. This process in the first place resulted in applicant getting number of options of land locations for his proposed project. This created a bit of confusion and delays in decision making. The government also experienced time delays in implementing the policy because of the problems faced at the level of getting number of clearances from various departments. Since the land was going to be provided at subsidised rates it would have resulted into loss to the development authority. Number of authorities were not prepared to implement and give clearances because there was no agreement on how the losses will be shared across the departments. It also created procedural difficulties in implementing the policy because most of the developmental authorities were selling these properties through auction. This was seen as major departure from set procedures and there was reluctance to depart from existing practices.

3.4 Involving Industry and NGOs in running PHCs

The primary health care forms backbone of health delivery system in each state. The surveys have shown that PHCs do not have adequate facilities to provide health services

effectively and utilisation levels of these facilities are very low (Rao, 1996). Very little attention is paid to improve the performance of PHCs and their utilisation. There are no effective mechanisms to evaluate and monitor performance of PHCs. Monitoring systems are extremely weak. Surveys have highlighted that a number of these PHCs are without doctors and many do not attend the facilities regularly. Under this scenario, harnessing on the local level support and private initiatives are emerging as an important option to improve the performance of the PHCs in various states. Two cases of Tamil Nadu and Gujarat highlight the nature of these initiatives.

Tamil Nadu experience

The initiative in Tamil Nadu by the State government has involved industry in improving the performance of PHCs. The primary role of industry was envisioned to adopt a local PHC, health sub-centre or district hospital. They had the responsibility of building, maintaining and equipping the facility. Under this collaborative arrangement the State government continued to provide staff and medicine. Initially, industry anticipated less flexibility in operations as it was going to be manned by the personnel from the government. However, the State government agreed to draw a flexible MOU where corporate had flexibility to increase or reduce their involvement depending on the performance of the scheme. Most of the industry houses choose the PHCs around their plants. So far, industry has committed to spend up to Rs. 13 million. The collaboration also provides opportunity to the State government to get feedback from industry on various management issues of the PHCs (Business World, 1998).

Gujarat experience

In case of Gujarat, SEWA-Rural was handed over entire primary health care services in one district by the State government. Under the agreement, the government agreed to finance the entire PHC services in SEWA-Rural's project area. These services were planed to be run on the same pattern as that in the Government, but managed wholly by SEWA-Rural. As per the memorandum of understanding, SEWA-Rural was required to fulfil the same targets in various health schemes, which the government fixed from time to time.

While SEWA-Rural was free to recruit its own workers, the criteria for their recruitment remained same as in the government, with some exceptions. However, SEWA-Rural could retain the flexibility in providing the necessary training to all its health workers.

3.5 Private involvement in RCH programme: MoHFW, GoI

The MoHFW, Government of India has recently announced schemes for implementing the RCH programme. The programme in past has experienced number of implementation constraints in the area of emergency obstetric care (EOC), MTP etc. *Inter alia*, the schemes of implementation include the involvement of private sector in the programme implementation. For example, one of the areas identified is shortage of anaesthetists in meeting the needs of EOC. The RCH implementation scheme now provides that the States can engage the services of anaesthetists on a payment of Rs 500 per case at the sub-district and CHC level for EOC. Similarly in the area of MTP, the districts can engage a private doctors trained in MTP to the PHCs once in a week or once in fortnight for performing MTPs and these doctors will be paid Rs 500 per day visit. The schemes for implementation also include number of other measures such as involving NGOs through state level registered societies (SCOVAs) for various components of RCH programme.

3.6 Contracting-out of services: Maharashtra, West Bengal and Tamil Nadu

Another way in which public-private partnership develops is through contracting-out of clinical and non-clinical services. Many states in India and several health projects of Government of India do have components which are contracted out to outside agencies. Some of the cases of contracting out are illustrated below:

- The state of West Bengal has been facing problems of manning the primary health care services. At district level the Government of West Bengal has constituted District Health Committees (DHCs) which would have responsibility of planning and managing health programmes and services. As one of the steps to ensure that PHCs are manned, the DoHFW allowed the DHCs to hire the services of private doctors on contract basis. During the recent budget, the GoWB has also proposed to bring 341 PHCs

under the supervision of Panchayat Samitis. These Samitis would have the power to appoint the doctors on contract basis.

- The health facilities in West Bengal has also started hiring vehicles for ambulance purposes and proposes to charge users on per km basis with a cap on total amount.
- The contracting of services in the area of diet and catering, laundry, security and IEC programmes is being implemented in many states in India (e.g., Maharashtra, Tamil Nadu and West Bengal). Mills and Bhatia (1997) discuss the case of eight Mumbai based hospitals and evaluate efficiency of contractual arrangements for non-clinical services.
- The areas, which are emerging as potential for contracts, include clinical and other non-clinical services. In Tamil Nadu contracting out for high technology services in major teaching hospitals has been identified as one important area (Bennett and Muraleedharan, 1998).
- The other area for contracting out of services is the maintenance of equipments and facilities. No data or information is available on contracting out of such services.

4 Issues and prospects

Public-private partnership in health sector forms an important recommendation in many health sector reform strategies now these days. Almost all-new projects developed to implement the programmes do have policy statement on involving the private sector in implementing selected programme components. The proposed scope of these partnerships generally focuses on both the clinical and non-clinical areas. On clinical side, it includes specialty care (e.g., tertiary and high-tech curative care), reaching to vulnerable and target groups of population (e.g., STD, HIV/AIDS, TB) and addressing problems of access in remote areas where public services do not reach (e.g., in RCH programme). On non-clinical side, the participation of private sector includes the areas such as diet and catering, laundry, security etc. Based on the discussion in previous section, the interaction between private and public in health can assume several forms. These relationships can be broadly classified on following three dimensions:

- Form

  The form of the partnership defines the organisational arrangements, implicit and explicit, between the government and private provider which would include forms such as joint venture, providing subsidies and various fiscal incentives, having informal understanding about the provision of services, 100% privatisation.

- Focus

  The focus of partnership would include clinical or non-clinical services, other provisions such as handling management aspects, providing technical support etc.

- Flexibility

  The flexibility to the private provider in terms of institutional and contracting arrangements and would include terms of having their own fee structure or personnel policy or training structure and flexibility in time frame.

This participation of private sector in health is envisaged through various mechanisms. The involvement of private sector is based on the argument that it helps to improve the efficiency of existing limited resources and also it ensures the availability of services, which is important to improve access to health care. Financial barrier to access is also taken into account by developing various mechanisms as part of the contracting process to protect the poor. However, the success of these has been quite limited. Not much attention has been paid to management and institutional issues in initiating and implementing these partnerships.

The developments in PPPs in health sector in India are in very early stage. However, the experiences gained from selected initiatives of the government with the support of private partners provide important insight into the processes and mechanisms in proposing to formalise these initiatives. The previous section has described some of the arrangements that have been initiated by the selected state governments and central government. The role of private sector in health is assumed to provide opportunities in strengthening the health systems since India has already a high presence of private providers. However, the

policies initiated by various governments have not asked hard questions which ensure effective use of private sector in health. There are many constraints in involving private sector in health, and these have not been dealt adequately. Therefore, under the present circumstances the involvement of the private sector may be less efficient and less effective in achieving the broad goals of health policy. As discussed in the previous section, it has not been possible for the government to implement some of these initiatives successfully. In this section, we discuss the inadequacy of institutional mechanisms for an effective functioning of these partnerships and the role of government in health sector reform strategies focusing on private-public partnerships. For example, the questions such as what has gone wrong in implementing these policy initiatives, what is the learning from these experiences, and do we lack necessary institutional mechanisms for efficient functioning of these initiatives are some of the issues which may provide interesting insights into issues and future prospects of these initiatives. The analysis of these selected experiences raises important issues which has implications for the future of such initiatives. The discussion rests on the basic argument that *inter alia* health sector reform strategies need well-defined policy and right institutional conditions. The experiences in implementing these policy initiatives suggest that the present institutional conditions are less consistent and not adequate with the spirit of the proposed initiatives. Therefore, without addressing the basic issues, these and other similar reforms in the health sector would be lopsided and having less chances of success.

4.1 Information

The private participation process starts with the policy statement from the government. The policy statement, *inter alia*, would define the scope and nature of any proposed partnerships. Right now there is no elaborate national public policy on private sector participation in the health sector. There is general reference to the private sector role in National Health Policy (NHP) of 1982 as it was discussed in previous sections. The NHP leaves the initiative to develop elaborate private sector policy to each state. Since health is state subject, each state has to have a view on the role of private sector. The state's health policy statement on private public partnership would be a source of information on terms

and conditions under which proposed collaborations, relationship, stakes and other arrangements can be proposed. Two of the states, which proposed these partnerships, did not have policy document on private health sector role. These state governments (Delhi and Punjab) provided brief policy statement in the form of an advertisement in national dailies. These were more in the form of inviting bids from prospective partners. Most of the details, both economic and institutional, were not available. Rajasthan, on the other hand, had elaborate policy statement describing the need for private partnerships and all other necessary information related to proposed form of partnership, eligibility requirements, time frame, location specification and other conditions, minimum investment requirements etc. However, the government lacked appropriate mechanisms to handle many tasks arising out of these collaborations.

Availability of information will play critical role in process of developing bids by the prospective partners. The private sector participants who would be interested in participating in a bid process may have to make number of decisions that would involve a complex process of information search and analysis. In the absence of appropriate mechanisms for information sharing, the private provider would incur high transaction cost. This would make these partnerships vulnerable to inefficiency and high cost propositions. Most of the policies did not provide sufficient information on various aspects of proposed partnerships and thereby generating high uncertainty and affecting the investment by private providers.

Besides information sharing processes, other important issue in these partnerships has been the absence of appropriate mechanisms to involve all stakeholders and transparency in the process. One of the ways, which would strengthen the process of developing sustainable partnerships, is through the involvement of all stakeholders and prospective private sector partners. Information, transparency and stakeholder involvement are critical components of the entire PPPs process. The community is one important stakeholder. Recently, the West Bengal initiative of involving Panchayats in contracting of services to qualified

doctors in remote areas is one such attempt in India to involve community in private collaborations in health.

The form of partnership has been primarily through subsidising the inputs, particularly land. The subsidisation of inputs is likely to remain an important form of arranging private collaborations. These resources have high common property element. One must recognise that public-private partnership going through bidding process would be open to public scrutiny at some point of time. The case of Delhi proves this point. The public litigation halted the process of handing over public hospitals to private providers. Any investigation would raise issues that would focus on inappropriate targeting of subsidies. The processes should be adequately described and these initiatives should not be seen by others as distribution of resources at throwaway prices by politicians and bureaucrats to their patronage groups. An elaborate plan mapping out various delivery points and developing links at various service delivery points would be important to justify the use of common property. Most of the initiatives did not have proper plan, except the land cites were identified. Changes were made, which were not based on any justification and were not communicated properly to various people involved in the process.

4.2 Co-ordination and monitoring

As revealed by the experiences, each proposed partnership involved considerable amount of co-ordination among different departments of the government. The finalisation of partnerships is not possible without involving the other departments having significant linkages in the process. For example, the departments such as finance, urban development, industry etc. play critical roles in the whole process. There are also experiences, which suggest that number of inter-departmental policies such as making amendments in certain statutes and co-ordination with various implementing agencies are to be considered well before the start of the process. Proper and adequate mechanisms and processes for these need to be defined in advance. These would necessary require institutional mechanisms within the Ministry to handle many of these complex interfaces. It is not possible to leave them to the private provider to sort out. The experiences suggest that the governments

lacked in developing adequate mechanisms which could handle the task of co-ordinating the activities and processes across departments.

In order to strengthen the public-private partnerships and in general the role of private sector, it is very important to identify areas of intervention to make it more responsive towards public goals and to minimise the unintended consequences of private sector growth. Significantly, despite the problems resulting from the growth of the private sector, little is known about these markets and viewpoints of various stakeholders. For example, as discussed in previous section, it seems that many such proposals have not taken into account stakeholder views. The development of these approaches is considerably top-down. The involvement of various stakeholders was not considered important in this process. There seems to less interaction and involvement of concerned departments in promoting such initiatives and, also lack of mechanisms to consider viewpoint of various stakeholders, largely consumers.

The basic assumption that setting-up of private partnerships with public health facilities is in public interest and therefore assuming these initiatives will be seen as public good has proved wrong. The case of Delhi suggests contrary to this where the public litigation has halted the process of handing over public hospitals to private providers. There is also a learning form these initiatives that if the process of creating partnerships are not steered properly, the entire initiative may be viewed as an extreme form of privatisation of public facilities. The privatisation of public health facilities or creating of such impressions would attract lot of attention and may be ultimately abandoned. This will significantly influence the process of implementing private initiatives.

The other major concern is inadequacy of appropriate mechanisms of monitoring the performance of these partnerships. For example, the West Bengal initiative of involving Panchayats in contracting of services to qualified doctors in remote areas is less effective because of lack of appropriate monitoring mechanisms to ensure that contracted doctors do provide services in remote areas. There is great deal of evidence that lot needs to done

and governments need to steer the process of nurturing these collaborations in an appropriate manner, if they are serious about it.

There are instances that raise doubts about the effectiveness of monitoring mechanisms to ensure the achievement of basic goals of these partnerships. Particularly, the ability of the government to target the populations who should benefit from these initiatives has received less success. For example, the duty exemptions granted to number of health care institutions in eighties were based on the condition that the organisations availing such benefits would provide a certain percentage (in most cases 30 per cent) of health care free to poor patients. It is now evident that many of these facilities did not meet these obligations. No monitoring systems were in place to identify or forewarn deficiencies in meeting these obligations. It is fact that many of the providers who benefited from these initiatives resorted to malpractice and falsified number of patients who were provided free care, or established sub-standard health facilities in remote areas for the poor for which utilisation were not up to the mark. Recently, through public interest litigation, the judiciary has intervened to investigate these lapses in monitoring and in fulfilling of various obligations. One important lesson from this experience is that the success of any private participation critically hinges on having adequate monitoring system in place which would ensure meeting the public policy goals of these initiatives. The present review of private initiatives suggests that there has been no attempt at the government level to address these monitoring issues. In the absence of appropriate monitoring system, the system of protecting the poor through the PPPs will remain rhetoric and there is no guarantee that this objective can be achieved. An important question is that how can one address the question of public goals through private initiatives. The next section discusses this issue.

4.3 Public goals and private initiatives

The collaboration between private-pubic is based on certain critical assumptions and its success depends on how far these conditions are met. The policy context and the on-going debate on private sector provide critical insights into the prevailing conditions. The development of these collaborations can not work in vacuum and in isolation. It has to

work within the framework of exiting private sector role and the success of these options depend on whether the prevailing situation adequately address these issues. One should ask questions similar to what many have been asking in other sector (e.g., in water and sanitation) in context of private sector participation. These questions are: (a) does the private sector arrangement fit the local circumstances? (b) is the regulatory environment in the country suitable for promoting public-private partnerships? and (c) does the reform respond to the concerns of those affected?

The development of PPPs can not be divorced away from the present context of private sector growth. It is important to consider the on-going debate on private sector role and implications of this growth and discuss whether the private sector participation fits in the present situation. Most of this debate has focused on issues of cost and quality. The studies indicate that private health care has significant influence on both the cost and quality of available health care services in India (Uplekar 1988a 1988b; Duggal 1989; Vishwanathan and Rohde 1990; Yesudian 1990; Nandraj 1994). The cases of superfluous and high cost of services rendered by private physicians and hospitals have also been reported (Uplekar 1989; Duggal 1989). Recently the issue of consumer protection has also been also addressed and effectiveness of legislation in this area (Tulsidhar 1994; Bhat 1996). The lack of monitoring mechanisms and absence of appropriate regulatory instruments raise lots of doubts on the effectiveness of public-private partnership approaches.

There is always a great deal of trade-off in policy decisions. In context of private-public interaction, an attempt to achieve all the following may involve serious trade-offs: equity and protecting poor patients; efficiency (technical and allocational); and quality of services For example, if there are areas where it is not possible to promote equity, should the government focus on improving the efficiency? The policy initiatives do not address the basic objective of private-public interaction and the public goals these initiatives should achieve.

It is also important to examine the question of public policy goals of these initiatives. Should the objective be to protect the poor through the private initiatives? The previous experiences in various programme implementations suggest that it has always been a problem to identify and target the programmes towards the poor. For example, the experiences of implementing user fees policy in various states and in other countries suggest the difficulty in identifying the poor. The important policy question therefore is whether the governments should focus on equity as public policy goal in the private initiatives in health. The experiences suggest that addressing equity and access as major concern may not be feasible. Many PPPs propose providing free care to population belonging to lower income groups. It has not worked. The targeting is difficult. The costs of developing effective monitoring mechanisms to do so may be too high to justify implementing them. Therefore, protecting the poor through the private public partnerships would be a misplaced idea. Should the private sector policy in health abandon the equity and access to poor as policy goal? This aspect has number of implications. Many policy recommendations propose the government to get out of super-speciality or tertiary care by promoting private sector in these areas. As the experience suggests, this would limit the options to population, the catastrophic financial burden of the poor would become a major concern. It is, therefore, important for the government to develop alternative mechanisms along with private initiatives. One option is to strengthen the public facilities along with the development of private sector. Alternatively, develop mechanism to protect poor from high financial burden by exploring social insurance options. For example, the case of Government of Gao to start catastrophic illness insurance for populations belonging to lower income groups, case of Maharashtra where public facilities are not sufficient to meet growing demands also initiated a scheme similar and example of other state government such as West Bengal to link the use of state sickness fund for meeting high financial burden of poor people are some of examples of health financing options. However, the working of these options itself pose number of management challenges and many of the issues are common to the problems addressed in this paper.

4.4 Market based subsidy and incentives

Most of the public private partnerships are based on the policy of providing input subsidy to the private provider to start his practice. This method is providing direct subsidy and is not market based. As discussed in previous sections, this subsidy is provided in number of ways, e.g., by subsidising land and other inputs. One of the ways in which the policy makers need to address the PPP initiative issue is whether the subsidising the inputs with conditions to provide a certain percentage free care to poor patients is an appropriate mechanism to attract private investment in health. Are there any other options? These points have not been debated. For example, there has been no debate whether subsidising the inputs of private provider or providing direct subsidy to the poor is right policy decision. The experience of other countries in reforming their health sector (e.g., National Health Services reform in the UK) suggest that the later can be effectively implemented by the government by becoming purchaser of services from private sector and making those services available to the poor.

The effective implementation of private initiatives, therefore, suggests redefinition of roles of various players in the health sector on above lines. This is a major health sector reform agenda in any country. The objectives can be effectively achieved provided there are constituencies, which would have prime role in financing and others who would have prime role only in provision of services. The success of private initiatives will critically hinge on the clarity in relationships between these constituencies. In one sense the constituencies who have financing role become purchasers of services. This split if not clearly understood can lead to many complications. So long as government thinks itself as provider of services, there is conflict in roles. The inadequacy of various organisational and institutional mechanisms is because of lack clarity on these roles. One of the health reform strategies suggests that government should move away from provision and should assume the role of financier. This role can be achieved either through handing over the provision to the private sector and government becoming purchaser of services. The premise is that having a role of purchaser of services, the government will be able to encourage competition among the providers and this will help gaining much more

efficiency in the system. However, the achievability of these results critically depends on number of conditions. One of the conditions would be having appropriate regulation in the system. As explained in Appendix 1, the free-for-all competition would result into unethical practices, demand inducement and cost escalation problems. Many developed countries, which have promoted competition as means of achieving efficiency, do experience number of such problems. In India, promoting private initiative therefore will require appropriate regulations to mitigate the unintended outcomes of private sector growth in health.

4.5 Institutions and organisation

Public-private partnerships in health in India are in very initial stages. Most of these initiatives will need significant institutional development work. Developing capacities to handle these initiatives require financial analysis capabilities, monitoring and evaluations systems and capabilities to analyse various options. These are just a few examples of the tasks and capacities required.

Public-private partnerships which are going to be developed on exiting public health facilities set-up, there would be questions of deployment of personnel and who controls them. Most of these initiatives also propose some type of governance mechanism. Government proposes to play key role in the strategic process of these facilities but would have limitations in getting involved in operations aspects. However, tendencies of excessive control become reason for lot of uncertainty and, therefore, limit the private initiatives. The governments role to control the facilities is also one of the reasons for the under-development of effective monitoring mechanisms to keep track of operations of these facilities in the interest of public goal. The considerable amount of interaction across various departments within the government also creates uncertainty in the process.

One of the major concerns about the PPPs would be the policy perspective of the government. These initiatives are being evolved in a background where we have not yet evolved a consensus on what should be the private-public mix of health care and what is the public policy towards

private sector. For example, one of the important policy concerns would be whether along with the promotion of the private initiatives, the government funding to public facilities would be protected? Will it displace other sources of funding as it has happened in some centrally sponsored programmes of the central government? Encouraging investment in the public sector by private sector do also have implications for allocating adequate resources to public facilities. In 1992, the UK government announced new provisions of allowing private sector investment in the National Health Service (NHS) and this was done without the reduction of public funding. See Appendix 2 for the brief description of the scheme. All private initiatives should ensure that the government spending on public facilities would not decline and remains protected. It is important that for effective PPPs public facilities are strengthened simultaneously.

Most of these problems arise because the policy frame of the government of India and all state governments does not have sector-wide view. The roles and contribution of both public and private are not appropriately spelled-out and defined. Questions such as what should be appropriate form and scope of these initiatives need to be debated and appropriate policy frame needs to be evolved. The present policy frame of various state governments and of the GoI primarily focus on public health programmes which are vertically divided. No policy frame has been evolved which takes sector-wide view, clarifying the role of public and private appropriately. The experience suggests that not having sector-wide policy on health has resulted into lop-sided development in this sector where the dependence on private sector has become considerably high. The implications of this are quite serious. It is evident that based on this, one of the areas where public-private partnerships are being suggested in curative super-speciality care. These areas require huge amount of investment in medical equipments and health care infrastructure. It can be observed that in the absence of any explicit policy of regional distribution of these facilities, excessive investments in medical technology and infrastructure may lead to the problem of over-capitalization in selected geographical areas resulting into demand inducement, cost escalation and unethical use of facilities. As experienced in the past, curative and tertiary services get mostly concentrated in urban areas. The private sector would have higher tendencies to grow only in urban areas. The experiences

in private sector initiatives discussed in this paper also suggest that private providers have higher preference for urban areas. It is where they see major scope for business. There is danger in government promoting the private sector and fueling the problem of over-capitalisation in this sector in certain areas. This would happen because government has not appropriate plan for health sector development. This would lead to number of inefficiencies, which arise because of the market imperfections and market distortions having significant effect on the behavioural characteristics of the physicians recommending the use of various procedures. In private sector, the providers of these facilities operate in a business like environment, having many obligations for example to repay the installments of the loan, needs for working capital requirements and the urge for growth. Even if the profit motive is not there, the investment in new technology give rise to number of financial problems leading to demand inducement conditions. The private sector operates in unregulated setting with no price controls and most of the patients having almost negligible insurance coverage. One of the factors, which would determine the price charged to the patient, is the investment in these equipments. Some of these technologies such as CT scan, MRI, ESWL etc. are expensive technologies, requiring high capital cost and have significant recurring costs. In the absence of proper regulation on distribution of these facilities and prices, the present system of payment method in private sector is likely to fuel the proliferation of medical procedures and technology. The undesirable consequence of this development would be situation of over-capitalization. Many urban areas in India have started experiencing this kind of trend. The unintended consequences of such trend is demand inducement, increase in prices and unethical use (see Appendix 1 for the explanation).

In absence of appropriate mechanisms to protect poor and under the present conditions, the investment in the technologies and private-public partnerships in high tech super-speciality care raise questions about equity and access. For example, Yong (1994) has examined the question of equity and shows that in case of Korea only people belonging to high-income classes use the MRI facility. Since the use of this facility is not covered under insurance, the use of MRI puts greater burden on low-income families than to high-income families.

Developing and strengthening an appropriate regulation would be an important pre-requisite for developing private initiatives. Information dissemination would play critical role in ensuring that health facilities in the private sector do not behave opportunistically. For example, in states where private nursing home or clinical establishment legislations are in place, there are no mechanisms in place, which would publicise the information about the facilities registered with the government. The governments need to evolve appropriate mechanisms to provide this information to public. This, no doubt, would bring additional responsibility on the government to implement these regulations effectively. For example, the recent case of failure of many non-banking finance companies in meeting basic requirements and exposure to high risk, the central bank have been constantly advising the prospective investors about such risks. This is one of areas where ministries of health at centre and state levels need to strengthen their capacities to play this role effectively. This will be one step towards generating appropriate conditions for proposed private initiatives.

There has to be an explicit recognition to the fact that private-public collaborations are possible if there are adequate incentive structures in place. The public policy towards private sector needs to adequately address this question. The subsidising of various inputs in these partnerships try to create such incentives. The public policy towards private sector needs to spell out the mechanisms and form of providing incentives to the private sector.

There is also a potential danger of private initiatives of the government leading to unequal standards of clinical care across public and private sectors. Having more and more of PPPs will create two different systems of health care delivery systems; public and private providing different quality of care to different clientele. This problem would further aggravate as a result of less allocation of government resources to public facilities. In the process ultimately poor will suffer. This problem arises because the availability of medical technologies gap across two sectors would widen and would be area of concern. The other factor is availability of skills in two sectors. The private sector would have significant attractions and there would be movement of personnel from pubic to private

further aggravating the problem in public sector. It has already started happening in many government hospitals in the country.

Ensuring appropriate quality standards have become a major issue in health delivery system, both private and public. It would be important that regulatory frame also focuses on ensuring adequate standards of care. The two areas which would need attention are institutionalising the process of standard setting and continuous medical education and training in clinical areas. The medical councils at the centre and at state levels have not assumed adequate interest in developing appropriate mechanisms for continuing medical education (CME) programmes and standard setting. One of the problems is the lack of infrastructure and capacity within these institutions to undertake this work.

Given the experiences in PPPs so far, management structure issue has assumed critical importance in implementing the new partnerships. Developing these structures is difficult task and takes considerable amount of time. However, once developed these structures ensure that various management system and process aspects of these partnerships are adequately addressed. If steered and directed carefully, these structures would also provide appropriate mechanism to monitor the performance of the private initiatives. This aspect assumes critical importance in ensuring successful implementation of PPPs. The recent experiences in PPPs (for example, cases of Delhi and Punjab) suggest that governments would be vulnerable in proposing and handling the PPPs directly by themselves. The governments would not be in position to provide appropriate structures for implementing these initiatives and will find difficult to organise necessary capacity required to manage these tasks. Taking a new task such as managing PPPs mean a big leap forward for the government departments under the present circumstances when government is facing number of human resource issues. The experiences suggest that it becomes difficult for the governments to mobilise the capacity to handle various issues arising out of developing these initiatives. Therefore, serious attention needs to given to form an appropriate management structure for effective management of PPPs and which can adequately address the question of capacity and implementation issues to manage these

initiatives effectively. This can be done effectively by creating separate organisation (out side the ministry) to which all resources are transferred and they implement the programme within the broad guidelines of the government. As discussed the desirability of having an appropriate organisation structure and institutional mechanisms also arises because of the need for effective monitoring mechanisms. Some of the recent experiences in implementing the PPPs through the district health committees (for example, DHCs in West Bengal) and through creation of registered societies in various states are an attempt in this direction. However, it is important that these agencies are provided enough opportunities of training and time to develop capacities and appropriate systems to handle these tasks better.

5 Conclusion

In conclusion, the paper discussed selected cases of private-public partnerships, which have recently been initiated by several state governments in India. The brief description of these initiatives suggests that these initiatives are in infancy stage and the sector lacks proper institutional mechanisms to implement these initiatives effectively. The paper has brought out number of policy and management issues in developing these options. First, it has been argued that we need to have "public policy towards private sector" and this policy framework should have sector-wide (addressing both public and private sector roles together) focus. The policy, *inter alia*, should address the question of public-private mix in health sector, scope of private-public partnerships, role of subsidies and incentives in promoting these partnerships, addressing issue of protecting the public sector from any reduction in budgetary allocations. Further, the paper points out that the success of any private initiatives critically hinges upon number of factors. There is need to have explicit and adequately described statement on PPPs, planned co-ordination across various departments within the government and various implementing agencies, ensuring availability of critical resource such as qualified manpower. The need to have appropriate monitoring and governance system, provision of adequate information to all participants and transparency, institutionalising appropriate management structure to handle new tasks and strengthening public systems were discussed as necessary pre-requisites for evolving

effective PPPs. The role of regulatory mechanisms to ensure proper standards of care is also considered important. This suggests the need for number of policy measures. Some of the broad sets of policy measures are summarised in Table 3.

Table 1
Medical and public health: capital and revenue expenditures

Year	Punjab				Rajasthan			
	Revenue	Capital	Total	Capital %	Revenue	Capital	Total	Capital %
1974-75	1437.96	82.86	1520.82	5.45%	2209.12	70.31	2279.43	3.08%
1975-76	1717.88	94.84	1812.72	5.23%	2630.54	69.95	2700.49	2.59%
1976-77	1787.37	120.03	1907.4	6.29%	2911.86	56.43	2968.29	1.90%
1977-78	2116.37	143.3	2259.67	6.34%	3523.51	40.63	3564.14	1.14%
1978-79	2353.87	156.84	2510.71	6.25%	3950.37	101.13	4051.50	2.50%
1979-80	2533.45	241.52	2774.97	8.70%	4311.23	155.16	4466.39	3.47%
1980-81	3530.97	296	3826.97	7.73%	4968.07	162.29	5130.36	3.16%
1981-82	4020.73	248.83	4269.56	5.83%	5312.94	184.30	5497.24	3.35%
1982-83	4223.92	197.46	4421.38	4.47%	6863.33	181.68	7045.01	2.58%
1983-84	5223.15	322.54	5545.69	5.82%	7452.67	120.14	7572.81	1.59%
1984-85	5860.51	247.84	6108.35	4.06%	8798.21	177.43	8975.64	1.98%
1985-86	7180.39	350.64	7531.03	4.66%	9623.15	316.99	9940.14	3.19%
1986-87	7628.47	478.92	8107.39	5.91%	11212.23	425.86	11638.09	3.66%
1987-88	9205.92	516.46	9722.38	5.31%	13223.90	506.85	13730.75	3.69%
1988-89	10942.12	491.53	11433.65	4.30%	14722.60	458.58	15181.18	3.02%
1989-90	14023.79	395.59	14419.38	2.74%	17473.45	406.79	17880.24	2.28%
1990-91	14675.01	328.46	15003.47	2.19%	20421.59	448.40	20869.99	2.15%
1991-92	16032.89	1430.73	17463.62	8.19%	22565.74	1634.35	24200.09	6.75%
1992-93	17200.92	994.24	18195.16	5.46%	26893.22	1221.04	28114.26	4.34%
1993-94	18927.16	670.73	19597.89	3.42%	30793.35	756.58	31549.93	2.40%
Average				5.42%				2.94%

Table 2
Public-private partnerships in health sector
Comparison of policy initiatives of three state governments in India

Characteristics	Rajasthan	Punjab	Delhi
Year of policy implementation	End of 1996	End of 1995 and renewed in 1997	May 1997
Policy statement	Explicit policy document publicly available	No policy document available	No policy document available
Implementing agency within the government	Medical and Health Department (MHD)	Punjab Urban Development Agency (PUDA)	Directorate of Health Services (DHS)
Information to prospective bidders	Detailed brochure containing information and guidelines was provided	No information available to prospective bidders except advertisement	General one-page guidelines for potential bidders besides advertisement
Proposed form of participation	100% ownership basis to • Institutions • Hospitals • Diagnostic centres • Charitable institutions	• Preferred form of participation by forming JV with government • Open to consider participation on ownership basis	Joint Ventures (government equity limited to 26%)
Eligibility requirement	Interested institutions were divided into four broad categories • Charitable institutions setting health facility as per government plan • All other charitable institutions • Institution interested in setting-up speciality hospital as per plan • For-profit-making institutions	**1995 Policy:** • Professional qualification must **1997 Policy:** • Minimum experience of 10 years running a speciality hospital; • Hospital should have affiliation with exiting centre; • Minimum earnest money Rs. 35000	Open to all
Condition for making facility operational	Construction should be complete in 2 years and hospital should start functioning	Within 3 years the facility should start operating	No conditions specified for operation of the facility;
Participation in management	no participation from government in management	no participation envisaged except in case of joint ventures	1/3 nominees on the board will be from Government of Delhi
Location specification and availability	• Choice of locations (urban and rural); • Exact location to be identified based on the request by applicant	• Choice available from 6 specified urban centres; • To be decided by the bidder	• Specified urban locations in Delhi • Readily available and in possession of government;

Free care to poor and other price specification	• 10% free IPD and free OPD for one hour in morning and one hour in evening for first two categories • No price specifications for last two categories	• No free care condition • No other price specifications	• Free care to proposed % of patients in OPD and IPD (to be proposed by bidding institution) • Selection of free care patients to be decided by the government
Minimum investment requirement	Not specified	Minimum capital cost of Rs. 500 million	Not specified
Incentives	• Subsidised land • Sales-tax exemption on equipments • No octroi • Other benefits from financial institutions	Subsidised land (offering below market price)	Land and selected valuable equipments as equity from the state government
Amendments in laws enabling policy implementation	• Exemption order for sales tax already issued • Amendment in Rajasthan Land Revenue Act	No information available	No information in guidelines. Take over of health facilities from Municipal Corporation.
Inter-departmental co-ordination	Departments of Health and Family Welfare, Finance, Industry, Revenue, BIP	PUDA Administration involved in implementation	Authorised tender committee of the government, no mention of inter-department co-ordination
Response and follow-up	14 applications received and they are in process	• Applications received in 1995 were approved but rejected later; • Fresh set of applications have been invited in 1997	• More than 30 applications received • Stay order brought through public litigation
Other initiatives in the State having implications for private-public collaboration	More than 50 bedded hospitals have been converted into registered societies (autonomy to take decisions; life line medical stores)	World Bank health systems development project to strengthen the secondary level hospitals (created Punjab Health Systems Corporation)	Apollo Hospital was started in JV
Public image	Hospital society concept is being implemented and no information on its performance	Trying to strengthen and keeping image of not privatising the health sector	Apollo Hospital viewed as high-tech and high priced corporate hospital and not as Joint Venture Hospital with government
Implementation problems	Attempt to have single window concept	Capacity within the PUDA to handle health project; Clarity about the process and technical issues	NA
Availability of qualified personnel	Government has set up one more medical collage and in the process of establishing paramedical centre	Paramedical staff is considered a major issue and training facilities need augmentation	Adequate supply of trained medical staff

Table 3
Policy issues and policy measures
in addressing the public-private partnerships

Issues/concern	Unintended implications	Policy measures
Expanding high-tech super-speciality services	Cost Quality Demand Inducement *Unethical practices*	• Protecting poor from catastrophic financial burden • Protecting and increasing government budgetary allocation to public sector • Development of monitoring mechanism and appropriate regulations • Rate regulation (change provider payment system) • Continuing medical education programmes
Geographic Distribution of Facilities	Equity: Access to Facilities	• Regulatory interventions such as • Licensing; • Creating health map; • Various types of incentives; • Drawing definite plan where money should be spent; • Remote area subsidy programs to allocate.
Financing of New Investments	Cost Quality	• Creating specialised financial channels within the existing set-up of financial institutions to provide funds to private health care sector for financing their new investments in appropriate technologies after examining its cost-effectiveness.
Utilization Patterns	Equity: Access in terms of ability to meet cost	• Developing appropriate financial mechanisms; • Protecting poor
Organisation and institution	Human resources issues within the ministry Capacities to handle new tasks	• Creating separate organisation outside the government to handle the task of promoting private sector initiatives programme

Appendix 1

Implications of encouraging more competition in health sector

We use the demand for health care framework to explain the implication of encouraging competition in health sector (see Figure 1 below). Assuming the aggregate demand curve of poor people and rich people have different elasticity (for the poor the elasticity is higher than the elasticity of demand for rich). Assuming the existing medical technology is priced at P_0 for which the demand is Q_p for poor and Q_r for rich. The rich people can afford more care and therefore the quantity demanded by them is higher than the poor are. Suppose more competition is introduced and number of high-tech super-speciality technologies are introduced. Because of its high investment requirements, it is priced higher than the existing procedure. We expect the demand for care from poor people significantly lower at P_1 price. The poor people will still utilize the existing facility. Higher the price differential lower are the chances that poor people will shift to the new technology. Equity implications are that less of poor people will be able to use the new technology. As the competition in health care (because of the use of this new technology) intensifies more and more providers invest in this facility as there is assured demand from the rich people. Other reasons for investment in technologies would also include improving the image of the private health facility and attract more clients. As the competition intensifies and other providers decide to install this new piece of equipment, the total demand will get divided resulting into downward shift in the demand curve for a single provider (e.g., for rich to D_r). Under the changed circumstances, providing the services at the existing prices will generates less revenue and as a result many providers will experience deficit situation. In order to cover the deficits, the provider has only option to push up the demand curve through demand inducement behaviour (using the mechanisms such as fee-splitting practice etc.) or resorting to unethical behaviour. If it were not possible to shift the demand up, the provider would reduce costs by sacrificing overall quality of care (e.g., promoting unethical use or sacrificing quality standards). The last option available to him would be to increase the price for the use of this facility.

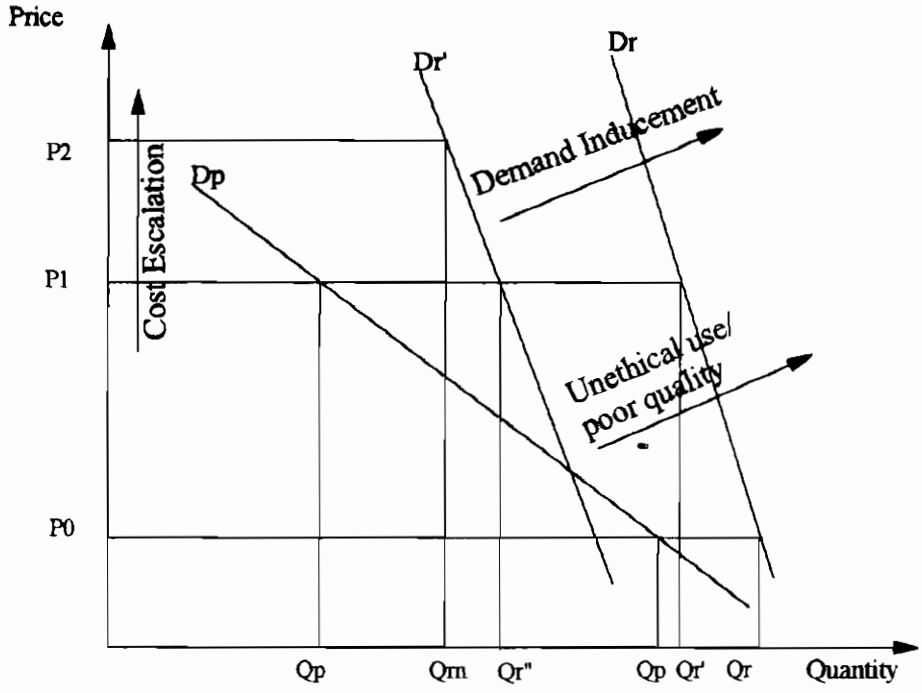
Price
Dr'
Dr
P2
Dp
Demand Inducement
Cost Escalation
P1
Unethical use/
poor quality
P0
Qp
Qm
Qr"
Qp
Qr'
Qr
Quantity

Figure 1

Appendix 2

Encouraging investment in the public sector by private sector

In 1992, the Chancellor of the Exchequer in the UK announced new provisions which allowed private sector investment in the National Health Service (NHS) without the reduction of public funding. This has become known as the Private Finance Initiative (PFI) which has the objectives of:

- enabling public and private sectors to work more closely together encouraging joint ventures, leasing of assets and the private provision of services in order to help finance capital intensive projects
- providing the means by which the private sector can genuinely assume some of the risk
- ensure that projects deliver value for money

The importance of the PFI in the NHS only gradually became clear. By 1994/5 NHS managers realised that conventional sources of funding for major building schemes had virtually disappeared and that all schemes had to be tested to see whether there was likely to be funding from the private sector. PFI moved from being an add-on to being considered a major source of capital investment in the NHS.

In 1996, there were some 50 schemes between £1 million-£50 million in the pipeline. The range featured MRI scanners, primary care centres, care parks and waste management as well as the provision of whole hospitals. In 1997, after 5 years, 14 PFI schemes have been given the go-ahead by the new Labour Government and there are many more ready to start.

Experience of first five years of the PFI in the UK has been mixed and there are many lessons that have emerged from the process. It is inconceivable that the PFI will not work in some form as private sector investment to support public sector services is accepted

politically as the only realistic way to achieve the scale of investment in its asset base that the NHS needs over the next decade. London and other cities in the UK remain over provided with worn-out assets and faces huge backlog maintenance bills which cannot be afforded. Almost the entire acute service rationalisation agenda in London now hangs on the success of about half a dozen capital schemes that are being pursued through the PFI process.

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