Private Partners in the Public Health System
Selected Cases from Tamil Nadu

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Abstract: *The paper points out that the wide and varied nature of the health sector has blurred the domain where the public sector and the private sector would function. The recent trends show that the private sector is increasingly playing a significant role in the public health system at all levels-international, national and sub-national, under the blanket of "Public-Private Partnerships"(PPPs). Such a trend needs to be seen in the context of global funding for tackling diseases like AIDS, Tuberculosis, and Malaria, the dominance of NPM thinking in the public health system, and the budget constraints faced by the national government. The paper then discusses the documented experiences of PPPs in the health sector in the Tamil Nadu context. The paper concludes that while there appear to be no alternative to PPPs their working in the health sector needs to be improved.* ***Email:** rajasulochana2k@gmail.com*

Health is a universal need. It must be met either by the public sector or by the private sector, and if possible, by both working together. Whichever the mode of supply and organisation, the heterogeneous activities that promote, protect or restore health should be:

- low-cost quality care (cost-effective), and
- accessible to all (equitable).

This paper attempts to explore the role of private partners in the public health system in Tamil Nadu using selected documented case studies

The first section of the paper presents the theoretical base for the public and private roles in the health sector. The second section discusses the international as well as the national context that has led the private sector to play a significant role in the public health system under the blanket of public-private partnerships (PPPs). The third section presents four documented cases of PPPs in healthcare from Tamil Nadu, of very different structure and objectives. The fourth section discusses the various issues and constraints in their working and concludes that there is no alternative but to improve the working of the PPPs in the health sector.

I

Public and Private Roles in the Health Sector

Health sector is wide and varied encompassing a multitude of services and programs, ranging

from maintaining clean water and sanitation to cosmetic surgery and organ transplants. Using economic principles, we can subdivide health care into three categories:

Public goods: Public goods are non-exclusive and/or non-rival in consumption. In the health sector, most public health and preventive measures like clean water, sanitation, vector control, road safety, air and water pollution control, fluoridation of water, and mass health education.

Merit goods: There are several types of merit goods. One type consists of services whose consumption produces greater social benefit than private benefit, such as family planning and certain primary-care services. Another type produces externalities such as vaccination and control of sexually transmitted diseases. A third type of merit goods includes services possessing significant interpersonal utility values, such as emergency services for trauma patients and medical services to relieve acute pain and basic health services for vulnerable people like children, women, elderly and minorities who may be powerless to make consumption choices to pursue private benefit. Finally, merit goods include services where individuals lack sufficient education or rationality to make rational consumption decisions, especially preventive services.

Private goods: Private goods are those services that exclusively benefit the persons who consume them, and that if consumed by one person, cannot be consumed by another. Because of their exclusivity, the market can produce and distribute them efficiently. Most of the curative medical services and drugs fall into this category.

According to economic theory, it is socially optimal for government to finance and possibly provide the first two types of services; while it may be more efficient for the free market to finance and provide the third (Samuelson, 1954).

Another important aspect of health care, pointed by Musgrove (1995) is that health care has three dimensions: Need, Demand and Supply (as shown in fig.1). These dimensions have implications for the appropriate public and private roles in the sector, such as whether, how and how badly markets fail. Market failure as an economic notion, refers to possible mismatches or disequilibria between what the market supplies, and what fully-informed rational consumer of health care would demand. It does not deal with the concept of need for health care, which is theoretically an unsatisfactory concept but is also difficult to do without (Culyer, 1995

Figure 1. Need, Demand and Supply for Health Care

People want health care not for intrinsic utility but because they need it and that if care is not provided their health will deteriorate or fail to improve. Just as demand and supply may be out of balance, there can be imbalance between demand and need or between need and supply of services. Market failures in the narrow economic sense are among the reasons for these imbalances (these are indicated on the figure.1 by asterisks). Some failures result from barriers to the operation of competitive private markets in bringing supply and demand together. Others distort demand from what it would be if based on complete and symmetric information and if there were no public goods or externalities; this causes imbalance between demands and needs.

While competitive private markets are generally the best way to bring demand and supply together, they are much worse suited to make either demand or supply match people's needs. Public intervention in the health market, in contrast, is aimed at satisfying those needs, and runs private or a purely public health care system is likely to control one of the three potential imbalances, at the cost of failing to control or even worsening one or both of the others.(Musgrove 1995). These dimensions explain why most health care systems are far from being all private or all public.

II

Recent Trends in the Public Health System

Health is now widely recognized as a basic human right, and the urgency of some global health issues has pushed global health policy to the top of the international agenda. The epidemics of HIV/AIDS and SARS, the potential impact of avian flu, and the international public goods dimensions of public health make global health policy both a national security issue and a foreign policy issue. Furthermore, it has become clear that the Millennium Development Goals cannot be achieved without massive infusions of new overseas development assistance, much of it targeted to health.

These issues have produced new global health policy dynamics among multilateral and bilateral donors, the new financiers (such as the Bill and Melinda Gates Foundation, Médecins Sans Frontières and Helen Keller International) , the new global programs (such as the Global Fund to Fight AIDS, Tuberculosis, and Malaria), and recipient countries. Multilateral and bilateral institutions and foundations, nongovernmental organizations (NGOs), and joint donor initiatives are helping countries to finance, rationalize, and operationalize health reforms (Gottret and Schieber,2006, p.1).

Another dimension is the dominance of neoliberal ideas, such as New Public Management (NPM) in the ongoing health sector reforms (Bennett and Muraleedharan 2000). NPM advocates a shift in the role of government from that of 'direct provider' to that of 'facilitator' for delivery of public services, through policy making, regulation, coordination of other actors, contracting and providing information. NPM encourages decentralization of government and performance-based measurements for public services. All of these increasingly blur the boundary between the public and private sectors.

The third dimension is that of shrinking budgetary support for the health sector. Low health expenditure by the public sector along with poor utilization of funds allocated in developing countries like India is a cause of concern. Public spending on health in India has stagnated at around 0.9 per cent of the GDP since 2003-04 and 90 per cent of this goes into recurring expenditures such as salaries and wages, drugs, consumables etc. As a result of stagnant budgetary allocations, the quality of care has suffered substantially in the secondary and the tertiary level of the health delivery system. The introduction of user fees for health services that were earlier being provided free in some cases, has forced patients to seek private health care

(Report of National Commission on Macroeconomics and Health,2005). Yet another ground level situation is that the number of deaths due to non-communicable diseases like cardiovascular disease, cancer, trauma and accidents has increased and is likely to increase disproportionately in future. The health infrastructure in India is not geared to handle this changing disease pattern load (Bhat, 2000).

The involvement of the private sector in the public health system is being considered as an alternative option, for augmenting resources in the health sector as well as for improving the quality of care. The earliest effort in this direction was spelled out in the National Health Policy (1982) document of Government of India which recommended that the states should design processes which encourage the establishment of practice by private medical professionals and investment by non-government agencies in establishing curative centres. The Tenth Five Year Plan envisages a partnership between public, for-profit private and not-for-profit private sectors to meet the health care needs of the poor and other disadvantaged populations. The National Health Policy 2002 too encouraged the participation of the private sector in primary, secondary and tertiary care. Recently, National Rural Health Mission (2005) has strongly supported public-private partnerships. Health being a state subject, several state governments took policy initiatives to attract private sector participation and management inputs into running primary health centres, the privatization or semi-privatization of public health facilities. More often, however, this has been done with the assistance and insistence of the World Bank (Purohit, 2001).

Public-Private Partnerships (PPPs) are collaborative endeavors that combine resources from the public sector with resources from the goals private sector to accomplish common health goals. PPPs involve a range of partners like Multinational corporations, Small & medium businesses, Pharmaceutical manufacturers, Private health care providers, Private foundations and trusts, venture capitalists etc.

PPPs provide opportunity to jointly define problem and its solution, share resources, risks, responsibilities and rewards, foster innovative approaches to work and bring new partners in the fold, help ensure sustainability of programs, Facilitate scaling up of interventions, and leverage cash, expertise, systems and/or networks

PPPs describe a range of possible relationships among public and private entities in the continuum between nationalization and privatization, depending upon the objectives they seek to achieve, which are stated as under:

- ***Access:***
    - **Voucher schemes** (a service purchase coupon for consultations, lab tests, surgical procedures, counseling, deliveries and drugs)
    - **Mobile Health Units** (deployed in partnership with the private sector in geographical areas with difficult terrain, areas in which transport facilities and road connectivity are poor, or PHCs that are situated in remote areas)

➢ ***Affordability:***

- **Community–based Health Insurance** (to reduce indebtedness among poor due to health care costs)

➢ ***Efficiency:***

- **Autonomy to hospitals or health service establishments** (freeing from state bureaucratic control lending more flexibility in decision making, improving efficiency, and accountability. and allowing institutions to generate alternate sources of funding)

➢ ***Financing:***

- **Build, Operate and Transfer models** (part-financing of large hospitals projects by the government providing, financial guarantees when needed, subsidized land at prime locations)
- **Joint Ventures** (equity participation of the public and the private sector in building large-scale establishments or super-specialty facilities)

➢ ***Outreach:***

- **Social Marketing** (using multimedia communication campaigns for promoting contraceptives use, oral hydration therapy, organ donation etc)
- Partnering with Grass-root organizations like Non-Government Organizations, non-profit Community-based Organizations, Self-Help Groups, Co-operative societies, Social Groups for effective information and communication campaigns, community mobilization and innovative and cost-effective service delivery.

➢ ***Risk Transfer:***

- **Traditional Public Contracting** (Operation-Maintenance-Service Contracts- for clinical and non-clinical services)

➢ ***Technical strength:***

- **Capacity Building** (training to improve the clinical skills of private medical practitioners particularly those working in rural areas and urban slums)
- **Involving Corporate Sector and Professional Associations**(in launching mass programs such as immunization, pulse polio, cataract operations, health camps, etc to promote self regulation, standard protocols, quality assurance systems and ethical practices)

In general, the focus of various private-public collaborations has been on: developing strategies to utilize untapped resources and strengths of the private sector; enhancing the capacity to meet growing health needs; reducing a financial burden of government expenditure on specialty and super-specialty care; reducing regional and geographical disparity in health care provision and ensuring access; reaching remote areas or targeting specific groups of population; and improving efficiency through evolving new management structures (Bhat, 2000).

III

Selected Experience of PPPs from Tamil Nadu

Tamil Nadu has the distinction of initiating several health sector reforms often channelling political action in the desired direction (NHDR, 2001). It is also known for its many interesting health interventions that ultimately served as models for other states to emulate. Some of them are discussed below:

Case 1: Emergency Transport service-Outsourcing

The Tamil Nadu government pilot-tested a scheme of contracting a non-governmental organization (NGO) Seva Nilayam Society to run transport services for emergency obstetric cases and road traffic accidents, through the funds from the RCH project in Theni district. As part of the contract, the government provided two ambulances, communication and life-saving equipment free of charge. The NGO provided salary of driver, maintenance of vehicles, fuel charges, and insurance. The NGO was allowed to recover the expenditure by charging Rs 5 per km from all patients. It was expected to offer services free of charge to 10 per cent of cases (for the poor), and all accident emergencies were transported free of charge. The NGO is expected to recruit two drivers and two nurses, train them and ensure they are available to provide 24-hour services working in shifts.

The scheme is monitored by a committee headed by the state Deputy Director (Health), the project director and the director of the NGO. In Theni district, around 30-45 emergency cases every month are transported, of which 30 per cent are obstetric emergencies. The public was made aware of this intervention through various information campaigns. With the success of this project in Theni district, the state Government decided to expand the service throughout Tamil Nadu.

Under the Tamil Nadu Health Systems Project (TNHSP), funded by the World Bank in 2005, the State Government developed a public-private partnership (PPP) with several NGOs to provide emergency transportation service in many districts. Under this partnership, the TNHSP provided equipped ambulance and running costs to the selected NGOs. Other minor expenses incurred for running the ambulance are borne by the NGOs. The NGOs met these expenses by charging nominal user-fees from those above the poverty-line. A monitoring and evaluation committee has been set up to evaluate the performance of these NGOs. A central control-room has been established in each district in the state with a common toll-free number of 1056.

The advantages of this scheme are: First, it is cost-effective for the government. This is because the scheme puts back into use old vehicles which are lying idle due to lack of manpower. Second, the NGO provides quality services with timely life-saving first aid services. Third, this scheme has raised public awareness of the available emergency service. However, the scheme is not self-sustaining for the NGOs involved, particularly because of high operating cost. The main concern is that the actual rate charged per kilometer of distance is around Rs 7 to 8 per km, contrary to the agreement rate of Rs 5 per km and some even charge extra sum under driver's allowance and cleaning charges. Monthly salary of the driver is Rs 3000 (not Rs 2000 as per the MoU). There is also the problem of monitoring -the representatives from the government rarely visit the facility to monitor the services. Accounts, log book and patient records are poorly maintained. Despite these limitations, the scope for continuation of the 1056 emergency service is quite high. This is due to exorbitant charges by the private ambulances.

Case 2: Adoption of PHCs by industries.

In 1997, the Government of Tamil Nadu appealed industrialists to adopt and revamp the functioning of PHCs so as to provide better service conditions to the rural poor. Three models of 'industrial adoption' were put forth, with model 1, the complete adoption, meant a one-time cost of about Rs 11 lakh and an annual recurring cost of about Rs 14.5 lakh which covers the full cost of running a PHC or taluk/district hospital (including salary of the staff, cost of drugs, purchase of equipment, civil work and maintenance, repairs and construction of staff quarters), are met by the industrial house. Model 2 allows the partial adoption requiring the same one-time investment and an annual recurring expenditure of Rs 4.5 lakh where the industrial house meets all costs except staff salaries, and Model 3, limited adoption model with the same one-time Rs 11 lakh and an annual recurring expenditure of Rs 3.0 lakh which involves provision of civil work, maintenance and repairs and provision of equipment. A Memorandum of Understanding (MoU) was signed between the partners: the government and the industrialists. . Most industries preferred partial adoption models, mainly to avoid the huge wage bill; complete adoption would have called for trimming the staff strength by 25 per cent and it would have met with considerable opposition by the government as well as the staff.

Number of PHCs adopted by the industrialists was around 90 (6.4 per cent) out of 1413 by October 2005 (Krishnamurthy, 2005). Most industrialists preferred partial adoption, since complete adoption would call for higher commitment of resources and also trimming of staff strength. The total support amounted to about 0.1 per cent of state government expenditure on PHCs. Activities performed under the industrial participation were creation, renovation and furnishing of operation theatres, appointment of staff nurse, construction or repair of wards, compound wall, fence, toilets, and staff quarters, provision of beds, telephones, transport, and drinking water facility, electrical wiring , blood donation by industrial workers, and provision or repairing of medical equipments and furniture.

The policy of industrial partnership to re-activate PHCs in Tamil Nadu, although through gentle coercion, did bring in significant intangible and limited tangible benefits to the PHCs. This one-time booster scheme benefited the rural community (better quality of care and

reduced transport cost), the PHC staff (better work environment and job satisfaction) and the industry (tax benefits, publicity and community rapport). However, the success of this scheme depended on the complementary inputs from the government (appointment of anesthetist) for certain industrial support (to build operation theatre). There is simply no mechanism in place to ensure such cooperation from the government, so that the industry would show continued interest in this scheme. As of now, this scheme is virtually ineffective.

Case 3: VHS-TAI clinics

VHS has been in the forefront over the last decade in the country's efforts to prevent and control AIDS through its AIDS Prevention and Control (APAC) Project, supplemented recently by the Tamil Nadu AIDS Initiative (TAI) Project. In 1995, VHS was selected by the United States Agency for International Development (USAID) as the nodal agency for implementation of the AIDS Prevention and Control (APAC) project through NGOs in Tamil Nadu. Funded by USAID under a bilateral agreement with the Government of India (GOI), it was initially a 7-year programme, the main objectives of which were education for prevention of AIDS, behavioural change communication, enhancement of STD care services, condom promotion, and research. The successful implementation of the programme has encouraged USAID and GOI to extend the project for a further period of 5 years (till March 2007).

VHS's Tamil Nadu AIDS Initiative (TAI) Project, which started in 2004, is supported by Avahan, the Indian AIDS Initiative of the Bill and Melinda Gates Foundation. TAI works towards its goals of prevention of the disease among marginalised groups. TAI is implementing prevention programs with commercial sex workers (both male and female), approximately covers 34,000 sex workers. The project reinforces safe sexual practices and increases the quality of STD services for these target groups in Tamil Nadu. TAI is expected to strengthen the existing services-both private and government-for rendering quality STD care management, and well-equipped clinics and trained and sensitive doctors to be available at these centres to service the target groups. STD drugs is supplied free of cost to the patients.

TAI aims to network with NGOs in the state, and is in the process of identifying capacity building organisations to train the NGO partners to implement the prevention programmes. Some of the capacity building exercises planned are orientation to the basic facts of STDs and HIV/AIDS, skills in outreach work, counselling, sensitisation exercises on sex and sexuality, communication skills, management of information systems (both financial and technical), and basic epidemiology. TAI communication goals are to increase consistent condom use, increase STD treatment- seeking behaviour, and reduce the stigma and discrimination towards the community.

TAI works along with the Health and Family Welfare Department, Government of Tamil Nadu, the Tamil Nadu State AIDS Control Society (TANSACS), AIDS Prevention and Control Project (APAC), Chennai AIDS Prevention Control Society (CAPACS), and Population Services International (PSI).

The APAC model and TAI clinics are unique in Tamil Nadu, since it is the first wholly private sector approach towards HIV/AIDS which has set an important standard for productive partnership of the government with private sector institutions. As of now, they are working well and there are no perceived disadvantages, a good working relationship exists among the public actors like TNSACS and NGOs.

Case 4: Aravind Eye Hospital

Aravind Eye Hospital was founded in 1976 by Dr Govindappa Venkataswamy (affectionately known as Dr V). Almost 30 years later, Aravind's innovative eye care delivery system is renowned worldwide for its technical excellence, operational efficiency and pioneering community work. It has become the most productive eye hospital in the world. The Aravind Eye Care System incorporates five hospitals (Madurai, Theni, Tirunelveli, Coimbatore and Pondicherry) which collectively perform 250,000 surgeries every year, an eye bank, an ophthalmic equipment and supplies manufacturing plant, a medical research foundation, community outreach programmes, a community health centre, education, training and consultancy services. This amounts to a staggering 42 per cent of total surgeries in the State relieving its burden

Much importance is given to ensuring that all patients are accorded the same level of care and high quality service, regardless of their economic status. As a result of a unique fee system and effective management, Aravind is able to provide free eye care to two-thirds of its patients from the revenue generated from the other third - its paying patients.

Aravind follows the principle that a large volume, high quality service results in a low cost and sustainable organisation. Aravind's network of hospitals has the distinction of being the most productive eye care organisation in the world, in terms of surgical volume and the number of patients treated. With less than one percent of India's ophthalmic manpower, Aravind performs about five percent of all cataract surgeries in the country. This is the most successful leadership driven model of PPP in eye care.

IV

Discussions and Conclusions

The above described cases are reflective of varied forms of PPP Models, which need to be analyzed on various dimensions: strengths, weaknesses, costs, equity element, quality element, sustainability, scalability, coverage, health outcomes, constraints and issues.

Several issues crop up while designing, identifying partners, and executing the partnership, that revolve around the following questions:

- ✓ Whether the government genuinely desires to partner with the private sector?
- ✓ Whether there is mutual trust and understanding among the public and private partners?

- ✓ Whether there is reconciliation of interests among the partners?
- ✓ Whether the government has the skill to negotiate with the private sector?
- ✓ Whether the government pays its dues on time?
- ✓ Whether there is an accreditation and monitoring mechanism to assure quality for standardized service through PPP?

If the answer to the above questions is positive, then the pre-conditions for PPPs in the health sector are present.

Given the fiscal scenario of many states, gaps in the public provision of health care, and interests shown by various key actors in health sector, PPPs will continue to draw policy attention in India. At the same time, it is necessary to guard against PPP becoming a policy to abandon government responsibilities.

In conclusion, PPP has to be understood as a means to an end. The main purpose is to deliver quality health service to one and all. PPPs are just a mode to strengthen the public health system through the flow of resources and technical expertise from the private sector. Ultimately the responsibility of ensuring good quality, low cost and accessible health care lies with the government, the means could be through the private sector.

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