

## Public Private Partnerships for Universal Health Coverage<sup>1</sup>

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### Technical paper for Management Reforms

#### Introduction

Universal access to health care and coverage are critical to achieve the United Nations' Millennium Development Goals (MDGs). In India a large and varied private sector plays a dominant role in the health field both in terms of the money expended for care and in the provision of services. Evidence indicates that households rely on the private sector even for essential services like maternal and child health care, and that this is financed by high out-of-pocket payments – more so than anywhere else in the world. However, much of this private sector activity is unregulated and does not contribute effectively to the national health agenda.

#### Private sector as a valuable partner for achieving universal health coverage

**Table 1: Different types of private providers**

	Formal		Informal	
Finance	Individuals/households		Individuals/households	
	NGOs/faith-based/community-based and other charities			Not-for-profit
	Foundations			
	Private companies			For profit
	Private insurance			
Provision	Pharmacies and pharmaceutical companies			Both
	Suppliers of other health-related products			
	NGOs/faith-based/community-based and other charities		Un-registered NGOs/faith-based/community-based and other charities	Not for profit
	Private facilities -- clinics and hospital			For profit
	Private practitioners		Private practitioners	

Source: PSP- ONE: Private sector partnerships for better health

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Although in the last five to six years the National Rural Health Mission (NRHM) has strengthened government capacity to provide access to basic health care services, there are still several constraints to providing universal access to health care. Thus a pragmatic approach would be to engage existing private providers to bridge this gap thereby scaling-up services towards universal coverage. As the role of the private sector is already large and it reaches out to all segments of the population, the relative costs and benefits of its effective engagement for universal coverage, compared to scaling-up public services, make it an option for serious policy consideration.

## **Present Public Private Partnership (PPP) models in India**

### **What is a true PPP model?**

For a relationship between the government and the private sector to be called a PPP it must be based on specific objectives, shared risks, shared investments and participatory decision making. Most PPPs working in India are contractual arrangements. The five consensus principles of PPP in the health sector are:

1. Should be pro-poor
2. Effective monitoring mechanisms should be in place
3. Both quality and costs should be monitored
4. Should be output based and the cost decided upon by fair process
5. Payment to the private provider must be made promptly and with dignity.

“**Contracting** is a purchasing mechanism used to acquire a specified service, of a defined quality and quantity, at an agreed on price, from a specific provider, for a specified period.” (Harding A.; Preker A.S. 2003) Contracting for services like cleaning or waste management at a public facility is the most common type of private engagement, and the simplest contractual arrangement in health. Diagnostics is the most frequently contracted out service from the public sector; again the contracts are commercial in nature and therefore easiest to implement.

Engagement of the private sector has allowed the country to scale up access to services within available public resources. Moreover, the arrangement includes accountability with action in the case of inadequate performance by the private providers.

Currently, under the contracting formula, the government and the private sector are implementing several initiatives in the states. These include: private providers being contracted for the Revised National Tuberculosis Control Programme (RNTCP); specialists made available for high risk pregnancies; social marketing; adoption and management of primary health centres; co-location of private facilities (blood banks, pharmacy); contracting out of medical education and training; and engaging private sector consultants.

While the contracts with the private providers are neither legally binding nor detailed, they cover the mutual obligations of both parties. An example of contracting is RNTCP joining with private providers for service delivery - RNTCP undertakes to distribute free drugs and supplies; to provide necessary training; and to ensure general management and coordination of the programme. The obligations of the private providers include the basic diagnostic and case management principles in line with set guidelines. They provide drugs free of charge, services at low cost and accept supervision and performance evaluation by RNTCP, based on which contracts are renewed.

This model has been extended to include:

- A triangular arrangement with NGOs partnering RNTCP to supervise and evaluate private for-profit providers.
- Monetary incentives such as some form of payment to providers. In the basic model the incentive was only implicit, that providers would garner more business in response to their dispensing free drugs.

Another example of contracting is the Chiranjeevi Yojana in Gujarat, India. To meet the MDG targets for maternal and child health (MCH), the state government set up a public private partnership in 2005 that contracted with private obstetricians practicing in rural areas to provide MCH care in their clinics, specifically to poor women who may not otherwise have had access to facility deliveries. The programme was initially implemented in five pilot districts where facility deliveries increased from 38% to 59%. The programme has since been expanded to cover the entire state.

### **Provider payment mechanisms:**

This refers to the manner in which funds are transferred from a purchaser to a health care provider, in this case a private health care provider. There are a variety of methods including fee for service, capitation, budget allocation for salary support, incentives and risk sharing. The particular mechanism adopted for payment has the ability to influence whether a provider functions in a manner so as to best meet the objectives of the purchaser. Payments are made either to an individual provider or to a health care facility, and in either case can be prospective (i.e. determined and/or made in advance) or retrospective (i.e. made after the service has been provided)

### **Issues with existing PPP models in India**

It is important to note that the private sector is not only India's most unregulated sector but also its most potent untapped sector. Despite issues of inequity, high cost, excessive use of clinical procedures and lack of quality standards or public disclosure of practices, the private sector is perceived to be more easily accessible, better managed and more efficient than its public

counterpart. Collaboration with the private sector in the form of PPPs would have to deal with the issues of improving equity, efficiency, accountability and quality.

This collaboration, however, calls for capacities on the part of both parties. Governmental capacity and mechanisms to monitor and ensure the quality and efficiency of private health services leave room for doubt. Many states lack the capacity to engage private providers in a manner that would be beneficial for universal health coverage. Best practice indicates that for successful engagement, government must have the capacity to effectively undertake contracting and provider payments. It is necessary to recognize that there are risks associated with contracting, including the fact that there may be only a few providers to choose from in rural areas thus limiting competition, and that vested interest may try to gain control over the contracting process. Both these risks would be accentuated by poor monitoring and evaluation mechanisms. Additionally, specific legal and administrative capacities are needed in contracting which often depend on the degree of experience with the initiative. However, despite these concerns, contracting is a useful regulatory tool for the state. By making judicious use of this tool, the state is able to better regulate the health system through interventionism that is flexible, reflective and responsive, and no longer based on authoritarian regulation.

### **Regulation and its constraints**

Five main regulatory bodies are available to align the private sector with the overall national health agenda: (1) government agencies; (2) financing agencies; (3) hospital accreditation agencies; (4) professional councils; and (5) NGOs and consumer protection agencies. These bodies have the potential to regulate the price, quality, quantity, distribution and information on health services in the private sector. However, the regulators are subject to three critical constraints that hinder the system's capacity to effectively engage with the private sector. These are:

- Political constraints which are difficult to overcome but may be removed through empowerment of communities. For this it may be useful to strengthen the role of non-governmental and community-based organizations (including consumer protection agencies), especially to ensure accountability in the system.
- Administrative constraints which are easier to remove. This will require targeting professional councils and government regulatory agencies on issues like accreditation, licensing and quality control.
- The lack of information, particularly access to information for consumers, is a constraint that is relatively easy to remove. This can be done through inculcating large scale consumer awareness through both government as well as parastatal bodies, like the regulatory bodies proposed as part of management reforms

### **Priority actions for engaging the private sector**

1. For stronger and more effective engagement with private sector, key government functions such as regulation, information collection and oversight should be strengthened. This would require strong financial and technical support to build the capacity of

regulatory bodies to develop and enforce quality standards and to manage health information systems.

2. Policy, based on national objectives and goals should be used for the engagement of the private sector. There needs to be a strategic choice between using existing private providers versus scaling up public services, including cost-effectiveness of the two alternatives. Policies and regulations that prevent private sector entities from providing reproductive health services and products also need to be re-examined and modified.
3. Build public-sector capacity to work with the private sector, including the development of skills to negotiate and oversee contracts with private providers. A “whole market approach” in health-sector planning (supporting a range of partners that have comparative advantages in reaching different segments of the population) should be the norm for achieving universal coverage.

There are mechanisms through which private sector contributions may be effectively engaged for progress on universal coverage. At the same time, these mechanisms can be successfully put into play only if government has the capacity to do so.

## References

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