PUBLIC-PRIVATE PARTNERSHIP IN HEALTH CARE: CONTEXT, MODELS, AND LESSONS

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VIRTUAL BREAKDOWN OF PUBLIC HEALTH SYSTEM:
Known Causes

UNFETTERED RAPID EXPANSION AND DOMINANCE OF PRIVATE HEALTH SECTOR
POOR FORCED TO SEEK SERVICES
FROM EXPENSIVE / UNREGULATED
PRIVATE SECTOR

- 80% of expenses from Out-of-Pocket
- Debilitating Effects on the Poor
- Concern towards unbridled commercial behavior of the private sector
RATIONALE TO COLLABORATE

Given respective strengths and weaknesses, *neither the public sector nor private sector alone* is in the best interest of the health system.
HYPOTHESISED BENEFITS
(of working with Private Sector)

- Improve **Access & Reach**
- Improve **Equity** (Reduce out of pocket expenses)
- **Better Efficiency**
- Opportunity to **Regulate & Accountability**
- **Improve Quality**/ **Rational Practice**
- **Imbibe Best practices**
- **Augment Resources**- Funds, Technology, HR
## ESSENCE OF PUBLIC PRIVATE PARTNERSHIP:
### Financing vs Delivery: Public vs Private

<table>
<thead>
<tr>
<th>Public Financing</th>
<th>Public Delivery</th>
<th>Private Delivery</th>
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<td>Public Hospitals</td>
<td><strong>CONTRACTING</strong> Demand/ Supply Side Fin.</td>
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<td>International Disease (TB/HIV) Control Initiatives</td>
<td>Private Hospitals</td>
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NOT ALL INTERACTIONS ARE PPP......
PPP ENCOMPASSES

.....a collaborative relationship between the partners with...

• Clear terms and conditions
• Clear partner obligations
• Clear Performance indicators
• Stipulated time period
• Overall Health Objectives
CORE PRINCIPLES OF PARTNERSHIP
(Venkat Raman & Bjorkman, 2009)

Partnerships entail

- **Relative Equality** between partners
- **Mutual Commitment** to Health objectives
- **Autonomy** for each partner
- **Shared decision-making** and accountability
- **Equitable Returns / Outcomes**
- **Benefits** to the Stakeholders
PPP MODELS:
COMMON MODELS

- Contracting (‘in’ and ‘out’)
- Build/ Rehabilitate, Operate, Transfer
- Demand/ Supply Side Financing
- Joint Ventures
- Mobile Health Units
- Telemedicine
- Franchising
- Social Marketing
- Public-Private Mix
SELECT PPP MODELS IN ACTION
CONTRACTING MANAGEMENT OF PRIMARY HEALTH CENTRES

Free services- diagnosis, consultation, treatment and drugs.

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Except select surgeries all services are free for poor patients
CONTRATING MANAGEMENT OF SUPER SPECIALTY HOSPITAL

40% beds for Poor patients; Free OPD services to poor.
CONTRACTING MANAGEMENT OF CT SCAN/MRI DIAGNOSTICS

Free for all poor Patients; Subsidized rate for others
DEMAND SIDE FINANCING FOR INSTITUTIONAL DELIVERY & INFANT CARE

Institutional deliveries through private obstetricians; Primarily for women from poor families
Institutional Deliveries. Primarily for poor women
Hospitalization for more than 1600 surgeries. Members of farmers’ co-operatives and their dependents.
MOBILE HEALTH CLINIC

Clinical & Radio diagnostics through health camps, lab tests. Free to all Below Poverty line (BPL) cardholders.

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Tele-diagnosis and consultation in cardiac care and specialist care. Free diagnosis, medicines and treatment for BPL patients
KEY LESSONS
KEY STAKEHOLDERS

- Political
- Bureaucracy
- Regulator / Legal
- Civil Society
- Public Health System
- Private Sector
- Poor Patients

DEVT. PARTNERS
PUBLIC HEALTH SYSTEM

• Lack of Policy Driven Strategy - thus lack continuity

• No Organisation/ Institutional structures to manage PPP or Private Sector

• Lack of Institutional Capacity to design, contract, monitor PPPs

• Primarily concerned with Input-Based contracting
PRIVATE SECTOR

• Diversity of Private Sector: Predominantly Individual / small units- not easy to contract. Big units interested, but on their own terms.

• Lack of Accreditation, Quality Standards

• Payment Delays – Thus financial risk

• No Grievance Redressal- Non- Revision of contracts
BUREAUCRACY

• **Top Bureaucracy:** Enthusiastic, but Success Takes them Away- Next incumbent not necessarily willing to continue

• **Lower Bureaucracy:** Do not comprehend or suspect privatisation; Fear Job Loss; Distrust Private Sector
POLITICAL CLASS/ CIVIL SOCIETY

• Ambivalent stance by Political Class

• Squeamish about Profit making

• Popular / Cultural Antipathy towards Private sector

• Govt. inability to regulate, thus suspect Govt. ability to manage PPP.

• Question Long Term Effects - Sustainability
LEGAL / REGULATORY FRAMEWORK

• Lack of Information on the Private Sector

• Lack of effective implementation of legal framework towards private sector

• Lack of penal authority

• Interference from political / powerful lobby groups
DEVELOPMENT PARTNERS

• Effective Pilots – Leave Foot Prints- But not on long term

• Focused on project management targets/ deadlines; Value for Money

• Need to focus on developing institutional capacity– beyond hand holding
ENABLERs

- Most PPPs have been “Initiatives in Good Faith” based on Trust, Relationship and Leadership vision
- Prior Consultation
- Pilot Testing
- Timely Payment
- Acceptable Supervision & Monitoring
- Well defined health objectives/ Goals
- Periodic review of contract clauses
CONSTRAINTS

- Lack of clarity on why PPP
- Defining Beneficiaries in High value services
- Local political interference
- Non-revision Contract
- Payment Delay
- Institutional capacity for monitoring
- Attitude / Personality Styles
IDEAL STRATEGY FOR STRONG PPP

Regulation
(Physical Standards, Accreditation; Legal Framework)

Institutional System
(PPP Unit; PPP Policy; Intl. Capacity)

PPP
(Infrastructure; Service Delivery)
SUMMARY

- Inevitability of working with the Private Sector
- PPP is not privatization
- Government continues to play critical but need capacity to play the new role
- Need to continue public sector reform-strengthen ability to deliver services
THANK YOU

Ref. Book:
A.Venkat Raman & J.W. Bjorkman

http://south.du.ac.in/fms/idpad/idpad.html