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A STUDY ON THE IMPACT OF PUBLIC PRIVATE PARTNERSHIP AMONG PHC'S IN PONDICHERRY

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"We still tolerate appalling inequities between our treatment of the rich and the poor. Though it may be no more than a dimly grasped ideal, both medicine and law strive to treat all people equally. In psychiatry, however, we not only fail to approximate this goal in our practice; we do not even value it as an ideal."

Thomas S. Szasz

INTRODUCTION

Health sector in India in recent years has metamorphosed from deficiency to enormous changes, in terms of increase in the number of health care providers and expansion of coverage of services. The past trend shows that Government spending in the health sector has declined from 1.3 per cent in 1990 to 0.9 per cent in 1999 in terms of percentage of the total budget allocations as well as percentage of GDP. Parallel trends are visible in the health budgets of various State Governments with a major share of budgetary allocation for meeting only the recurrent costs of maintaining existing level of public health care delivery system. In most of the States, salaries and wages account for about 75 per cent or even more of the total health budget. This situation results in constant shortages of services and facilities, especially in terms of diagnostic and treatment facilities, non-availability of medicines, long queues for procedures/diagnosis and overcrowding in the facilities in rural areas. The biggest problem is that of accountability of health personnel and utilization of health and family welfare services by the underserved and under privileged population. It is evident that a significant proportion of people requiring health care seek services of the private sector and a lot of untapped potential exists in the private sector for supporting public health initiatives. Given the extent of private sector dominance in the health care system, it was felt that any significant improvement in health care is inconceivable without the active involvement and co- operation of the private/voluntary sector. The foundation of a relationship should be built in a manner that the private sector becomes a partner with the state in order to achieve various public health goals. As a result, Public Private Partnership (PPP) has emerged as a policy option for utilization of existing health care facilities and services of private sector in achieving public health goals and improving efficiency of resources at the operational level.

WHAT IS PARTNERSHIP

The name itself means different things to different people. Partnerships depend on agreement about key principles according to ethical guidelines. However, many purported partnerships do not fit this definition because of basic inequalities in the relationship. Partners often bring different levels of power to the interaction. Many times they are not able to call upon the same level of financial resources or expertise. So there exist different levels of influence. Sometimes the partners' roles change during the relationship's course. For these reasons, partnerships are dynamic but inherently unstable.

There are different kinds of 'partnerships' and it is important not to place them all within one group. The main categories include country-level co-operation between a public body and a private sector one and those occurring on a global level between, for example, United Nations organizations and commercial enterprises or their representatives.

There are three main types of partnerships

Product development partnerships, initiated by the public sector in response to market failure,

Systems/issues partnerships, such as the Roll Back Malaria initiative, which involves co-ordination of different groups & Product-based partnerships, such as donation programmes which are most often initiated by the private sector.

The types of partnerships being pursued have changed over time. For example, in the 1970's there was a stand-off between the public and private sectors which resulted in a separation of their activities. The political climate of the time ruled out any possibilities of partnership and instead there was a feeling of hostility, antagonism and conflict between the two. In the 1980's the private sector began to expand and gain influence. Public sector institutions began holding discussions with commercial enterprises, though often in secret. Most recently, the 1990's have ushered in an era in which the private sector has grown dramatically. This has encouraged governments and international organizations to work much more closely with industry and civil society in an effort to achieve health goals.

WHY PARTNERSHIPS

The shift towards ***public-private partnerships on health*** is the result of increased global integration due to

- The scope and pace of goods moving across borders
- The lack of geographical boundaries for infectious diseases
- The increased possibility for rapid communication (Internet)
- The spread of ideas
- World-wide products and marketing

These developments have reduced state sovereignty. Decreasing government control means that there is a growing need to collaborate with the strong, corporate sector.

Public-private partnerships (PPPs) are complex, long-term contracts between private and public units[1]. PPPs normally involve a collection of expensive fixed assets being acquired by a private unit, which then operates and manages the assets to produce and deliver services either to the public unit or to the general public on behalf of the public unit. At the end of the contract, the public unit often acquires legal ownership of the fixed assets, sometimes without payment or for a payment that clearly is less than the market value. The fixed assets are often referred to as infrastructure assets because many of the large projects undertaken by means of PPPs involve the provision of services to the public that government is normally expected to provide, such as transportation, communications, health, and education services.

Many types of PPPs have emerged since 1990s when Health Care Reforms were undertaken as part of the large-scale structural reforms across the developing world. 'This was in response to deficiencies in the public sector provision and in the light of the perceived private sector strengths of quality and efficiency.' Expectations were that such partnerships would ensure equity, provide quality care, create efficiency and encourage coherence and sustainability of the health system. The nature of these reforms was diverse, ranging from the private introduction of mandatory health insurance, to the contracting of private providers for clinical services, to the use of private distribution networks for the marketing of public health care interventions and the manufacture of drugs and supplies. An increasing interest in the prospect and potential of PPPs to provide material aid and social protection can be mainly explained by three factors-firstly, due to fiscal pressures; Governments (both at the Centre and State) have to re-allocate the budgetary resources with utmost effectiveness; secondly, private providers, both, non-profit or for-profit- play an important role in social service provision: a role which has been largely neglected by Governments. For instance, many studies have shown that more than 80 cent of the household health care expenditure goes to private providers running hospitals and maternity homes and other services. And thirdly, given per the intrinsic, albeit different strengths and weaknesses of the state, for – profit and non-profit institutions, the question arises as to what extent the complementarities can be organized and synchronized in the provision of health care services. It is well known that private hospitals do not admit poor and indigent patients to the required extent as was envisaged when the land was allotted to them for building of the hospital. In this

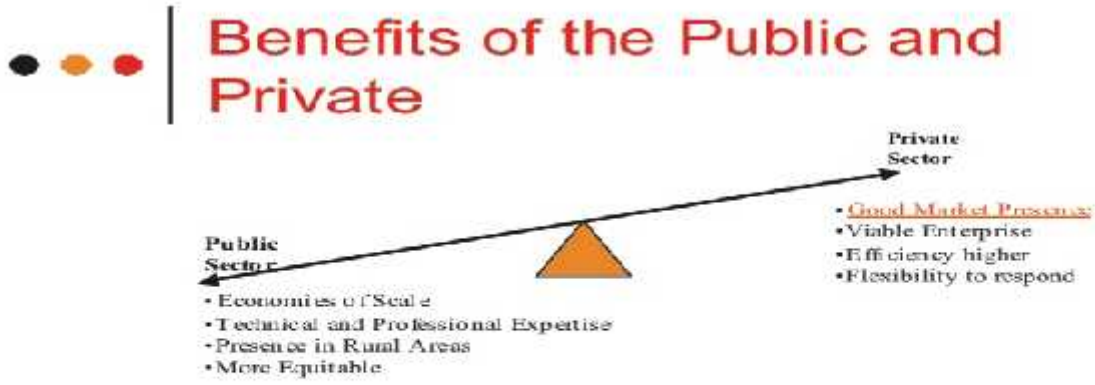
context, PPPs are defined as a collaborative effort, between private and public sectors with clearly identified partnership structures, shared objectives, and specified performance levels; and indicators for delivery of a set of health and family welfare services in a stipulated time frame. The main objective is to deal with the problem of poor health services delivery at two levels- namely, improving accessibility, availability of quality healthcare services in underserved areas and increasing mobilization of resources, for health care, from different sources. Taking care of such embedded problems would ensure that PPP initiatives would make even the private sector facilities available to the poor through reduction in their costs. Greater choice of services would be available to the poor. It is envisaged that the synergy between the public and private systems will reduce the duplication of efforts and wastage of funds. By developing different models of PPP the specific needs of the people in states can be fully or substantially met. This partnership can provide the public with good quality, high-tech care wherever needed at affordable prices. Resource mobilization through philanthropy, subscriptions, donations etc., is easier and more efficient by creating formal channels of private partnerships in providing public healthcare.

AN OVERVIEW OF PPP MODELS IN HEALTH SECTOR IN INDIA

India has shown some progress in basic health indices today but as compared to other developing countries it is very slow. There is huge scope and need for improvement. One of the biggest benefits of PPP is the economies of scale associated with it and added values of efficiency and effectiveness. The fact that over 56 per cent of the rural medical needs are met by the private sector points to the need of creating synergies between the public and the private partners. Flexibility in action is the new mantra. There is no fixed definition of how PPPs can be established but some factors need to be kept in mind. These are clearly identified aims and objectives to be met. A well-defined partnership structure is crucial for a successful partnership. Exchange of skills, better management and wider range of services are some of the benefits associated with PPPs which would work as one of the important components of strategies to achieve NRHM goals.

The Tenth Plan has the following goals

- Establish 2000 vision centers in rural areas
- Provide 350 additional facilities for inter-ocular surgery.
- Establish 50 pediatric units at the tertiary level
- Provide 50 non-recurring grants-in-aid to NGOs
- Provide 25 non-recurring grants-in-aid to eye banks
- Establish 5 new regional institutes of Ophthalmology.
- Train 1200 eye surgeons



PPP leverages the benefits of both

There are 7 key determinants to PPP in health care,

1. Policies, Legislative Measures and Procedures
2. Institutional Framework
3. Communication
4. Partner Selection
5. Adopting Life-Cycle Approach
6. Process Integrity
7. Good Governance

POLICIES, LEGISLATIVE MEASURES AND PROCEDURES

A comprehensive policy and legislative framework which clearly defines roles of partners needs to be adopted. Emphasis should be on developing well tested procedures, guidelines and contractual arrangements early piloting of schemes and demonstration projects.

INSTITUTIONAL FRAMEWORK

Establishment of PPP Cells within the Directorates with necessary powers and responsibilities to partners and staffed with experienced professionals will ensure smooth implementation of PPP. Accreditation and service quality monitoring mechanism needs to be established. A regulatory authority with necessary statutory powers effective and transparent dispute resolution should be established.

COMMUNICATION

Creation of avenues for free communication and data sharing amongst all concerned stakeholders is need of the hour. Partnership with the media needs to be done on issues which are of public interest. Effective advocacy and open communication with the public receiving the service, any employees affected by the project, the press, labour unions, potential bidders, financial backers, and any relevant interest groups is a mandatory requirement.

PARTNER SELECTION

If good partners are not selected the PPP initiatives will flounder with slim chances of being taken seriously by either partners. It is essential to know- what kind of experience and track record do the private partner bring to the project. Will they be able to sustain a relationship within the terms and over the period of the contract? Will they be able to manage the opportunities and risks inherent in the project? It is important that the public sector partner be willing to retain the risks that the private partner cannot control, quantify or ensure. It is also vital that the public partner's administrative personnel have a sound understanding of PPPs and alternative delivery methods.

ADOPTING LIFE-CYCLE APPROACH

The costing of existing and/or planned public services must be conducted on a full life-cycle basis. It is particularly important for the public sector partner to determine if a project is affordable to the Government. To

this end, the public partner must ensure full life cycle costing at an early stage, taking into account the full cost of the assets and risks inherent in undertaking a project.

PROCESS INTEGRITY

The process must be fair, open and transparent. Bureaucratic procedures should not be permitted to cripple a project. Private partners need a precise description of what is required and a clear indication of any hurdles foreseen on the part of the public partner. The process also requires sound contract management arrangements, with early identification of the people to be involved in contract administration.

GOOD GOVERNANCE

Planning should be done diligently. The public sector partner must ensure that its monitoring, regulating and enforcement roles are recognized and effectively undertaken.

PPP AND HIV/AIDS IN THE HEALTH CARE SECTOR: KEY CHALLENGES

For most **governments** in developing countries, working with the private sector is still a new concept. Not only are there challenges between the private and the public sector, but also the relationship among private sector actors themselves affect the success of co-investment. **Donors** are also confronted with different types of challenges. A reluctance to engage with the private sector for development in general and to fund private sector initiatives in particular is quite common. This can be due to a lack of familiarity with these procedures and the lack of an enabling environment, such as appropriate channels for communication with the private sector. **Bottlenecks** for greater **corporate activities** include lack of familiarity with running community-based health programmes, fear of financial liabilities (particularly given the limited time horizons of donor support), a paucity of good country- and sector-specific case examples, and a lack of appropriate partners or tools. Since **NGOs** are often being involved in programmes directly on site, their contribution to co-investment mainly consists of the provision of technical assistance and implementation support (including the training of service providers). NGOs could also have a particularly important role acting as intermediaries or bridges between the public and private sectors. The GBC summarized key challenges for implementing PPPs in its pilot projects in Cameroon, India and Nigeria (2003).

Some of the relevant ones are listed below

1. The highest-level political commitment is the critical starting point in a national response.
2. To promote multi-sectoral collaboration, relevant platforms are required for cross-sectoral information sharing and coordinating implementation.
3. Without clear methodologies for interacting and defined responsibilities, public-private partnerships are rendered futile, despite the willingness of stakeholders.
4. Bureaucratic processes and local politics within countries have paralyzed the rollout of programmes. Even Global Fund CCMs, if not formulated in a functional or appropriately managed structure, can act as yet another bureaucratic hurdle at national level.
5. Current thinking on business contributions and participation on HIV/AIDS is limited to drugs, diagnostics and health service delivery but based on its core competencies, the business sector has highlighted a vast range of inkind contributions.
6. There is little experience on integrated approaches to addressing HIV/AIDS, TB and Malaria. Most programmes involve a vertical approach to each of these three diseases, and current funding initiatives propagate this view. Integrated approaches through strengthening of health systems and forming successful PPP potentially offer greater benefits for efficiency and sustainability.
7. Small and medium enterprises are a neglected segment of the business sectors' AIDS response, and yet remain potentially more vulnerable to the impact of AIDS. SMEs could profit from the expansion of HIV/AIDS workplace programmes through the supply chain of larger companies, as well as from the services offered by national business coalitions on HIV/AIDS.

To overcome these challenges, sharing of information on programmes and on good practices is required. The development of a joint approach with delineating clear roles and responsibilities would also help achieve the

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agreed objectives. The UNAIDS '3 Ones' initiative addresses the need to harmonize all efforts supported by donors and the private sector. Large and multinational companies have a special role to play in terms of sharing best practices from a wide variety of settings and supporting the efforts of smaller companies. Needless to say, it will take time and persistence to build the necessary trust among the different partners.

During the last five decades the Government, at the Centre and the State, has built up a vast health infrastructure throughout the country. A large number of well-equipped hospitals, medical research centre, both in the private and public sectors, maternity homes located mostly in the urban areas and a network of rural dispensaries and Primary Health Centre's have been set-up to meet the health needs of the people. Despite the development of infrastructures, coverage in terms of health services availability to the needy in the rural areas is well below expectations. The delivery of health services in the rural, remote and backward areas, by and large, is still inadequate and therefore requires a new thrust and momentum. In order to improve the outreach of health services in these remote and backward areas, new initiatives have to be developed, implemented and sustained. The National Rural Health Mission (NRHM) is the latest in the series of Government's action programmes to reach these areas with new frameworks which would improve the situation in the health sector and bring in incremental benefits to the larger population. In this initiative, the proposal of establishing systems for working with the private sector hold lot of promise since it would allow government to plug gaps of accessibility and availability of services for the under-served and un-served sections of the society.

The Public Private Partnership (PPP) is a new and essential strategy to extend the scope of the existing health system in the nation-wide perspective and securing the willing cooperation of NGOs and social activists for this purpose. This does not however mean that the government would abnegate or forfeit its key responsibilities .The Government in collaboration with the private sector intends to provide the required financial and managerial resources for the health sectors in order to improve outcomes of health investments. Large sections of the population in this country are faced with a dilemma of making a difficult choice between the public and the private sectors. A public service for which they have to incur opportunity costs, though less expensive, is often not easily accessible, unresponsive and lacks accountability, even as the private sector, if available, is expensive, exploitative and also lacks accountability.

It is in this context, the importance and the need of a partnership in the health sector becomes important. The key word in the partnership being co-operation, inter- reliance, dependence and mutual benefit. A partnership, which blends the best of the public and private sector in, a synchronized fashion to meet the demand of quality services to the remotest and farthest areas, both socially and geographically.

The study focuses on the impact of Public Private Partnership among Primary Health Centre's in Pondicherry and attempts to bring out the importance of a healthy public-private partnership and the benefits it can bring about in improving health services through the Primary Health Centers in the rural areas of Pondicherry.

THE STUDY IS DESIGNED WITH FOLLOWING OBJECTIVES

1. To identify the role of Public Private Partnerships among Primary Health Centre's in Pondicherry.
2. To analyze the effectiveness of Public Private Partnerships in implementing Health Services.
3. To elucidate the terms and conditions needed for Healthy Public Private Partnerships.
4. To bring out the innovative strategies and actions that would facilitate development of Public Private Partnerships.

METHODOLOGY

An Explorative design is used for the study to find out the impact of Public Private Partnership among Primary Health Centre's in Pondicherry. The study is carried out in the 3 Primary Health Centre's which are undertaken by Pondicherry Institute of Medical Sciences which is a Private Medical Research Institute and Hospital rendering medical services to the people in and around Pondicherry. The respondents were the patients who acquire medical services from the primary health centre combining both in-patients and out-patients. A total of 50 respondents

were selected randomly and were interviewed through schedule and focused group discussion. All were observed and their experiences with respect to the combined medical services provided from PPP are analyzed through proper statistical tools. A comparative study is conducted between the private and public health Centres with regard to the execution of Health Services and the effectiveness in the Implementation of Health Services provided by the Public Private Partnership and its impact on the respondents is also evaluated.

SOCIAL RELEVANCE AND UTILITY OF THE STUDY

Public-Private Partnerships provide a potent innovation in the health sector. Public partnership with the private sector is arguably desirable because the private sector is pervasive (easily accessible), caters to meeting the health care needs of a very large section of the population, has a distinct preference for patients, possesses formidable resources, is more efficient and better managed. However, the private sector is also expensive, inequitable, unregulated, and lacks quality standards. The worst affected by the anomalies and inequities in the health system are the poor who, forced to seek health services from the private sector due to inherent deficiencies in the public health system, must pay out-of-pocket. While the private health sector will continue to thrive, it would be the responsibility of the government to augment private sector resources, and to use their management skills to improve the overall efficiency, equity, access, and quality of the health system in general. Therefore public partnership with the private sector is not only rational but also inevitable.

Despite its vast potential, PPP in health in India is at an early stage. These initiatives are hindered by the lack of evidence-based policy on what should be the private-public mix in health care.

This study will provide insights on the experiences of the inpatients and outpatients, on the medical services provided by the combined effort of Public Private Partnership. The findings of the study could provide future directions in adopting and experimenting with innovative methods of PPP.

FINDINGS

1. The Age of the respondents varies because the sample population consist of respondents belonging to all age group who comes to PHC, but Majority of the respondents were in the category of middle age, approximately 30-60.
2. Similar to the age, Sex of the respondents also vary, Still majority 69% of the respondents were Women.
3. While considering the marital status of the respondents, greater share of respondents were married, only very few young, unmarried patients visit the PHC.
4. Major population of respondents are illiterates, few has crossed till primary education and very few to the Graduation.
5. In regard to the low persuasion of education, the occupation of the majority respondents were Agricultural Cooley's, Fisherman Community & Industrial Labourers, few were Self employed by possessing petty shops etc. and majority of the women were house wives.
6. Majority of the respondents have low-income level of below 1000/ months since because of their occupation and few others have no income at all.
7. Since the study is conducted in a PHC in rural villages, major population of the respondents dwelling in rural areas and very few are from Sub urban.
8. With respect to frequency of visiting the PHC, majority of the respondent felt that they are use to visit the PHC whenever there is a need, i.e., in times of necessity and few others visit at least once in the week and very few visit felt that regularly they visit once in a month. With this the utilization of PHC from the respondents is known.
9. Greater population of the respondents felt that the PHC is in a place which is easily accessible to them and they can reach it by walk but few other felt it is of little distance, a way to travel half an hour, but which is also not far. By this we could clearly understand that the accessibility of PHC to the respondents.
10. With regard to the assistance and hospitality provided by the PHC Staffs, higher percentage of respondents has expressed that there are ANM's and ward boys over there to guide them and take care of them at times of necessities.

11. Since the PHC is situated in their own village area, the respondents felt that they didn't have communication problems with the PHC Staffs.
12. Though little percentage of the respondents expressed that there is lacking of doctors at times of necessity, still greater share of respondents felt that they are able to find doctors one or other always in the PHC, which is actually a good and positive aspect which could be found in PHC due to the PPP.
13. It is an unique aspect that more than 90% of the respondents expressed that they were very much satisfied by the medical services and health care provided by the PHC after the Public Private Partnership with PIMS.
14. Greater share of respondents felt that the doctor's are much patient friendly and easily accessible at times of necessity, but still few respondents expressed that doctors are much kind with them.
15. Half of the respondents were happy with the assistance provided by the paramedical staffs, but rests of them were not much happy about their service.
16. Greater share of respondents felt that they could get only few medicines prescribed by the doctors in the pharmacy of the PHC, rest of the medicines were available at the private pharmacies, in which they are forced to buy.
17. Majority of the respondents opined that the medical laboratories are available with PHC and for the rest like X-Ray's, ECG's, Scan are not available and they have to approach PIMS to avail those facilities at a concessional rate.
18. Many of the respondents are not satisfied with the room facilities.
19. Half of the respondents expressed that they are satisfied with the cleanliness of the PHC, still rest of them were dissatisfied.
20. Almost all the respondents felt that the PHC should have ambulance facility during emergencies.
21. After the establishment of PPP with PIMS, 50% of the respondents opine that they prefer PHC for minor illness and for major illness, they prefer to Private Hospitals, due to lack of medical Equipments and specialized doctor's in the PHC.

CONCLUSION

The paper supports the argument that PPP is the right policy option for improved health service delivery to the people as far as simple health service delivery is concerned. There is no evidence to suggest that more complex PPP arrangements including joint venture, direct contract, lease, and concession can equally produce such positive results. Indeed, we need to do more work to improve these simple collaborations but much more into more formalized PPP arrangements.

REFERENCES

1. Baru, R. 1999. Private Health Care in India: Social Characteristics and Trends. New Delhi: Sage Publications.
2. Bately, R. 1999. The New Public Management in Developing Countries: Implications for Policy and Organizational Reform. Journal of International Development 1195:761-765
3. Bennett, S. & Muraleedharan, 1998 The role of government in adjusting economies: Reforming the role of government in Tamil Nadu health sector, Development Admin. Group, University of Birmingham & Health Policy Unit, LSHTM: London, Report no. 28
4. Bhat, R. 2000. Issues in Health: Public-Private Partnership. Economic and Political Weekly 30:4706-4716
5. Björkman, JW. 2001. Multiple Systems, Multiple Reforms: South Asian Health Policies in Comparative Perspective in Handbook of Global Technology Policy edited by Stuart S Nagel. New York: Marcel Dekker, Inc. Pages 167-220
6. Björkman, JW and Kuldeep Mathur. 2002. Policy, Technocracy and Development: Human Capital Policies in India and the Netherlands. Delhi: Manohar Publishers.
7. Catchlove, B. 1998. Public-Private Partnership in Australia. Hospital Quarterly 1(2)
8. McPake, B. & Hongoro, C. 1995. Contracting Out of Clinical Services in Zimbabwe. Social Science and Medicine 41(1):13-24

9. Mills, A. 1996 Contractual relationship between government and the commercial private sector in developing countries: Are they a good idea in health?, in Bennett, S., McPake, B, and Mills, A. (ed.) Private health providers in developing countries: Serving the public interest? :London, Zed press.
10. Mills, A. & Broomberg, J. 1998. Experiences in Contracting: An Overview of the Literature (WHO technical paper 33, Geneva)
11. Mills, A., Brugha, R, Hanson, K., and McPake, B. 2002 What can be done about the private health sector in low-income countries? Bulletin of the World Health Organization, 80: 325-330
12. Muraleedharan, V.R. 2001. Public-Private Partnership in Health Care Sector in India: A Review of Policy Options and Challenges. Private Health Sector in India: Review and Annotated Bibliography. Mumbai, CEHAT
13. Palmer, N. 2000 The use of private sector contracts for primary health care: Theory, evidence and lessons for low income and middle income countries, Bulletin of the World Health Organization, 78(6): 821-829
14. Purohit, B.C. 2001. Private Initiatives and Policy Options: Recent Health System Experience in India. Health Policy and Planning 16(1):87-97.
15. The Lancet. 2000. News item. 356:1663
16. Venkatraman, A. & Hemanth, K. (2002). Contracting Out Support Services in Select Public Hospitals in Delhi" (research report), Faculty of Management Studies, University of Delhi
17. WHO 1999. WHO guidelines on collaborations and partnership with commercial enterprises, Geneva, WHO.
18. Widdus, R. 2001 Public- Private partnership for health: Their main targets, their diversity and their future directions, Bulletin of the World Health Organization, 79: 713-720
19. World Bank. 1993. World Development Report – Investing in Health. Washington, DC
20. World Bank. 2001. India - Raising the Sights: Better Health Systems for India's Poor. (Report no. 22304, HNP Sector-India) Washington, DC

[1]*The use of public and private in the term "public-private partnerships" should be interpreted broadly. The private unit should be a for-profit enterprise, which might be a public corporation. The public unit will normally be a government unit, but it could be a public corporation. Obviously, a PPP contract between a government unit and a wholly owned public corporation would raise many questions about independence. It will often be convenient here to refer to "governments" rather than "public units." It is also possible for a private non-profit institution to engage in this type of contract in that same way that a public unit would.*