

COMMENT

Public-private partnerships for providing healthcare services

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Abstract

The public-private partnership is an initiative to improve efficiency, effectiveness and equity in the provision of healthcare services. This essay comments on the lessons that should be learned from some examples of such partnerships in various Indian states.

The private sector is the most important source of healthcare services in India, providing close to 80 per cent of all services, according to the government's own reckoning (1). A related fact is that nearly 75 per cent of health-related expenses are out of pocket and occur at the point of service delivery.

Over the last few years there have been many initiatives to improve the efficiency, effectiveness and equity in provision of healthcare services in the country. Public-private partnership is one such initiative.

Before considering emerging public-private partnerships in health in India, it may be worth recalling that healthcare has historically (even in developed nations) been a private sector activity. The emphasis on the government's responsibility for providing or supporting healthcare services for the entire population is recent. The National Health Service in the United Kingdom, often seen as the model for delivering universal and comprehensive healthcare services, was established only in 1948, after World War II.

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

A key difference in the public-private partnership 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 other hand, is experiencing unprecedented economic growth and there has been an explicit commitment to increasing state funding on health from 0.9 per cent to 2-3 per cent of the gross domestic product (2). Thus the primary 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 public-private partnerships in different Indian states to learn some lessons before it is too late.

Recently I was in Namkum where the Jharkhand state health department has many of its offices. While waiting for a meeting with the director of the National Rural Health Mission (NRHM) I saw a convoy of vans and jeeps passing through the compound. On enquiring, I was told that these were among the couple of hundred ambulances that the government had given to various private organisations two years earlier, to facilitate the transport of patients from the interior to hospitals. However, no programme guidelines had been drawn up, no agreements signed and no arrangements made for operational costs. The government was still to formalise procedures. In the interim, many of these vehicles were, reportedly, being used as taxis.

One of the earliest state governments to start public-private partnerships since the NRHM was announced was Bihar. In some areas this was introduced to provide pathology and diagnostic services, operate ambulance services in the state and run additional primary health centres. The ambulance contract ran into trouble right at the outset and had to be suspended. The pathology laboratory started contracting out the work and I have heard complaints from members of patient welfare committees in Bihar that government clinics are now ordering many more investigations than they did before.

Yet another story relates to partnerships to run additional primary health centres. Some 30 such clinics were handed over to non-governmental organisations (NGOs) in 2006. I heard complaints that the government did not release money on time, or that funds being given to NGOs was much less than what was being spent in a similar government institution. I learned that these contracts were not renewed this year.

The most high profile public-private partnership in the country today must be the Chiranjeevi programme launched by the Gujarat government. Gujarat is one of the most industrialised states in the country and a major hub of the pharmaceutical industry. Field experience tells us that, despite official figures to the contrary, the state's maternal mortality ratio is high, reflecting poor access to healthcare.

There is also a great disparity between districts in access to healthcare. The state government drew up an ambitious scheme to ensure institutional deliveries for the poor through the active engagement of the private sector. In a pilot project, obstetricians in five districts were offered a financial package roughly Rs 1.75 lakh for every 100 deliveries they conducted. This amount was arrived at by proportional costing of a normal delivery, an assisted delivery and one with a surgical intervention. The first year of the programme has been completed and it is now being implemented all over the state.

The scheme sounds remarkably simple in its conceptualisation and delivery and typifies what may be called a win-win situation. The state issues a service voucher worth about Rs 2,000 to each poor pregnant woman and ensures that the provider is reimbursed: it is something like a pre-paid taxi service but you don't have to pay for the receipt. While some adverse reports have started coming in, certain design elements may be of greater significance. For example, the process of recruiting 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 caesarean delivery.

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 per cent, one can expect around 8,000 childbirths among the poor in the district each year. With the Chiranjeevi programme a total of up to Rs 1.5 crore will be provided as cash vouchers to ensure institutional delivery for all poor women. This reasonably large amount to be shared by 100 obstetricians practising in the district is effectively taken away from strengthening services at the primary health centre and community health centre, services that would have provided services for diarrhoea, tuberculosis, malaria, hepatitis, chikungunya and a host of other health conditions – besides ensuring safe deliveries. But then as I 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.

There have been some reports from Gujarat that government centres are referring easy cases to private practitioners; private practitioners refer difficult cases to district hospitals. Government centres do not wish 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 Vande Mataram scheme, launched with much fanfare by the then union health minister in collaboration with the Federation of Obstetrician and Gynaecologists 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 healthcare service delivery through the public-private partnership approach should be welcome. However current efforts are inadequate on many counts and the problems must be addressed if a robust, accountable and quality public-private partnership mechanism has to be developed. Some measures that need to be introduced are:

- Setting up a set of technical and ethical parameters and standards for service delivery common to different levels of the healthcare system. A beginning has been made with the Indian Public Health Standards and these should be applicable to both the public and the private sector.
- There must be new regulatory mechanisms for the healthcare system including the pharmaceutical industry which is among the least regulated in India.
- The cost of healthcare should be regulated just as other consumer products are, through a system of maximum prices. The voucher system can be seen as a precursor of this mechanism.
- An efficient monitoring and enforceable system should be introduced of penalties for breach of regulations and standards.

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.

References

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