Public Private Partnerships: Good, Bad, Ugly
A Practical Look at PPPs

Tejal Barai – Jaitly
Independent Research Consultant, Mumbai.
Email: tejal.jaitly@gmail.com

Abstract: *Public Private Partnerships come across as an inevitable component of the health system of our country today. But without systems in place, this innovation could prove counter productive. While PPPs may not 'bad' in their concept; but in their planning and implementation, monitoring and regulation are indispensable.*

'We need to devise a new pattern of public-private partnership in healthcare delivery.....the role of public sector in healthcare delivery cannot be wished away,....we have an obligation to streamline the public health system.'-Manmohan Singh

India has managed to build large public health infrastructure – which is in a state of disarray. It also has state of the art private facilities (largely promoted through government incentives). While this chasm is absurd in itself – it clearly highlights what our public health sector can achieve and what the private sector can contribute. This is roughly where PPPs come in. Even while historically there are numerous examples of the government engaging with the private sector for various programmes, PPP as a formal strategy for implementation of government health programmes is a relatively new development, and has gained momentum in the last decade, particularly since the launching of the National Rural Health Mission.

There are a number of apprehensions around PPPs. The government has for decades promoted the growth of the private sector – but to partner with it without implementation of the relevant laws for accreditation and regulation and without stringent monitoring mechanisms – does not particularly send out the right signals. There are fears of privatisation and relinquishing of responsibility as the government is increasingly looking towards the private sector. More critical – PPPs seem to be going way the private sector went – no monitoring and therefore not much is really known about them. In most government documents (Barai-Jaitly 2010), PPPs have been identified as a strategy much below a number of other key strategies that clearly aim at revamping the public sector. And yet, it has been touted as the latest mantra for ensuring the much desired health status of the population. As a result of many PPPs seem to be initiated without much thought and planning.

So, good, bad or ugly, PPPs are here to stay. Rather than beating it down, it is only wise to take a practical look at the new 'phenomenon'. Having felt the need to do so, CEHAT has launched a number of initiatives. To start with, it organised the National Conference on the 'Emerging health care models: Engaging the private health sector' on September 25-26,

2009 (see www.cehat.org). Following this, it has prepared a report, *Public Private Partnerships: Reflections and Way Forward.*

A basic conceptual issue with PPPs is the multitude of definitions. In order to have some kind of synergy in order to promote a more constructive debate, there needs to be one acceptable definition. PPPs are a 'mode (italics added) of implementing government programmes/schemes in partnership with the private sector'.(GOI 2004). This definition is simple, and implies and highlights key aspects. It stresses the fact that PPPs are a 'mode', i.e. simply a method of implementation or delivery. Secondly, it implies that PPPs have to pursue the same priorities as those of the government programmes - of promoting equity, accessibility, etc., in health care. It naturally follows that the primary purpose of PPPs, is that it should contribute towards the attainment of the public health goals and they are meant to augment (not replace), existing public services and infrastructure. In order to achieve this it should obviously have to directly provide the service/products or aid in delivering of services/products (GOI 2004). Other definitions found in literature seem to generally fall within the purview and understanding of the above definition.

PPP involves the 'lumping' together of sectors that they are actually diametrically opposite each other. Not only do they function on different principles and values, but also on different purposes. How the private sector is going to be cajoled into getting in sync with public sector goals is still rather ambiguous.

The rationale for promotion of PPPs has often been to increase efficiency, cut costs, increase outreach, etc. However, none of these claims have been proved satisfactorily or consistently. There is in fact conflicting evidence to the same (GOI 2004). It seems a rather dangerous situation wherein PPPs are being promoted without sufficient factual evidence. At the same time, as Rajsulochana in her paper in this issue 'Private Partners in the Public Health System: Selected Cases from Tamil Nadu', argues, that 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.

In order to initiate PPPs the government has to develop suitable technical and management proficiency – presently there seems to be more of a hurried approach – which could, and has often proved counter productive. This was clearly the case in Bihar as revealed in the study 'Private Partnership (PPP) Initiatives in Bihar: Successes and Failures' by Mona Gupta, where lack of expertise and hasty planning led to the failure of many projects as well as a number of poorly implemented initiatives. Her study is based on primary research as well as secondary research work. The Government of Bihar, initiated a large number of PPPs. Some of these were successful and others not so. Those that were successful, had led to increased accessibility of health services. However, hasty planning, delay in payments, lack of technical know-how, limited number of private players interested in catering to grass roots and capacity to monitor the projects were the prime reasons for failure.

Moreover, in a situation where there is government monopoly, introduction of PPPs in such 'parched' circumstances too does not necessarily ensure successful PPPs. This has been clearly brought out in Deepak Mili's paper, 'Public Private Partnership in Health: An Understanding of PPPs in Primary Health Care in Arunachal Pradesh'. A SWOT analysis in six districts revealed that while there was a doctor present at the PHC's, PPPs had not really solved the problem of vacant posts, as these continued to plague the system. Moreover, it was found that the success of these PPPs was a result of a strong leadership, threatening sustainability.

There are also fears that the government is relinquishing control over the public sector or heading towards privatisation. However, this does not seem to be true. Moreover, privatisation essentially involves transfer of ownership of assets from public to private ownership, after which the original 'owner' has no control or right over the assets. This is certainly not the case in PPPs. Through PPPs the government is acknowledging its limitation, identifying areas where the private sector can contribute and strategically using it for the benefit of the people. It continues to retain full responsibility for the provision of the service. At the same time, it has set out a massive agenda for the revamp of the public health services, through which it will continue to provide healthcare to the masses.

Models under PPP is another area of ambiguity. Most PPPs can be placed under one of the three models: social marketing, social franchising and contracting. While they might not be entirely mutually exclusive, they have their own characteristics which make them distinct. Moreover, most variations in specific constituents of various PPP projects have been found to fall under one of these or at least get in closer alignment with one of these models.

The time needed for revamping of the public sector and in order to have any postive impact, it becomes necessary that the period of enagement with the private sector in a particular PPP, has to be significant. This clearly rules out single – point contributions, donations or subsidies. It does not, however, exclude PPPs comprising of multiple partners – each with a clearly defined role to play. Such is the case with the PPP presented in the paper by SNEHA, 'Public Private Partnerships formed by SNEHA: Initiative For Newborn Health, ASK partnership, Arogya Sarita'. In one of their key PPP initiatives, City Initiative for Maternal and Newborn Health, details have been drwan up through participatory consultations. The government (in this case the Municipal Corporation Greater Mumbai, MCGM) provids the services, infrastructure and monitoring. The community contributes towards problem identification, mobilisation and monitoring of the project. The ICICI Centre for Child Health and Nutrition is the corporate partner that provided funding, design inputs, networking and dissemination. The Centre for International Health and Development contributes towards design input, evaluation, networking and dissemination. While SNEHA, the NGO partner, is the one binding the whole PPP together and responsible for implementation and monitoring. Through their experience of some very successful PPPs, two key findings evolved: It takes atleast two years for successful PPP to develop, and two, despite equal partnerships, one partner eventually ends up taking and performing a lead role.

Another major area of contention in PPPs in the acceptance of user fees and of incentives to private practioners. However, the primary goal of the private sector is to make profit, and its success is guaged on the basis of the amount of profit a private player makes. In case of many PPPs the incentive for the private partner is 'profit from volume', which essentially means that through the PPPs, people are charged much less than the 'prevailing market rates' in the private sector, thereby attracting large volume of patients that cover up for the 'nominal charges'. While user fees are a contentious issue, there are many successful PPPs that have actually managed to bring healthcare to the poorest by charging a nominal user fee in order to engage a private player. One such example is a very interesting and old model of PPP, the Vadu Rural Health Program (VRHP). The VRHP has a dual role: with the public sector as a private partner and with the 'private' practitioners as a proxy to the government. 22 villages were assigned to them by the government. The purpose was to establish a highly efficient, technically robust outreach programme that would be a very good example for other PHCs. At the same time, good quality curative services would be administered through the King Edward Memorial Hospital (KEMH) management. In this model, outreach activities of a Primary Health Centre (PHC) such as personnel, equipment and supply are financially supported by government. The designated PHC undertakes all activities that they were traditionally supposed to, except that the headquarters are at the KEMH. It was also unique in the sense that a privately owned funding agency provided additional financial support to create a program that would provide good quality healthcare to rural population at affordable costs. Moreover, governmental support makes it necessary that services are provided for almost no cost to people below certain socio-economic status. This way it is competing with the private sector for their share of the patients. A small part of the fees is paid to the specialist as an incentive. Compared to fees of specialists in private sector in the area this incentive is negligible, but the volume of patients makes up for it to some extent.

PPPs are then have to be accepted as an inevitable part of the health delivery scenario. The issue is to ensure that they actually work without anulling the state's responsibility for health care.

References

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