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Improving Health Care Services in India: Public-Private Partnership is the Way Out

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Abstract

A Public-Private Partnership (PPP) is a government service or private business venture which is funded and operated through a partnership of government and one or more private sector companies. Public-Private Partnerships and Collaboration (PPPs and PPC) in the Health Sector is important and timely in light of the challenges the public sector is facing in healthcare finance, management, and provision. PPPs and PPC in the health sector can take a variety of forms with differing degrees of public and private sector responsibility and risk but are characterized by various similarities as well. In our country, with regard to health care, the main responsibility is that of the state which aims to provide free access to health care system to all sections of the society. But a look at the health infrastructure of our country shows that in rural areas, in particular, there is insufficient infrastructure, be it hospitals, primary health care systems, ambulances etc. Hence, the urgent need of the government is to immediately take measures that will help to develop a basis to provide the needed medical support to all. Although the private sector is inequitable and expensive with over-application of clinical/operational procedures, it is perceived to be easily accessible, better managed and more efficient than its public counterpart. It is expected that PPP model in the sector will prove the success story of Indian health care system.

Keywords: *Public-Private Partnership, Health Care.*

1. Introduction

'Health is Wealth' and a healthy population is the 'Wealth of a Nation'. Though India enjoys the benefit of 'demographic dividend', it is still unable to reap the economic benefits because of the low level of employability which does not give them the scope to participate in the gross domestic product of the economy. On the one hand, the country is being considered as a strong emerging economy, but on the other we find millions lying untreated and dying due to non-availability of a medical facility. Several indicators and reasons for poor healthcare in India are:

i) There are only 90 beds per 100,000 populations with a world average of 270 beds.
ii) India has just 60 doctors per 100,000 population and 130 nurses per 100,000 populations against world averages of 140 and 280 respectively.
iii) Public spending on healthcare stands at 1.407% of GDP (in 2014) up from 1.052% (in 1995).
iv) India's out of pocket health expenditure stands at 89% (of private expenditure) in 2014, down from 91.36% in 1995.

This is the state of affairs that is in existence for a long time. In spite of efforts to develop health care in the country, the overall state is very shabby. If we look into the healthcare system in India, we see that it consists of a universal health care system run by the respective State Governments. The Constitution of India makes every State responsible for 'raising the level of nutrition and standard of living' of its people and 'improvement of public health' among its primary duties. But, with the rising per capita income, the demand for healthcare is income elastic. Griffin (1991) estimated an average income elasticity of 1.3 on the basis of Asian data.

But, due to deficiency and insufficiency in health service, we are slowly moving towards a full-fledged public-private partnership model in healthcare. This model is a government service or private business venture which is funded and operated through a partnership of government and one or

more private sector companies. These schemes are sometimes referred to as PPP, P3 or P^3.

PPP refers to the involvement of a long-term relationship between the public and private sector which aims to achieve the twin objectives of high growth and equity on a sustainable basis. Heilman and Johnston (1992) define PPP as 'a combination of a public need with private capability and resources to create a market opportunity for which the public need is met and profit is made'. According to Buse and Walt (2000), PPP is to bring together a set of actors for the common goal of improving the health of a population based on the mutually agreed roles and principles. The World Economic Forum (2005) defined PPP in a different tone as a form of agreement which entails reciprocal obligations and mutual accountability, voluntary or contractual relationships, the sharing of investment and reputational risks, and joint responsibility for design and execution. Such an arrangement, therefore, helps to bring together resources and expertise from both the sectors. In practical cases, it will not only help to remove the imbalance between public and private healthcare services but will also improve the quality of healthcare for patients through better utilization of resources and sharing of experience and expertise.

PPP in the health sector is important and timely in light of the challenges that the public sector is facing in healthcare financing, management, and provision. Though such an arrangement may be of various types with differing degrees of public and private sector responsibility and risk, they share common objectives, risks, and rewards. But, to bring together two different sectors which have a different outlook is very difficult and the success depends on how aligned the entities are towards achieving the laid out goals. Thus, in a mixed public and private system, as in India, the private sector tends to focus on such services which can easily generate profits while the public sector also has to carry out unprofitable activities.

The health care system in the country can be broadly divided into four sectors, namely,

i) Public sector including government-run hospitals, dispensaries, primary health centers and community health centers, etc.
ii) The private non-profit sector, including charitable institutions, NGOs, trusts, missions, and churches, etc.
iii) Private sector which runs the private hospitals, clinics, and private practitioners etc. and
iv) Private informal sector, including practitioners not having any formal qualifications (traditional healers, herbalists, vaidyas, etc.)

2.1 Significance of the study

The role of healthcare in improving a nation's wealth and spurring economic growth is well established. India is among the fastest growing economies in the world and is poised to become the second largest economy in the world according to a recent report from the Price Water House Coopers International Limited (PWCIL, 2010). There is positive news from a recent PwC report titled "World in 2050: The long view: How will the global economic order change by 2050?" which mentions that during the next three decades, the global economy will be driven mainly by emerging and developing economies comprising of the E7 economies of Brazil, China, India, Indonesia, Mexico, Russia and Turkey growing at an annual average rate of around 3.5% over the next 34 years compared to only around 1.6% for the advanced G7 nations of Canada, France, Germany, Italy, Japan, the UK and the US. But in stark contrast, the same economy performs extremely poorly in terms of the Human Development Index. India got a rank of 119 out of 169 as per UNDP (2010) which has further worsened to a rank of 131 out of 188 countries (UNDP Report, 2016). Thus, the study looks into the different aspects of PPP arrangement in health care based on the poor state of health services in the country.

2.2 Objectives of the study

The paper aims to look into the state of healthcare and discusses relevant issues on PPP in the healthcare industry in the country.

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3. Public-Private Partnership (PPP) and Privatization

The business environment is changing and new needs are emerging. One basic need of every living thing is good health. Looking into the current infrastructure and healthcare delivery mechanism, we cannot expect a drastic transformation because change is a slow process. But, the question is how to change? PPP is one such possible mechanism. The other mechanisms are liberalization or deregulation which means the activities organized by the State would be provided by the private sector e.g. allowing government doctors to do private practice after office hours, allowing private doctors to use public facilities, etc. apart from privatization in health care services. The ways to improve social sector has always been an area of interest. Mitchell (2000) discussed the various partnership models in the social sector and points out the requisites for such a model to be successful and discusses the benefits that will arise out of such a venture. Burger and Hawkesworth (2011) point that taking decisions by comparing PPP model and traditional is difficult since many non-financial factors also play a vital role in the evaluation process. Though the terms PPP and privatization look to be close, there are differences which are as follows:

a) *Responsibility:* Under privatization, the responsibility for delivery and funding a particular service rests with the private sector. PPP, on the other hand, involves full retention of responsibility by the government for providing the service.

b) *Ownership***:** While ownership rights under privatization are sold to the private sector along with associated benefits and costs, PPP may continue to retain the legal ownership of assets by the public sector.

c) *Nature of Service***:** While nature and scope of service under privatization is determined by the private provider, under PPP the nature and scope of service are contractually determined between the two parties.

d) *Risk and reward***:** Under privatization, all the risks inherent in the business rest with the private sector. Under PPP, risks and rewards are shared between the government (public) and the private sector.

4. PPP in Indian Health-care industry: An urgent need

The term PPP can be defined in quite lucidly. One component in a PPP is the public sector that includes organizations or institutions financed by the State revenue. The other party, viz. the private sector comprises of those organizations and individuals working outside the direct control of the State (Bennet 1991). Broadly, the private sector includes all Non-State entities, some explicitly seeking profits (for-profit) and others operating on a not-for-profit (NFP) basis. The former are conventionally called private enterprise and the latter non-governmental organizations (NGOs). The for-profit private health sector set-up encompasses the most diverse group of practitioners and facilities. But, likewise, the character of not-for-profit organizations varies in terms of their size, expertise level, and geographical spread. NFP services are provided through charitable clinics or hospitals which are run by collecting the very small amount of services and depend mainly on grants or donations.

The need for PPP has arisen because of the weak health infrastructure that we see even after seventy years of independence. During the 1950s, the private sector in India catered to only eight percent of healthcare facilities. A World Bank (2001) report, however, points to an upside-down picture. It mentions that 93% of all hospitals, 64% of beds, 85% of doctors, 80% of outpatients and 57% of inpatients are in the private sector. This is an evidence to show the remarkable growth of the private health sector in the country (Baru, 1999). The main reasons behind such a trend are that the private sector is considered to be easily accessible, better managed and more efficient than its public counterpart. It is expected that PPP with such a sector will help to improve equity, efficiency, accountability, quality, and accessibility of the entire health system. Advocates argue that the public and private sectors can potentially gain from one another in the form of resources, technology, knowledge and skills, management practices, cost efficiency and even a make-over

of their respective images (ADBI 2000). Moreover, the other potential gains from PPP are innovative services, increased value for money, better institutional integration, customer-focused services, among others (CII Report). The potentiality of success through PPP has been talked about on different platforms.

The major reasons in support for the business model are cost efficiency, risk transfer, increase in productivity, broad support, enhanced social service through voluntary organizations, reduced competition and accelerated delivery. However, there are specific issues which include political and legal problems, cultural gap, lack of coordination, higher transaction cost**,** corruption and compatibility of objectives. Weiner and Alexander (1998) point to the issues of accountability, growth, and development that are challenging to such public-private partnerships. Similarly, Allard and Trabant (2007) also discuss the various issues that have been relevant for Spain.

5. Poor status of Healthcare in India: Some evidence

The demand for PPP in healthcare is the outcome of the poor state of healthcare service in the country. It is true that there has been an improvement in the quality of healthcare in recent times, but it is also to be admitted that regional, gender and locational disparities continue to persist. Achievements in health indicators have fallen short of expectations, especially as far as the delivery to the poor people is concerned. India's ranking in terms of health performance indicators continues to be unsatisfactory even in comparison to some of its poorer neighbors. The following points highlight the pitiable state of health services in the country.

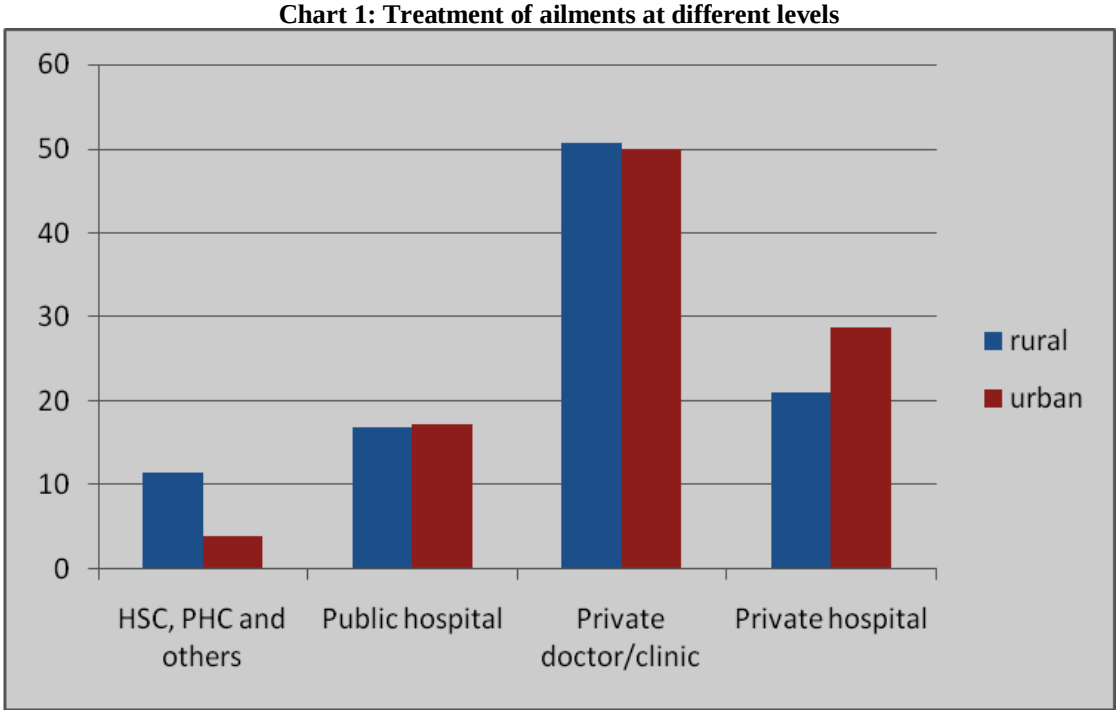
- While India has a male life expectancy of 63.3 years, the figures for Bangladesh and Sri Lanka are 63.4 and 68.8 years respectively. On the other hand, China enjoys a much higher male life expectancy of 71.4 years. Indian female life expectancy (66.6 years) is higher than that for males but is still far below that of China (74.9 years) and Sri Lanka (76.3 years) *[State of World Population 2008, Reaching Common Ground: Culture, Gender and Human Rights, UNFPA]*.
- India has an Infant Mortality Rate (IMR) of 54 per 1000 live birth. In comparison, Nepal, Bangladesh, Sri Lanka and Bhutan have lower IMRs of 53, 51, 11 and 44 respectively. China's IMR is only 23, suggesting a huge gap in delivery and quality of healthcare services in India.
- The incidence of early fertility is highest in India with 62 births per 1000 women in the age group of 15-19 years, far in excess of that in Pakistan, Sri Lanka and Iran with figures of 36, 25 and 20 respectively. China's performance in terms of this indicator is also far better than all mentioned countries with 8 births per 1000 women in the same age group.
- With regard to conditions provided for delivery of infants, 47% of births in India take place under skilled supervision while in Sri Lanka, it is commendably high at 97 %.

It is true that the health network in India has expanded rapidly but still it remains widely skewed, with wide disparities in availability and quality of services. Though medical services are available in tier 1 and 2 cities, the quality of service and infrastructure is very poor in rural areas. The irony is that medical tourism in India is becoming popular with patients coming from overseas, but our own citizens do not have proper access to basic healthcare services.

6. Healthcare in India: Over-dependence on private sector

In the following paragraphs, the authors discuss the different aspects of the health sector in the country. The chart below (No. 1) shows the over-reliance of the people in the private sector for medical treatment and receiving healthcare services.

Chart 1: Treatment of ailments at different levels



Source: Compiled from NSSO Report

It is very clear that the private sector has come to the rescue of the healthcare industry, be it in the urban region or rural. The other important aspect of health coverage in India is the availability of patient services in the country that points to an inclination towards the private sector (table 1).

Table 1: Beds and utilization of Patient Services in India

	Public	Private	Source
Beds	51%	49%	NCMH(2005)
	62%	38%	NSSO (60th Round 2004)
Out Patient Use	22%	78%	World Health Report 2010)
	30%	70%	NSSO (60th Round 2004)
In Patient Use	40%	60%	NSSO (60th Round 2004)
	44%	56%	World Health Survey India 2003

Source: Survey reports

The NCMH Report of 2005 points out that the private sector, with 49% of a number of hospital beds is providing services to the extent of 60% in in-patient care and 78% of out-patient care in the country. This indicates the dominance of the private sector in rendering healthcare services. One of the prominent reasons is the severe shortage of manpower at different levels in the public healthcare delivery mechanism as pointed by the NRHM report (table 2).

Table 2: Human Resource for Health estimates for Healthcare Services

Cadre	Currently serving in Rural Public Sector*	Current shortage* (rounded off)	Estimates of total required for 2020 #
ANM	1.9 lakh	15,000	7.42 lakh
HW (male)	52,000	94,000	4.4 lakh
Nurses	58,450	13,700	14.9 lakh
Doctors	25,800	6,148 $	3.67 lakh
Specialists	6781	11,361	2 lakh
Managerial, nonclinical	15000** / 12762#	NA	1.6 lakh

*Source : *RHS 2010, #HLEG estimates;*

** Working Group on NRHM

Note that the above data relates to the Public Sector

The shortage figure for doctors relates to doctors at PHCs. ANM- Auxiliary Nurse Midwife, HLEG- High-Level Expert Group.

7. Spending on Public Healthcare: A sad story

In the above discussions, the authors point to the dominance of the private sector and thereby, the possibility of having PPP in the healthcare system in the country. This section discusses the main reasons that have resulted in such a shabby state of public healthcare in the country.

The table below makes a comparison between the different economies in terms of health expenditure. It is evident that the European countries are far ahead of the Asian counterparts.

Table 3: International Comparison of Health Expenditure

Country	Total Health Exp. as a % of GDP				Government Exp. on Health as % of Total Exp. on Health			
	2005	2010	2013	2014	2005	2010	2013	2014
Non-Asian countries								
USA	15.15	17.02	16.90	17.14	44.36	47.48	47.61	48.30
Germany	10.52	11.25	11.16	11.30	76.13	76.22	76.75	76.99
France	10.60	11.20	11.56	11.54	77.99	77.51	77.08	78.21
Canada	9.57	11.20	10.67	10.45	70.24	70.39	71.03	70.93
UK	8.24	9.51	9.34	9.12	80.85	83.53	83.31	83.14
Brazil	8.27	8.27	8.48	8.32	41.51	45.80	45.12	46.04
Mexico	6.04	6.39	6.30	6.30	43.33	48.53	51.74	51.77
Asian countries								
China	4.66	4.89	5.39	5.55	38.77	54.31	55.81	55.79
Malaysia	3.29	3.99	4.02	4.17	51.36	57.29	54.83	55.18
Indonesia	2.79	2.74	2.93	2.85	28.79	37.69	39.43	37.78
Thailand	4.64	5.41	6.18	6.53	72.80	82.11	85.27	86.00
Pakistan	2.91	3.02	2.70	2.61	23.54	31.64	36.77	35.15

Sri Lanka	4.06	3.43	3.68	3.50	45.56	45.27	57.18	56.06
Bangladesh	2.68	3.06	2.88	2.82	36.11	34.28	28.11	27.90
Nepal	5.72	6.43	5.69	5.80	27.70	44.58	39.04	40.33
India	***4.28***	***4.28***	***4.53***	***4.69***	***26.49***	***27.13***	***28.41***	***30.04***

Source: World Health Organisation

In India, while both health expenditure as a percentage of GDP and public spending as a percentage of total health expenditure is low when compared to developed countries, the scenario is different in comparison to advanced European countries and some South-East Asian countries as well. However, health expenditure as a percentage of GDP in India is higher than in other Asian economies like Malaysia, Sri Lanka, Indonesia, Pakistan and Bangladesh though public spending as a percentage of total health expenditure is significantly lower than all these countries except Bangladesh.

Table 4: Expenditure on Health

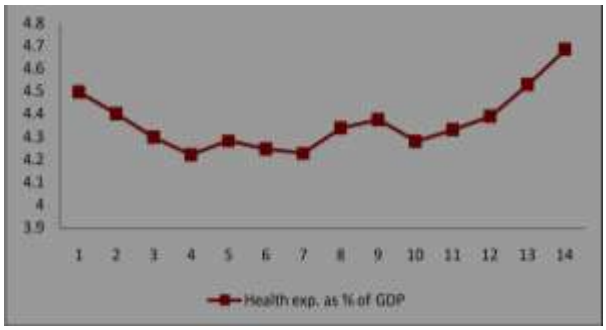
Country	**Total exp. on health as a % of GDP**		**Government exp. on health as a % of health expenditure**		**Private exp. on health as a % of health exp.**		**Govt. exp. on health as a % of total govt. exp.**	
	2004	2014	2004	2014	2004	2014	2004	2014
Brazil	7.07	8.32	47.02	46.04	52.98	53.96	5.15	6.78
Russia	5.19	7.07	59.58	52.20	40.42	47.80	11.28	9.49
India	4.22	4.69	24.23	30.04	75.77	69.96	4.04	5.05
China	4.72	5.55	37.97	55.79	62.03	44.21	10.00	10.43
South Africa	7.93	8.80	40.60	48.24	59.40	51.76	12.79	14.23
Global	9.80	9.90	58.60	60.10	41.40	39.90	15.30	15.50

Source: World Health Organisation

In terms of expenditure on health as a percentage of GDP, India not only lagged behind the other four countries of the BRICS in 2004 and 2014 but also was far below the global average during the two years. Moreover, the per capita healthcare expenditure in India is around US$60 which has been stagnant during the last decade or so. This sum is insignificant compared to China (around US$ 300) or Brazil (around US$ 1000). A look at the figures shows that the share of general government expenditure on health as percentage of total expenditure on health was the minimum in India (of the entire group) in both 2004 and 2014. Consequently, the maximum pressure is on the private sector to provide health services.

The chart below (No. 2) gives a view of the health expenditure in India as a percentage of the country's GDP. It is clear that between 2001 and 2014, there has been no substantial change, though of late there has been a slight improvement after 2010.

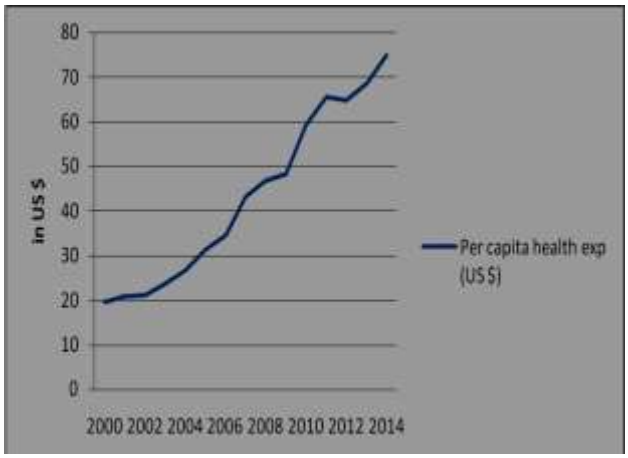
Chart 2: Health expenditure in India as a % of GDP during 2001-2014



Source: Compiled from World Bank Database

It is heartening to observe that health has not been the priority for governments over decades. But, even worse is the fact that the health expenditure per capita is on the rise (see chart 3 below). It is due to the rising cost of medical treatment but it is sad to know that 80% of the people do not have health insurance cover.

Chart 3: Per capita health expenditure (in US $)



During the period 2000 to 2014, though the per capita health expenditure has escalated almost four times from US $ 20 to US $ 75, there has not been much increase in the health insurance coverage in the country. A Hindu daily report (December 22, 2014) mentions from IRDA data that only 17 percent of the country's population was covered by health insurance at the end of March 2014. Furthermore, it adds that poor households meet almost 70% of their health expenses from their own pocket, thereby forcing them to move into further poverty. Hence, there are enough evidence and logical support to prove that the healthcare industry is in a bad shape. PPP is the solution to the looming problem that is a concern not only for the government but also for the policymakers.

8. Conclusion

Inadequate and inefficient expenditure on the public health system has led to the deterioration of quality and has adversely affected the vast population of the poor who need healthcare services the most. This has forced many among the poor to shift to private healthcare which is almost unregulated and very costly. Presently, the majority contribution towards providing health care services in India comes from the private sector which was not the case just after independence. During the 1950s, the private sector in India catered to only eight percent of health care facilities (World Bank, 2004) but recent estimates indicate that 93% of all hospitals, 64% of beds, 85% of doctors, 80% of outpatients and 57% of inpatients are in the private sector (World Bank, 2001). Hence, the private sector has taken the major lead in providing healthcare services. The public sector that does not aim at profit-making has still a long way to go but budgetary constraints over the years do not allow the governments to increase the allocation towards health drastically. Though, the per capita health expenditure is on the rise, the government spending on healthcare has remained stagnant or revealed minimum rise over the years. Hence, in this scenario of budget

constraints and low spending in healthcare, PPP is a prospective model that can change the overall scenario of health care services in the country.

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