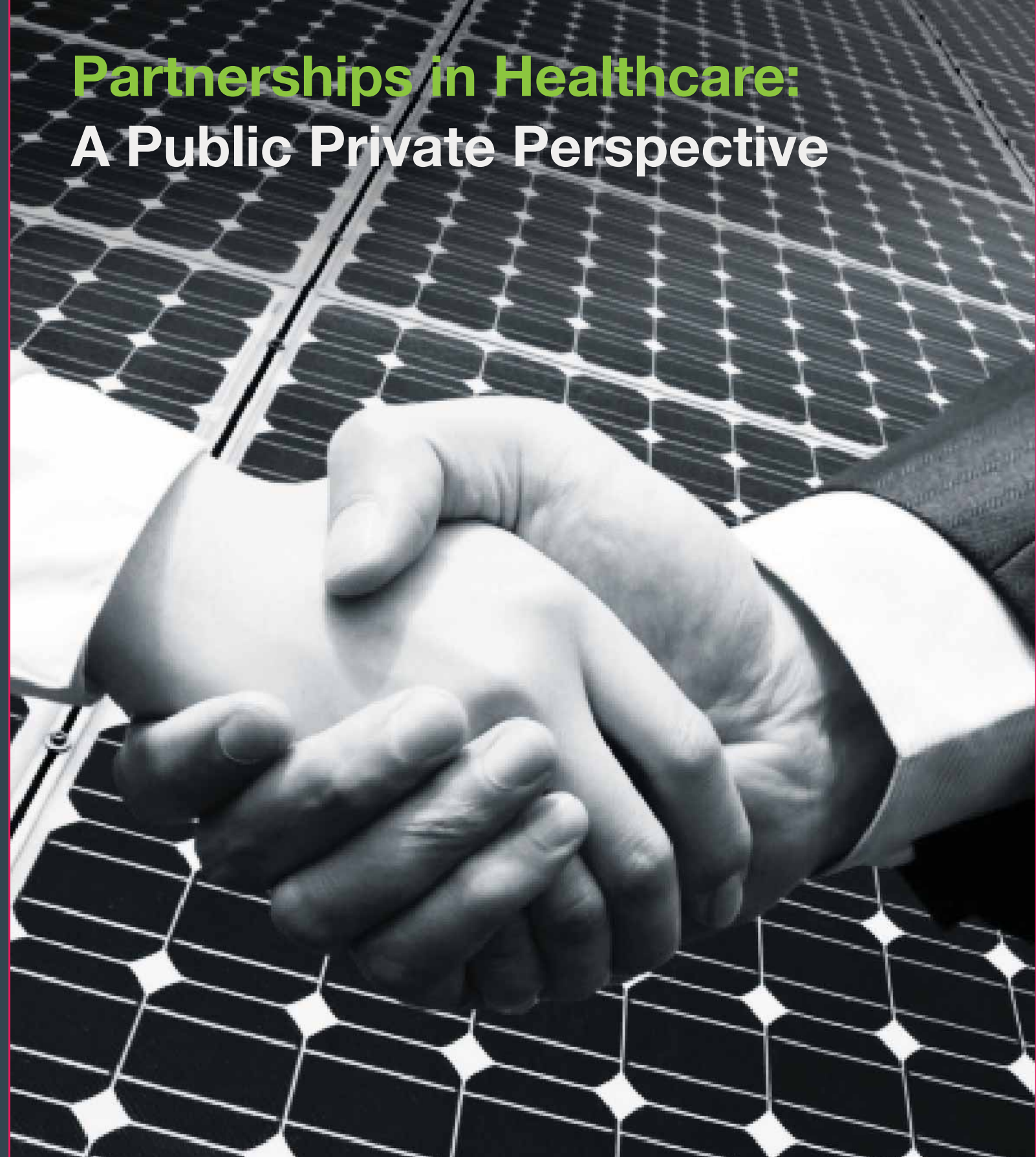


Partnerships in Healthcare: A Public Private Perspective



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Table of Contents

Executive Summary

The Textbook

• Introduction to PPPs	03
• Types of PPPs	08
• Funding PPPs	18

The Ground Reality

• Public Expenditure on Healthcare	25
• Political and Market Issues in Healthcare	32
• Case Studies	36

Seeking Common Ground

• Governance of PPPs	44
• Contract Challenges	54
• The Road Ahead	62
• Recommendations	63



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Executive Summary

Private healthcare in India is one of the fastest growing sectors. In metros and tier 2 cities, new, polished hospitals mushroom, and as some Indian corporate hospitals seek an Asian presence, it is difficult to believe that the oldest corporate hospital here is younger than many of us. Hospitals are queuing up for accreditation; some are developing new healthcare models, and breaking fresh ground. At the same time, medical costs are increasing and getting out of reach of even the middle class.

The public sector too has seen many changes since 2005, as district level planning has finally commenced, and some very readable district reports have come from little heard places. Almost all reports acknowledge that there are gaps to be filled, yet the tones have become hopeful — now we are at least aware of the problems at hand and the public sector has finally begun to seek solutions rather than just pass the buck.

Interactions between the private and public sectors have taken off at a varied pace across states. In some states, both sectors have begun understanding the other's needs and have got into arrangements that are sustainable, while in others, the mutual suspicion of the other's intentions has never disappeared. Unexpectedly, PPPs have mushroomed in niches of healthcare that we hardly knew existed.

In the following three sections, we seek to explore the fundamentals of healthcare, markets and contracts in order to get a perspective of how PPPs actually work and why things function the way they do:

Section One contains the fundamentals of PPPs in general — their rationale, objectives and principles, and describes the various permutations possible and risk sharing in each. It gives a brief overview of the funding options possible, including viability gap funding and the advantages of each.

Section Two delves into Indian public spending in the past decade both for Centre and for States, and healthcare expenditure in the overall expenditure plan of the government. It then devises a method for ranking healthcare in the government's list of priorities. We then incorporate Public Choice theory to understand political behavior and analyze the political and market efficiencies in healthcare and the rules against which PPPs can be evaluated. We take up four case studies of PPPs of national importance and describe their genesis, highlights and weaknesses. We gauge the efficacy of politicians, bureaucrats and community as change agents.

Section Three dwells on the role of governments and regulators in governance and the importance of performance measurement in a PPP contract. We conclude by exploring newer options for PPP's and lay down what we believe is the way forward.



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The Textbook

Public Private Partnerships: The Basics

Public-Private Partnerships are defined as a variety of co-operative arrangements between the government and the private sector in delivering goods or services to the citizens. PPPs provide a vehicle for coordinating with non-governmental actors to undertake integrated, comprehensive efforts to meet community needs. They aim to take advantage of the expertise of each partner, so that resources, risks and rewards can be allocated in a way that best meets clearly defined public needs. (Axelsson, Bustreo and Harding 2003)

A public-private partnership (PPP) in the healthcare sector is an approach to address public health (and social development) problems through the combined efforts of public, private, and development organizations. Each partner makes a contribution in its area of special competence, bringing in expertise that is often not available in development projects. The partners in a PPP rally around a common cause, while at the same time pursuing some of their own organizational objectives.

Through the correct use of PPP mechanisms, public sector organizations such as the Ministries of Health or Education — may achieve their objectives faster, and with smaller investments. Private sector organizations are able to expand their markets, develop new marketing techniques, and contribute to the communities in which they do business.

Development organizations achieve their strategic objectives in collaboration with others, leverage new resources for public health, and gain experience with a highly feasible and sustainable approach to public health promotion.

¹Source: WHO

Objectives of Public-Private Partnerships

It is necessary that Public-private partnerships display that the following objectives are met in a balanced way to reflect the best interests of all stakeholders:

1. To ensure government services are delivered in an economical, effective and efficient manner;
2. To create opportunities for private sector growth and to contribute to the overall economic development of the District/State/Country through the stimulation of competitiveness and initiative; and
3. To ensure the best interests of the public, the private sector and the community are served through an appropriate allocation of risks and returns between partners.



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Characteristics of Public - Private Partnerships²

Public private partnerships are characterized by the sharing of investment, risk, responsibility and rewards between partners. The reasons for establishing such partnerships vary, but generally involve the financing, design, construction, operation and maintenance of public infrastructure and services. The underlying reason for establishing partnerships is that both the public and private sectors have unique characteristics that provide them with advantages in specific aspects of service or project delivery.

A partnership that draws on the strengths of both the public and private sector to establish a complementary relationship is usually the most successful arrangement.

The roles and responsibilities of the partners may vary from project to project. For example, in some projects, the private sector partner will have significant involvement in all aspects of service delivery, but in others, only a minor role. While the roles and responsibilities of the private and public sector partners may differ on individual servicing initiatives, the overall role and responsibilities of the government do not change. In all cases, the government remains responsible and accountable for delivering services and projects in a manner that protects and promotes public interest.

²Source: Ministry of Municipal Affairs – British Columbia, IFC, ppinindia, European Investment bank



PPPs differ from traditional contracts in several key respects

1. **Complexity:** A PPP is an inherently more complex operation than traditional contracts, as many players with competing interests are involved in the same. A great amount of assistance from qualified legal, financial or technical experts to undertake the requisite due diligence is required.
2. **Financing:** Traditional government contracts are government-funded. PPPs typically entail financing wholly or predominantly from the private sector.
3. **Risk Allocation:** There must be some sharing of risk in a PPP, e.g. project completion risk (costs/time/specification), operating risk (demand/operating/performance/continuing quality), etc., and the provider has to be paid a premium to accept these risks.
4. **Duration:** PPP contracts may extend for 30 years or longer. This greatly complicates the difficulty of projecting service demand, and quantifying other risks such as technological and regulatory change, and currency fluctuation.
5. **Coordination:** PPPs require a much greater amount of communication and coordination among the players involved so as to ensure effective implementation of the project.



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Principles³

All public-private partnerships are typically based on the following guiding principles:

1. **Project definition:** The project is of sufficient size and/or complexity to provide an opportunity to the private sector to demonstrate its initiative, innovation and expertise.
2. **Competitive private sector market:** Sufficient qualified private sector proponents exist to ensure a competitive process.
3. **Shared rewards:** The public receives 'value for money' from the initiative, while the private sector can reasonably expect to receive a fair return on its investment.
4. **Premise of risk transfer:** Risks are allocated to the partner best suited to assume the risk.
5. **Signed contract:** The acceptance of a usually long-term relationship established through signed contractual arrangements.
6. **Communications:** A proactive, ongoing and transparent communications plan designed to keep people informed is implemented.

³Source: www.gnb.ca

Possible Models for PPPs

There are a variety of PPP models. The type of PPP model is chosen depending on the aim of the project, its complexity, and the need of the healthcare sector. Each model has varying degrees of responsibility and risk allocation between the partners, coupled with the differences in the contracts. The different types of PPP models are described in this section.



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Operations &
Management

Build Operate
Transfer

Design Build
Finance
Operate

Lease

Concessions

Joint Venture

Increasing Private Sector Participation



1. Operations and Management

The O&M model indicates a contractual arrangement for the management of the whole or part of a public facility by a private player. Such contracts allow private sector skills to be brought into service design and delivery, operations, labour management and equipment procurement. The ownership of facility and equipment is retained by the public sector and the private player is given certain specific responsibilities.

Usually the contract period is short: typically 1 to 5 years; however the contract period may be longer depending upon the complexity of services. The private player is paid a fee to manage and operate services; by and large, the fee is performance-based.

Management contracts are quite common in the healthcare sector for providing services such as laboratory and imaging services, and also pharmacy and non-core elements of healthcare operations such as laundry, food and beverage services.



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2. Build – Operate – Transfer (BOT)

In this type of arrangement, the private sector builds an infrastructure project, operates it, and eventually transfers ownership of the project, or a major component of it, to the government. In many instances, the government becomes the firm's only customer and promises to purchase atleast a predetermined amount of the project's output. This ensures that the private player recovers its initial investment in a reasonable time span.

At the end of the contract, the public sector assumes ownership but can opt to assume operating responsibility, contract the operation responsibility to the developer, or award a new contract to a new partner.

There are many variations to the basic BOT structure, like:

Build–Transfer–Operate (BTO): The public sector contracts with the private player to design, construct and operate the proposed facility. Once completed, the private player transfers ownership of the facility back to the public sector. The public sector then leases the facility back to the private partner under a long term contract to operate the facility.

Build–Own–Operate (BOO): The public sector either transfers ownership and responsibility for an existing facility or contracts with a private partner to build, own and operate a new facility in perpetuity. The private partner generally provides the financing.

Design–Build–Operate (DBO): The public sector contracts with the private player to design, construct and operate. Ownership of the facility remains with the government.

Design–Build–Finance–Operate (DBFO): The private player is responsible for designing, building, financing, and operating the facility. DBFO arrangements vary greatly in terms of the degree of financial responsibility that is transferred to the private partner.

Private Finance Initiative (PFI): PFI is a type of PPP where the private sector consortium finances, builds and maintains the project in return for an annual fee from the government for a period of 25-30 years, throughout the life of the project.

A Special Purpose Vehicle (SPV) is responsible for the financing the project. The creation of a 'Special Purposes Vehicle' company for the delivery of a particular project allows for private financing of the project. The SPV is formed by a consortium made up of a building firm, a facilities management company and equity finance providers. The SPV designs and builds a facility and then manages it for a number of years under a number of sub-contracts. The government pays the SPV a risk premium over and above the cost of the project.

3. Lease

Under a lease contract, the private player is responsible for providing the service, operation and maintenance of the infrastructure. All capital investments are made by the public sector and the operator provides the service at his expense and risk. Thus the risks of the investment are borne by the public sector and the operational risks are borne by the private player.

The private player is responsible for the overall operations, including setting and maintaining quality standards, collection of tariffs etc. Part of the tariff is given to the public authority to service loans raised to finance the facility. The duration of the leasing contract is typically for 10 years and may be renewable for up to 20 years.



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4. Concessions

In this type of PPP model, the public entity hires the private sector operator (concessionaire) for the full delivery of services, including construction, operation, maintenance, management and rehabilitation of the system. The private player is responsible for all the capital investment/expenditure and providing the assets, whereas the ownership of these assets will be retained by the public sector during the concession period. The public sector is responsible for establishing performance standards and ensuring that the concessionaire meets them. It could be said that the role of the public sector shifts from being the service provider to regulating the price and quality of service.

The private player pays the public sector for the concession rights and the public authority may contribute to the capital investment if necessary. Usually payments by the government may be necessary to make projects commercially viable and/or reduce the level of commercial risk taken by the private sector.

A concession contract is usually valid for long periods and typically ranges from 5–30 years so that the operator has enough time to recover the capital invested and earn an appropriate return over the life of the concession.



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5. Joint Venture

In this type of PPP model, the public sector and the private player jointly own and operate the facility and consequently share revenues, expenses and assets. Under a joint venture, the public and private sector partners either agree to form a new entity or jointly own an existing company and assets by contributing equity.

Often a joint venture is developed where the public sector seeks technological expertise or technical service arrangements from a private player. Here, both public and private partners have to be willing to invest in the company, share certain risks and set the terms of dissolution during the formation of the JV.

Increasingly, PPP models are becoming an amalgamation of the five basic types of contracts we have described, selecting the best from each contract to suit the needs of the target population. The table following sums up these models.

Format	Stakeholder support; Political will	User charges: Cost-recovery	Information level required	Level of capacity needed	Relevance of credit rating
Service contract/ Management contract	Not important	Not critical in short term	Can proceed with limited info	Minimal	Not critical
Management contract/ Performance incentives	Low to moderate levels needed	Preferred but not necessary in short term	Good info required to get incentives	Moderate	Not critical
Lease	Moderate to high levels needed	Necessary	Good system info required	Strong	Not critical
BOT	Moderate to high levels needed	Preferred	Good system info required	Strong	Impacts risk premium in cost of capital debt and Equity
Concession	High levels needed	Necessary	Good system info required	Strong	Impacts risk premium in cost of capital debt and Equity



Potential Advantages of PPP

A PPP that bundles out several service-pieces together has certain advantages over a traditional sequential model. For instance in a sequential model, the government first bids out for the project design, approves it, and then again sends tenders for construction, and later contracts separately for the maintenance. Whereas in a design, build, maintain (DBM) PPP, a single consortium is responsible for all the three tasks. Hence in a DBM, since the same provider now performs the whole task, the provider has an incentive to design the project in such a way that the construction is smooth and construct in such a way that maintenance is efficient.

Hence a PPP can encourage:

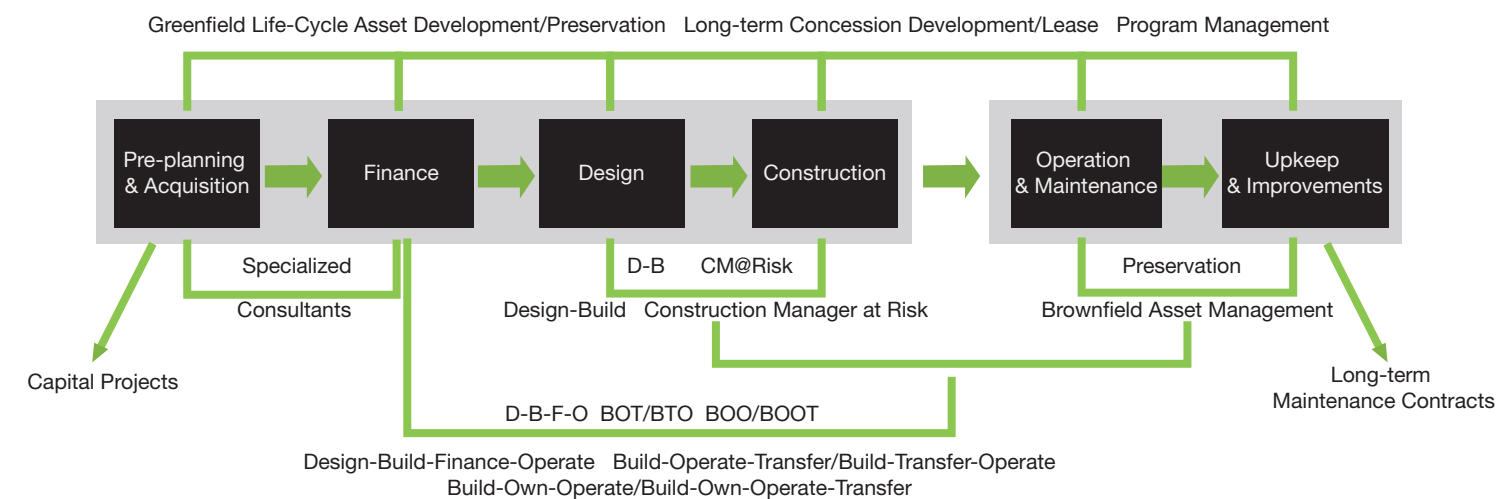
- Innovations in service delivery;
- Better institutional integration throughout the life-cycle of the facility; and
- The potential for increased value for money relative to traditional approaches, as possible increase in project cost at inception is offset by better efficiency during the lifecycle.

Other potential advantages are:

- Access to new private capital including taxable equity and either taxable or tax-free debt to supplement scarce public funds.
- Higher quality and customer satisfaction due to focus on performance-based standards, enhanced quality control and assurance, and contractual accountability.
- Public agencies are able to focus on their strengths, including long-term service planning and management, environmental clearance, permitting, right-of-way acquisition, standards setting, and performance measurement and reporting – having turned over part or all of financing and/or day-to-day operating responsibility to their private partners.



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- Source: Adapted from Pekka Pakkala. *Innovative Project Delivery Methods for Infrastructure – An International Perspective*.

PPP FUNDING: A SNAPSHOT

The key to establishing an effective and efficient healthcare delivery system in any country is to ensure the three 'A's: Availability, Accessibility and Affordability.

Despite being a country of a billion people, India has one of the lowest public spending on health at a mere 1.4 % of its Gross Domestic Product (GDP). This is much lesser than the recommended 5% by the World Health Organization (WHO).

In view of global standards, overall spending on healthcare by the government is considerably low. As a consequence, the out-of-pocket burden on the country's citizens increases multi-fold. We have seen some very fruitful but sporadic healthcare initiatives by the government in its attempts to ensure healthcare for all. However, the need of the hour is to ensure, through innovative initiatives, that healthcare is made accessible to all at an affordable cost and that the quality of care is not compromised upon. One of the most promising initiatives is Public-Private Partnership (PPP).

The true success in such a partnership is to ensure cost-effectiveness for all parties involved with no compromise on quality and ensure a win-win situation for all stakeholders and end-users.

In this section, we shall attempt to decode the various aspects and avenues of funding that are available for PPP's and the complexities that they bring to the front.



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Funding Avenues

Let us discuss some of the most common avenues of funding available for PPP Projects:

- a. Financing from the government
 - i. Complete capital expenditure cover (including land)
 - ii. Viability Gap Funding (VGF)
- b. Financing from external agencies
- c. Financing from a private partner
- d. Annuity-based financing for healthcare infrastructure



A. Financing from the Government:

The basis of a PPP is the partnership between the public (read government) sector and private sector to ensure provision of services to the population with a win-win situation for all involved parties. Hence, the most commonly observed mode of funding for a PPP is where the government and private partner/s both contribute to funding the venture in question. Quite often the PPP is supported by investment from the government in the form of land, complete capital expenditure cover/infrastructure cover, subsidies, grants etc. Also, with the objective of making the PPP projects commercially viable, the government provides Viability Gap Funding (VGF).

Viability Gap Funding:

To avail of the VGF Scheme from the government, certain minimum criteria⁴ need to be fulfilled, as enlisted below:

- a) The project/venture in question must be posed by the Central Ministries, State Governments and Statutory Authorities.
- b) The one-time or deferred VGF will be provided with the objective of making the project commercially viable.
- c) For delivering an infrastructure service on payment of a pre-determined tariff or user charges, the partnership will be based on a contract or concession agreement between a government and private sector company.
- d) The scheme will apply only if the contract is awarded to a private sector entity where 51% or more of the subscribed and paid up capital equity is owned and controlled by the private entity.
- e) The private sector company will be eligible for VGF only if it is selected on basis of open competitive bidding and is responsible for financing, construction, maintenance and operation of the project during the concession period.
- f) The viability gap funding cannot exceed 20% of the total project cost.

⁴Source: Ministry of Municipal Affairs – British Columbia, IFC, pppinindia, European investment bank



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To understand the applicability of the VGF Scheme to a PPP project, let us explore the Andhra Pradesh Government's undertaking to provide quality diagnostic services in their state medical colleges in Kakinada, Kurnool, Warangal and Vizag. In July 2010, Wipro GE entered into an agreement with the AP Govt. along with Chennai-based Medall Healthcare to provide the diagnostic imaging services in the four medical college premises. The AP Govt. has assured a VGF of Rs. 2.8 Crore to help build the entire project; the project cost is over Rs. 20 Crore. The user-fee/tariff for these services have hence been fixed – and they are at a concessional rate of almost 50% than those of local market rates. This is a classical example of where the VGF is provided against provision of services at a pre-determined fee so that the private partner is incentivized to provide the services leveraging their expertise and competitive edge.

B. Financing from External Agencies

Another avenue of financing that PPP's have been able to attract is from external agencies and multilateral agencies such as the World Bank, COMSEC, IFC, ADB etc. Most often, these are in areas which are mutually goal-oriented for all agencies involved.

While an external agency is generally looked upon to lend the technical assistance to the whole PPP process in terms of advisory on the transaction and framework, increasingly, they are also looked upon for financial assistance. The financing generally acts as a cover or guarantee and/or risk insurance, and in certain cases, it also helps in credit enhancement.

Some of the observed benefits of participation from such agencies are listed below:

- a) Better loan terms and financial structure to improve project viability
- b) Mutually beneficial concession contracts
- c) Improved environmental and social risk mitigation
- d) Enhanced public consultation
- e) Improved corporate governance in the project

C. Financing from a Private Partner

The private partner, whether a corporate, a single entity, or a group/consortium of private players, comes together to participate in a PPP to make a venture profitable as well as aide the government in its bid to provide services to the public at large. There are various arrangements through which the private player funds a PPP assignment and some of those, such as PFI, DBFOT, DFOT and DBFO, have been discussed in detail under 'Types of PPP'.

D. Annuity Based Financing

for Healthcare Infrastructure

Annuity-based funding is similar to a loan taken by individuals to buy a house or a car in the sense that the financing is strictly a debt or loan taken by the government for a specific purpose that has to be serviced over a period of time irrespective of how the venture performs. It becomes one of the various methods of borrowings for the Government. Many a times, annuity-based project development is referred to as a PFI (Private Financing Initiative). The key feature here is that the private developer is not taking a demand risk on itself i.e. irrespective of the usage levels of the asset created, the private developer is assured of the returns. The government agency has to, in a way, pledge its anticipated and future revenues towards payment of the annuity to the private partner; this way, the investment decisions of the future governmental agencies get curtailed.



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FINANCING: A Note of Caution

The Economic Survey⁶ of India (2008-09) — an annual publication of the Ministry of Finance, Government of India illustrates the need for increased public-private partnership in key areas such as infrastructure, but also cautions against a number of problems confronting PPPs. In particular, the Survey notes the following six key hurdles faced by PPPs:

- Policy and regulatory gaps, specially relating to specific sector policies and regulations.
- Inadequate availability of long-term finance (ten year plus tenure) — both equity and debt.
- Inadequate capacity in public institutions and public officials to manage PPP processes.
- Inadequate capacity in the private sector — both in the form of developer/investor and technical manpower.
- Inadequate shelf of bankable infrastructure projects that can be bid out to the private sector.
- Inadequate advocacy to create greater acceptance of PPPs by the stakeholders.

Further, structuring the financing of a PPP is very important as it needs to address the following issues to make the PPP a win-win situation for all involved agencies:

- A risk-sharing methodology should be evolved to ensure that the projects are more attractive to investors.
- Hand holding of projects by the government till the initial hurdles are clear.
- Providing minimum guaranteed returns to projects with higher social rate of return than internal rate of return. It is hence imperative to structure the financing of a PPP in a manner that will leverage the government's limited budgetary resources for investments in infrastructure and allow the private sector to efficiently and effectively run assets and activities in the public domain, through a transparent mechanism. The risks, in such a venture, when allocated appropriately, should be shared by all involved agencies, so that reliable, sustainable service is provided to the populace.

⁶<http://indiabudget.nic.in/es2008-09/esmain.htm>

Healthcare: The Situation On Ground

We shall try and sketch a premise of the healthcare scenario, for we need to understand the ground reality before we use case studies to dissect Public Private Partnerships.

Basic Financial Facts

- Healthcare in India is a State subject with the Centre confining itself to vertical national health programmes. Funding is predominantly at the state level. In 1990-91 the Central share of healthcare was just 9% of the total. This share has been steadily increasing over the years.
- Through the 1990's, the share of public spending on healthcare as a percentage GDP kept declining; the gains of liberalization were not allocated to trickle into health.
- By 2004-05, public spending on healthcare was about 0.9 % of the GDP, ranking India 171 among 175 nations on healthcare spend. In May 2004, a Common Minimum Programme (CMP) was announced, in which the newly elected government decided to raise this public spend to a broad range of 2-3% of GDP over the next five years. A pioneering National Rural Mission (NRHM) commenced in May 2005 to improve access and availability of quality care in rural areas with a focus on disadvantaged states and vulnerable groups: women, children and the poor.
- By 2009-10, five years after the announcement of the CMP, proportion of public spend on healthcare to GDP had increased to 1.4%.



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- From 2004-05, while the economy grew by nearly 13.5% year on year nominally, public healthcare spend increased by about 5% points more (18.7%). Most of this rise was due to increasing share of funds from the Centre. Central spending increased by almost 30% (29.76%) year on year from 2004-05, though it grew from a low base. More than 95% of the increased central spend was Revenue Expenditure, on account of NRHM which employed about eight lakh social health activists, ASHAs.
- The State spend on healthcare grew by about 16% in the same period, more than 27% of the health spend in states was on capital expenditure (even after including the spend on Family Welfare; Family Welfare has minimal capital expenditure.) In 2008 however the State Finances deteriorated due to the economic crisis and implementation of the Sixth Pay Commission. The revenue surplus which had been maintained since 2006-07 declined, and became a deficit in 2009-10. 28 of the 30 Indian states have enacted the Financial Responsibility Legislation which sets an upper limit on their Gross Fiscal Deficit/Gross State Domestic Product and hence limits their spending.
- With the fiscal position worsening, and a cap on the deficit, States cut down on healthcare spend in 2009-10. Total state health expenditure grew by 9.9% which was lower than the rate at which the state nominal GDP grew. Capital Investment stalled (growth of 0.3% nominally and hence negative growth in real terms) and though the Centre tried to compensate, the total Centre plus States' Capital Expenditure grew by 4%, which is again negative in real terms.



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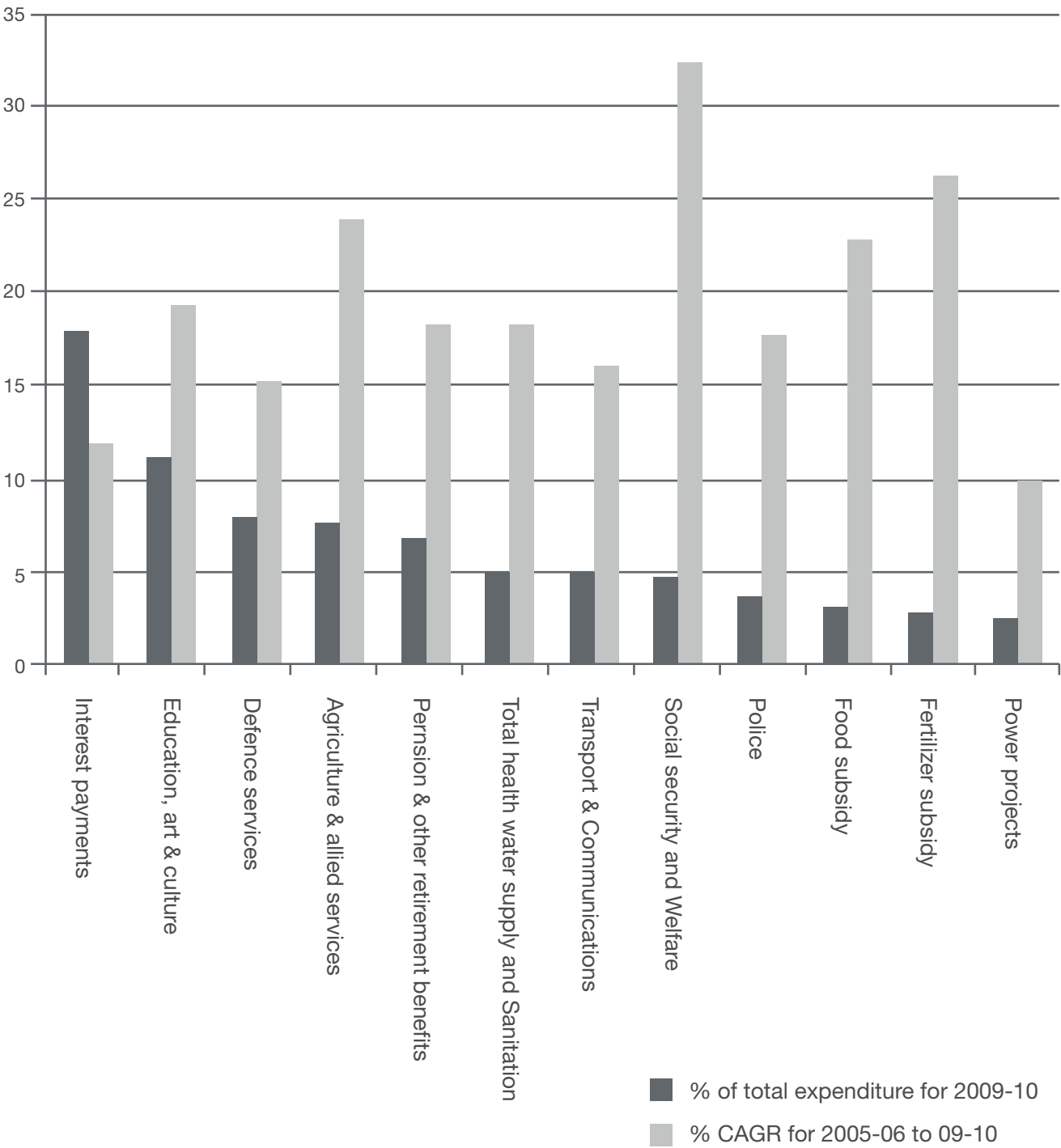


Key Points from this Discussion:

- Since 2004-05, healthcare is one of the priority areas for the Central Government. However, for the State Governments, which contribute a shade less than three fourths of the total health spend, healthcare is not a high priority.
- The Central Government has decided to invest in primary healthcare and is keeping a foot on the pedal even during times of macroeconomic slowdown. Slowdowns are, however, adversely affecting Capital Investment and, consequently, the condition of public secondary and tertiary hospitals, almost all of which are under State Governments.
- If the current trends of public health spends persisted along with the GDP growing at the nominal rate of 13.5%, it would need 7.5 years more from 2009-10 for the public health spend to reach 2% of the GDP and 17 years more for it to near 3% of GDP. Truly, the 2004 Common Minimum Programme had plans for a generation to come.



PRIORITY SECTORS FOR PUBLIC EXPENDITURE OF STATE AND CENTRAL GOVERNMENTS: INDIA



- * The top 12 public services in India take up over 75% of government expenditure.
- * Debt servicing forms more than one sixth of the expenditure, while the public goods of Defence and Police form more than one tenth of the total and so does education.
- * Both pensions for government employees and fertilizer and food subsidies combined take up more expenditure than healthcare and family welfare.
- * On the back of NREGA – the flagship programme of the Government, Social Security has grown the fastest in the past four years. Fertilizer Subsidy, Agriculture and Rural Development, and Food Subsidy have grown faster than average; though as per the latest budget, the Fertilizer Subsidy is to be pruned, this is akin to pushing up the prices, before a discount sale.
- * Compounded growth of Health and Family Welfare in the past five years has been near the median.

Hence, if we rank the twelve sectors as per the Government's Priority, using a rough and ready method of combining the ranks by share of total expenditure and CAGR, we get the table illustrated further below.

Methodology: The expenditure heads are ranked in order of their Expenditure Share and in order of their Growth Rate. The Ranks are simply added up to a score — no weighting is done.

For instance, Defence has the 3rd highest Expenditure Share and 10th highest Growth Rate.

It shall be totalled as 3 + 10 = 13. Any expenditure head that gets a score less than 13 gets ranked above Defence.

In the case of a tie, the expenditure head with the higher Expenditure Share gets ranked higher.

PRIORITY LIST BY SECTOR FOR STATE AND CENTRAL GOVERNMENTS' COMBINED

Expenditure Heads	Combined State and Centre Rankings
Education art & culture	1
Agriculture & allied services	2
Social Security and Welfare	3
Pension & other retirement benefits	4
Interest payments	5
Defence services	6
Medical, public health, water supply, family welfare	7
Fertilizer subsidy	8
Food subsidy	9
Transport & Communications	10
Police	11
Power projects	12

Education tops the list, and this can have positive development for Health in the next decade or so as female literacy is highly correlated with lower Infant Mortality.

Rural India is the next priority with Agriculture and NREGA. Health is again near the median, just above the two Subsidy expenditures. If both the Subsidies are considered under a single subsidy head, Health gets to be eighth in the line.

Both Transport and Communication and Power, the two infrastructure sectors which have had a large share of privatization and PPPs, rank low.

PRIORITY LIST BY SECTOR FOR STATE GOVERNMENTS

Expenditure Head	State Ranking
Education art & culture	1
Agriculture & allied services	2
Social security and welfare	3
Pension & other retirement benefits	4
Transport & communications	5
Urban development	6
Interest payments	7
Medical, public health, water supply, family welfare	8
Major & medium irrigation	9
Compensation & assignment to panchayati raj	10
Police	11
Power projects	12

Since Healthcare is a State subject, we check the priority list for the States too.

Below are the rankings considering the top 12 expenditure heads by the States.

These heads form almost 85% of total state expenditure. Hence, for the State Government, and the country as a whole, healthcare comes low on the priority list. Meanwhile Indian figures, for both infrastructure and manpower, are at just one-third of WHO-recommended norms for developing countries; in key health indicators like infant mortality rate, India is worse than Namibia or Nepal or Bangladesh. When 18 pregnant women die iatrogenically in a big town hospital, such as in March 2011, it is taken as matter of course. Let us analyze why this is so.

Healthcare in India, excepting for a handful of exceptional states, has twin failures: a political/governmental failure and a market failure; we define failure as actions in the status quo that lead to sub-optimum outcomes.

Market Failure

Doctors too behave with rational self interest. Their preferences are Skill Enhancement, Monetary Benefits and acceptance within a peer group network. Doctors do try to maximize skills: they work for long hours at low pay for long years so that they reach the level of skill they aspire to. But many doctors reach a ceiling with regards to their skills, and some reach that ceiling faster than others. Hence for many, the expected utility from skill enhancement diminishes over the years.

Regarding monetary utility, studies (McGuire 2000) reveal that:

- Doctors have market power: they can price discriminate to a high degree and hence can charge each consumer what that consumer can bear to pay
- Because they know more about the patients' ailment than the patient does (informational asymmetry), they can increase the quantity of healthcare consumed for their own benefit as long as it is not flagrantly harmful to the patients' health (prescription of unnecessary tests, unnecessary scheduling of visits etc.) Hence, if put on a price cap they can induce greater consumption of quantity.
- They have an opportunity cost of time, and seek revenue per patient greater than this opportunity cost.



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Doctors are trained almost exclusively in urban areas, with little sensitization to the community at large and with minimum exposure to Public Health, they are unable/unwilling to maximize their Skills in an isolated rural setup with basic infrastructure in a location they cannot identify with and the prospects of career advancement unclear. Hence, they find little scope of skill enhancement. The option of maximising monetary benefits becomes attractive.

Rural health spends are not low; by NSSO data, on an average, a village of about a 1000 people has an expenditure of roughly INR 5 lakh annually on OPD expenses, and INR 1.5 lakh on hospitalization expenses (in 2003-04 prices) (Note: More than half this expenditure is on medicines.) Hence, in the absence of effective monitoring, absenteeism in rural setups follows; there is an opportunity cost to the doctor's time spent inside a public health setup. Collusion with the local political centre for redistribution of this excess income might follow: the public-public partnership for private gain.

There are a fair number of rural areas where the health spend is much lower than annual average INR 6.5 lakh; in these areas, there shall be no supply of doctors at the price the area offers.

In areas where there is no supply demand mismatch, medical costs can keep escalating, as doctors control the amount of care that the patient consumes. Hence fee-for-service model in medicine, where doctors are paid for the number of procedures they do, is a model which is very easy to measure and gets in revenues, is the model which has been followed by almost all leading hospitals.

As against this models which emphasize team work and pay for out comes not number of procedures increase efficiency and quality of out comes, but are not easy to implement and are rarely followed in hospitals.

Hence, the market failure, we described, with respect to doctors holds true for hospitals too. This, along with the cost of hi-tech equipment in modern hospitals leads to a cost spiral. Escalating medical costs lead to demand for private insurance which in turn is plagued by adverse selection: asymmetric information again: the customers know more about their disease profile than the insurance companies and therefore have an incentive to lie about their past medical history. Verifying medical history of customers or just adding it to their business risk adds to insurance premia; systemically are inefficiencies piled on the other till healthcare expenditure becomes unsustainable for the economy.



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Hence a Public-Private Partnership can succeed if it either colludes with the scenario strategically or if it alters the scenario fundamentally and lays its own rules. It can do so by:

- Making healthcare politically important;
- Lobbying power of the private partner;
- Being politically neutral but be driven by unobjectionable objectives like Millennium Development Goals;
- Shows effective means of reducing market failure;
- The PPP is small and bypasses the political eye; is a local solution to a local problem, seeking local efficiency;
- It is a community initiative, which politicians and markets are forced to accept

Any PPP that does not take into account the Political and Market Reality does so at its own peril.

The PPP might succeed by enhancing both Market and Political failure and appealing to the weaknesses of both the Politicians and the Market. Eg. Politically, it shall favour the few at the expense of the many and market-wise promote inefficient practices like increasing the doctor's/hospital's market power. Or a PPP might succeed by being constructive, benefitting all and correcting the power imbalances in the market. Only one of these two maximises welfare.

We shall now examine selected case studies and garner a few key points.



CASE STUDY 2: CHIRANJEEVI Concept

To devise a voucher system for the BPL maternity population to enable them avail of private obstetricians.

Spearhead

Dr. Amarjit Singh, the Principal Secretary for Health, IAS, and a PhD from Liverpool on the cost-effectiveness of the National Blindness Control programme, conceived the scheme and laid down its networks.

Design

The Government deliberated the scheme with SEWA, the acclaimed NGO and the Federation of Obstetric and Gynecological Society of India (FOGSI), the professional organization representing practitioners of obstetrics and gynecology in India, to devise a package rate for a delivery.

The package included the weighted average of rates of a normal delivery, complicated delivery, caesarian section, travel reimbursement to mother and the accompanying trained birth attendant etc. A pilot project was conducted in five of the most backward districts empanelling almost three-fourth of those districts' private obstetricians

Innovation

The doctors were paid a sum of INR 15000 in advance at signing of an MoU, unlike most PPPs where payment comes in months after the service has been delivered. This advance amount was to be topped up after a certain amount of deliveries. Hence, the government always paid for service in advance to gain credibility with the doctors.

Repeated reviews of the scheme were performed by a team of respected researchers from IIM Ahmedabad. Dr. Amarjit Singh extended absolute cooperation to every independent evaluation of the scheme.

Results

Between January 2007 and January 2010, about 4,35,047 safe deliveries were carried out by 768 obstetricians. These represented roughly 55-60% of the total deliveries by the Gujarat BPL population in this period. Over 26 months of the scheme, each doctor earned on an average almost Rs.10 lakh, which is a fair amount of marginal income.

Each pregnant woman, on the other hand, paid INR 654 on an average as costs of medicines for the child and herself as many doctors refused to bear costs of the same out of their package.



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Highlights

More than half of the States' private sector obstetricians agreed to be part of the scheme.

Maternal Mortality rate for the mothers availing of Chiranjeevi scheme fell significantly, by an estimated almost 55-90%. (Mavalankar, Amarjit Singh et al.)

The neonatal mortality rate too dropped, though its significance cannot be ascertained. The scheme was very well-targeted.

A study ascertained that 94% of the beneficiaries were below poverty line, hence leakage was low.

Concerns

Apart from a couple of senior officials in the government, the scheme has been managed by external consultants and fresh ad hoc recruitments. With Dr. Amarjit Singh having been transferred to New Delhi, the scheme could lose its sense of purpose.

The quality of care has not been evaluated, nor has it been audited if the gynaecologists have been selecting cases and refusing high risk cases; in case of a refusal, no further referral chain has been defined for the patient.

While the package rates have been kept low enough for Chiranjeevi to cover operational costs for the doctor it does not cover costs of medicines adequately, and, as per the doctors, the costs of a truly high risk pregnancy. The base rate of INR 800 for a normal delivery is low and it pulls down the package rate. As doctors do measure costs, there are fair chances for cream skimming and some anecdotal evidence of the same for in Surat. (Acharya)

The scheme is an excellent ad hoc measure; however, in the long run, government institutions need to be strengthened.

Possible Scaling up

Dr. Singh has suggested that Jharkhand, which too has a bare cupboard in the public sector, could benefit from this scheme.

Conclusion

Dr. Singh's training in public health was an enabling factor for change; Chiranjeevi was one of a series of innovative measures he initiated in his tenure. That he chose a universal theme, an MDG, insulated him from political risk; that the FOGSI was made an initial participant, cleared the road.

His openness to external evaluation meant that he was keen to learn on the job yet, enhance his skills.

The package to the doctors too was derived to gain maximum efficiency, paying for just marginal costs, but perhaps the package cut it too fine and it is time for a revision.

Case Study 3:

HBNC: Reducing Infant Mortality

Background

SEARCH is an NGO started by Dr. Abhay and Dr. Rani Bang, two medical doctors with a Masters in Public Health from Johns Hopkins School of Medicine, Baltimore.

Treasuring Gandhi's ideals, they returned to India and settled in Gadchiroli, one of Maharashtra's most backward districts, to put their learning into practice.

"Research is to be conducted where the problems are, and not where the facilities are."

"Research should address the needs of the community I work with, not the research community I belong to."

The Discovery of HBNC

So began the journey. The women in the Gadchiroli community revealed that what concerned them the most was their children dying; back then in 1990, out of every eight newborns, one died in infancy; it happened all the time.

Abhay and Rani Bang decided to take up controlling infant mortality as their challenge.

They trained a team of health workers, dais and paramedical staff in management of pneumonia in newborns. After one year of intervention in the late 1980's, infant mortality for the treated villages had reduced by 25% from 121 to 89.

The Bangs observed that three fourths of the infants who died didn't make it past four weeks; Pneumonia was a major cause, so was low birth weight and asphyxia (choking).

WHO guidelines suggested management of pneumonia in a hospital set-up. However, hospitals were few in Gadchiroli and mothers did not like to take their sick infants to far flung hospitals. Hence they decided to work on a home-based therapy — Home Based Newborn Care (HBNC).

They trained female health workers to treat asphyxia by clearing mucus out by a sucker; and low birth weight by encouraging frequent breast feeds and warmth. Also, they trained the health workers on detection of signs and symptoms of pneumonia. Infants developing pneumonia were advised hospital care, but if the mother was unwilling, the health worker was trained to administer an injectable antibiotic.

A physician visited a village every two weeks and verified data and continued the training. Every birth was tracked, death recorded and cause investigated. Data was recorded also of a certain number of control villages where no intervention was performed except recording of data.



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The Result

From 1995 to 1997 the Infant mortality reduced from 74 to 38 per 1000 births in the 39 villages in which they had intervened. By 2003 Infant Mortality in their administered area was down to 30, about 15% lesser than Mumbai's Infant mortality rate. The study was published in Lancet, one of the leading international medical journals, in 1999.

Replication

HBNC was replicated by other groups of NGOs in a project called ANKUR, across seven sites in Maharashtra (2001-05). IMR was reduced by 47%.

Incorporation of HBNC into NRHM

Inspite of evidence of the effectiveness of HBNC, National Rural Health Mission adopted another programme, Integrated Management of Neonatal and Childhood Illness (IMNCI) for training their health workers, despite IMNCI having had no demonstrable effect on Infant Mortality.

Dr. Bang persisted, and finally, in 2010, National Health Systems Resource Centre (NHSRC) adopted HBNC in its training guidelines to health workers and HBNC was incorporated into the national programme with one important exception: the ASHA has not been allowed use of injectable drugs for pneumonia, but instead was asked to refer the infant to the primary health centre; though administration of injections is not a complicated process, and can be learnt by a health worker, perhaps injections symbolize the power of a doctor or nurse; hence a mere health worker was debarred from its administration.

HBNC should be effective even after this excision, though; it has more training inputs and patient visits than IMNCI and is, unlike IMNCI is focused on neonatal health.

Conclusion

Reducing Infant Mortality is possibly the top national priority in health goals; Gadchiroli achieved the IMR goal of under 30 in 2003, it took seven more years for HBNC to roll out to the nation. Seven years is not unusually long for any governmental process, except that India is way behind schedule in reducing IMR below 30 till 2015. Possibly, the delay was because of SEARCH's and HBNC's insistence on the importance of community and respect of community rights.

One of the main features of political failure is that it rarely takes community rights into account, and is swamped by special interests, acting for the benefit of a few at expense of the many, though infant government should exist for protection of community rights.

Hence the relationship between government and NGOs has been one of hierarchy than of dialogue, and insecurity, since NGOs do a role that is actually the governments', and do it in many cases better. Yet community ownership and participation is the only sustainable way to ensure that doctors don't stay absent, drugs do not get out of stock and care is administered near at hand. With community participation and ownership, Healthcare can be a common pool resource, accessible to all and shared by all.



CASE STUDY 4:

RSBY

Concept

The UPA government had in the 2004 Common Minimum Programme mentioned a health insurance scheme for the poor. Rashtriya Swasthya Bima Yojana (RSBY) commenced in 2008, seeking to cover the BPL population from routine illnesses requiring hospitalization. The policy has a sum insured of INR 30,000 per family. The premium is shared by the Central and State Governments.

Conceived by Mr. Anil Swarup, M.A. in Political Science, IAS. Director General, Labour Welfare

Modus Operandi

Every State Government bids out coverage for certain selected districts in the state to public and private insurance companies. The insurance company along with the smart card subcontractor is responsible for enrolment of the families. The insurance company ties up with public and private hospitals. Package rates are defined for 725 procedures.

Innovation

Biometric smart cards are given to every member. All ailments have defined package rates and when the appropriate diagnosis is entered and the smart card swiped, auto deduction of the claimed amount takes place and an sms is sent to the insurance company. The smart card is valid all over India in the network hospitals; as BPL families migrate often, this is useful.

The independent evaluations of the scheme by researchers from international organizations have been made available in public domain. Even presentations of various stakeholders like hospitals have been made open to public scrutiny.

Result

Population of about 8 crore is covered over almost one-fourth of the total districts in India. Both public and private insurance companies have participated, and private insurance companies have about two-fifth of the total number of districts. 54% BPL in the covered districts got insured.

There is wide variation in claim incidence in the 78 districts, which have completed one year. Average incidence of hospitalization is a substantial 2.6% (higher than rural average by NSSO 2003-04 figures). However, claim incidence is lower than 1% in almost 30% of the districts. Hence, awareness for the scheme varies across regions.

Average claims ratio is almost 80% which is better than most group health policies the insurance agencies undertake. Insurance companies are able to make sustainable, though not excess profit.



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Highlights

Most of the 725 ailments covered are routine, not rare. Hence it has definite financial protection for the poor.

The bidding process is very competitive. RSBY has 11 insurance companies bidding for the districts. There is complete Risk Transfer to insurance companies. If insurance companies are lax and cannot control fraud, it is they who suffer, not the government. Performance of private insurance companies is healthier in some aspects like even population coverage, than the public sector units.

Concerns

Insurance companies also control enrollment, a task they may not be best equipped to do. Enrolment is on the basis of 2002 BPL data which is full of holes.

Even though there is no evidence of skimming the cream and not enrolling the old, disabled and vulnerable in studies, so far, there is definitely scope for risk selection.

Insurance companies along with local communities are also supposed to create awareness about the scheme, a thing they have definite disincentive to do. More the awareness, more the claims – more the claims, more the chance of a loss.

District studies show that insurance companies are, in some districts, even forgetting to provide basic requirements to the customers: a list of network hospitals. Hence, instructing the local administration to teach all beneficiaries about the scheme is essential. A call centre may help too.

Package rates are low; for some hospitals, lower than their marginal cost. This is in a way beneficial, as it may not induce them to perform unindicated procedures, but it poses problems in providers giving patients complete coverage including cost of medicine.

With increased awareness, and increased volumes, the scheme shall need increased finances. However, these costs may be overcome by the productivity gains it provides for the BPL population.

Challenge

The scheme is being expanded to cover all NREGA individuals, which shall greatly expand its volumes. Mr. Anil Swarup's tenure ends in August. The scheme should remain transparent even without his efforts.

Conclusion

We chose this case because it is a PPP of huge scale and yet has important points of difference with Aarogyasri; possibly for the BPL RSBY can have greater utility.

What Chiranjeevi and RSBY demonstrate is that schemes conceived by top bureaucrats, who have been given freedom of action, may produce excellent results for welfare.

Bureaucrats gain no utility from electoral agenda, and at the mature stage of their careers, at Principal Secretary level etc. they have advanced enough in their careers for career advancement to be a on the top their priority; since they are without the pressure of towing the line. They have access to immense resources: the levers of power.

Also bureaucrats have experienced political failure very close at hand and can know better how to avoid it, they have also a fair idea of market failure. If acquainted with efficient market makers, they can be active agents of change. But as HBNC demonstrates community participation is crucial for sustainability.



PERFECTING HEALTHCARE

Governance of PPPs

“Governance is the means by which to infuse *order*, thereby to mitigate *conflict* and realize mutual *gain*.”

—Williamson, 2009

In the pages that follow we shall focus on this aspect, which is the lifeblood of a partnership. We shall broadly discuss the expected roles, rules, and post contractual aspects in a PPP for the public sector. We shall discuss governance issues generically, aspects common to PPPs across sectors, and then briefly dwell on specific aspects of healthcare.

Today, there is growing realization that given their respective strengths and weaknesses, neither the public sector nor the private sector alone can operate alone, in the best interest of the health system. There is also a growing belief that public and private sectors in health can potentially gain from one another. Involvement of the private sector is linked to the wider belief that public sector bureaucracies are inefficient and unresponsive, and that market mechanisms will promote efficiency and ensure cost effective, good quality services.

However, within a PPP arrangement the same bureaucracies, believed to be bloated and unresponsive, are to restructure and effectively manage the private partner and ensure that the partner delivers the service.

This is not impossible, provided the new role of bureaucracy in this set-up is clear.

We have had some sterling success stories with the bureaucracy as the manager/regulator.

¹ADB. 2000. *Public Private Partnerships in Health. Executive Summary Series No. S34/01. Executive Summary of Proceedings (30 October-3 November) Ayutthaya, Thailand. Tokyo: Asian Development Bank Institute.*



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“We have to manage the biggest management event in the world, but the Core Staff in the Election Commission of India is just 300. Despite a multitude of political pressures the CEC manages to be independent, and that's the best way because constitutionally civil servants are supposed to be independent. Infact after the General Election, Mr. Bimal Jalan, former RBI Governor said, “The same civil servants who are considered to be inefficient, lazy and corrupt, deliver a world class event because they are under a different command.” (Adapted from a media interview of Mr. S.Y. Quraishi, Chief Election Commissioner)



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THE ROLE OF PPP UNITS

PPP units create, manage, and evaluate PPPs and are a critical element in supporting efficient PPP schemes. A PPP unit is usually located within the Finance Ministry/Treasury.

The rationale for a dedicated PPP unit is:

- Individual government departments know that the ultimate responsibility for any agreement that the department may conclude rests with the government as a whole, and not the department alone. These agreements include payments in PPP contracts. Therefore, since Central/State Government as a whole will have to make good on PPP payments, a government department may commit to an agreement while it knows that its own budget allocation will not be sufficient to make the payments and count on a bailout from the Government Finance Department.
- A dedicated PPP unit could prevent such free-rider problems by requiring the departments to demonstrate that future payments are expected to fall within their budgetary allocation. Such approval will then constitute a precondition for the final conclusion of the PPP agreement.
- A dedicated PPP unit may be established to create a knowledge centre that can provide individual departments with technical assistance when they set up PPPs.
- As compared to the public sector, financial transactions in the private sector are more complex as they involve calculations of discount rates, risk valuations, internal rates of return etc. Figures which the government does not usually calculate. Hence in structuring deals with the private sector, the PPP unit needs internal experts or it needs resources to bring in consultants on an ad hoc basis. While it is leaner to work with ad hoc consultants, this comes at the cost of not building in an internal knowledge base in crucial financial matters.
- A PPP unit could also keep an eye on departments through its regulatory approval mechanism to ensure that PPP deals fulfil all the legal and technical requirements involved in the creation of PPPs.
- The provision of regulatory approval as well as the provision of technical assistance constitutes the main functions of most PPP units, including those in the UK, Australia and South Africa.
- The PPP unit can help the separation of policy and practice, i.e. the PPP unit is responsible for PPP policy, advice and oversight, but the spending ministries, not the PPP cells, are responsible for promoting actual projects. This reduces the risk that the PPP unit becomes a mere promoter of PPPs.

- The main task of the PPP unit is then, not to advocate or execute PPP projects, but to ensure that transaction costs are as low as possible and that Value For Money (VFM) is the main decision criterion for a PPP. If a PPP unit is also responsible for the projects, it might cause a conflict of interests for the unit; we might end up in a situation where it is responsible for overseeing, preparing and executing a project. As such this may cause a PPP unit to promote PPP projects merely to justify its existence, causing it to lose its focus on value for money.
- For healthcare projects, PPP cells should require a well-respected medical expert with wide experience of forming Healthcare Performance Indicators besides measuring and evaluating the same. Similarly, a hospital design expert and construction expert should provide specialized inputs at both the pre-contract stage and monitoring stage. Hospitals are one of the fewest of entities that are complex in design, micro-detailed in construction and confounding in performance measurement. Only dedicated experts can provide inputs for the same.

States equipped with a PPP Cell:

Andhra Pradesh
Assam
Bihar
Chandigarh
Chhattisgarh
NCT of Delhi
Goa
Gujarat
Haryana
Karnataka
Kerala
Madhya Pradesh
Manipur
Maharashtra
Nagaland
Orissa
Pondicherry
Punjab
Rajasthan
Tripura
Tamil Nadu
Uttarakhand
Uttar Pradesh
West Bengal

Source: www.pppindia.org



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PERFECTING HEALTHCARE

CASE STUDY 1:

AAROGYASRI

Background

Rajiv Aarogyasri Health Insurance Scheme in Andhra Pradesh is one of the most well-branded PPP schemes ever. Brainchild of Y.S. Rajasekhara Reddy, a medical doctor by profession and one of the most popular chief ministers of Andhra, the scheme envisioned social protection of the poor from a devastating health crisis. The scheme was piloted and ramped up in several stages and was operationalized for the entire state in December 2008, four months before the state elections of 2009, which the ruling party comfortably won. By this time, the scheme had enrolled more than 80% of the state's population: Aarogyasri is the NREGA of healthcare.

Key Features

The scheme covers 942 procedures, the surgical procedures are both secondary and tertiary, the non-surgical therapies covered are all tertiary care. The premium is Rs.450 per family. Premium is paid directly by the government on behalf of the family. All claims are cashless. Even food and travel are covered.

There are around 350 hospitals enrolled; more than three-fourth are private. An enrolled private hospital releases 25% of its beds for Arogyasri patients. As per a release on the Arogyasri website, the average claim size is INR 29897. This is almost equal to the average claim size in any retail health insurance scheme. Claim frequency is about 6 per thousand, with an enrolment of 7 crore people. By 2003-04, NSSO figures rate of hospitalization in Andhra per 1000 people is 22 in rural and 28 in Urban areas.

Hence, Aarogyasri claim incidence is roughly one-fourth of the total claim incidence in 2003-04. A part of the scheme is managed by a private insurance company, the other part is self funded by a Trust on whose board are the Chief Minister, the Health Minister and the top bureaucrats. The insurance company, as per a media interview of its CEO, employs 40 retired police officers to check fraud. The means used by the Trust to check frauds in its half of the policy is not known.

The media rarely reports fraud; there was some opposition from the TDP initially to the scheme. Later, at election time, TDP too promised to continue the policy, after it renames it in its deceased leader's name.



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Highlights

- Excellent IT support. Thorough linkages with the other PPP initiatives in the state, the statewide 108 Ambulance and the Dial 104 Healthcare helpline efficient call centre.
- Enthusiastic participation from the private sector.

Problems

Andrew Mitchell and Ajay Mahal have in January 2011 reported an evaluation of households in two districts in Andhra Pradesh and measured the health spends for a fairly large sample. The health spends of families possessing a Aarogyasri card are marginally *more* than those without the card.

Hence, there is no impact of Aarogyasri on health spends. However, if the utilization patterns of NSSO (2003-04) are maintained and provided, there is no marked regional variation in claim incidence, Aarogyasri forms one fourth of total number of claims; and these high value claims of nearly INR 30000.

Hence arguably, Aarogyasri has enlarged the pie; people who get treated for treatments covered in Aarogyasri would not have earlier undergone treatment at all. Also, as per the January 2011 evaluation, about 70% patients approach a hospital directly for even minor ailments without first being screened in a primary care facility. It is not known if Aarogyasri has brought about this behavioral change.

Concerns

One part of the scheme having 60% of the procedures is self-funded and there is no risk transfer here; the Aarogyasri trust decides on the premium amount, collects the premium, and settles the claims itself. As per a newspaper report, only 11% of the total premium of INR 925 crore went to government hospitals and about INR 800 crore passed to private hospitals.

This year, though the allocation has remained steady at INR 925 crore, more than one-fifth of the total health budget for the state. The government's expansion plans continued and it has allocated INR 350 crore this year for a similar scheme for government servants.

No systematic evaluation for the scheme has been done by a neutral third party, no evaluation of quality and actual outcomes.

The tariffs are not just covering marginal costs but are yielding sufficient profit. While this is good for sustainability, it is not known if the scheme incentivizes overuse of medical care.

Conclusion

Hence, a policy that treats rare but critical ailments and does not save the patient any money, has made healthcare an electoral issue. That it does not directly cost the customer a penny possibly helps. Also, that the originator was a popular Chief Minister and not just an MLA kept competing political interests on bay



THE ROLE OF GOVERNMENT in PPPs

We have, in an earlier section, analysed politics and its motives. A political commitment from the highest authorities is crucial not only in playing the role of the project champion who convinces the public that PPPs can bring promised benefits, but also in assuring private actors that political commitment in the long-run will be consistent and that political risks are minimal.

The long-run nature of PPP contracts means that the contracts will be in force in most cases over a number of elections (generally the concession period ranges from 15-30 years i.e., minimum of 3-6 tenures for the government). This requires political support and commitment to stretch over party lines so that the private partners know that political support will be continued independent of who comes to power in the next election.

Weak political support has the following important consequences:

1. Government would not make the changes to legislation necessary for creating a strong PPP frame work.
2. The private sector would be reluctant to participate in PPP projects.
3. Even if a PPP is underway, shifting policies that try amend the PPP contract or harm PPP performance would require the government to compensate the private partner for the costs that these changes create, thereby negating the value for money proposition of the PPP.

Building on prior success is important for winning public approval and thus mitigating political risk. Conversely, PPP projects that go awry make it difficult for future proposals. Because of the importance of the services that many PPP projects deliver, PPP proposals often face opposition for a variety of reasons.

One of the most vociferous criticisms of PPPs arise from confusion between PPPs and privatisation, overlooking the fact that PPPs involve a strong role for government and governance – in setting objectives for the PPP. However, at times criticism may be justified, particularly if a PPP under consideration is simply an inappropriate alternative to full public provision through traditional procurement. The criticism may also be rooted in the perception/belief that a profit-motivated private sector cannot provide public goods (like healthcare) equitably without raising prices or sacrificing service quality. Such issues are the core challenge that can make or break PPPs.

The risk of corruption in PPPs is also an equally serious issue that affects the execution and/or sustenance of a PPP. Since competition largely disappears once a PPP contract has been concluded, competition in the bidding process is the only opportunity to ensure the selection of a qualified contractor. Corruption, particularly at this phase, would seriously undermine the integrity and capability of the PPP to deliver benefits.



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Of all the corrupt practices, lack of accountability represents the biggest risk, either because malpractice is not detected or faces no consequences when detected. In addition, in a changing environment, even the best regulations to ensure transparency may become rapidly obsolete and inadequate, making it easy for the less scrupulous to circumvent them. Areas of concern in public procurement that relate to the presence of both corrupt and unethical behaviour are the following:

- **Information asymmetry** – The integrity of a fair and competitive bidding process can be undermined by the discretionary power of a public purchasing agent or a private bidder who possess information not available to the government. Or, a purchasing agent may consult with a private firm for technical advice even when the firm is bidding for the contract. Thus, while the ultimate technical tender requirements and procedures are legal, they seem to fit precisely the specifications of a single firm.
- Hence technical bids, meant to separate the competent from the pedestrian, become tools for fixing the contract; usually technical qualification is a prerequisite for the financial bid; if only one firm in the know, qualifies, he can fix the contract price, and all the bidding has achieved is wasting time in order to appear fair. Even e-tendering cannot solve the leakage of technical specifications.
- Even when technical bids are filled by multiple bidders in a more or less fair process, huge complications can happen at evaluation of bids
- **Contacts, informal networks and collusion** – While informal contacts and networks can help facilitate transactions for building trust between parties, they could also be abused to influence the bidding process. Bidders could collude to raise prices and restrict output.
- **Conflict of interest on the part of public officials** – Public officials who sit at the nexus of public-private interaction may be susceptible to conflicts of interests. These conflicts might arise from personal financial interests, family ties, or post-employment considerations.
- **Political financing** – Politicians not directly involved in the bidding process may use their influence to sway bidding outcomes favourable to their political interests. Though such activities fall in “grey-zone” with respect to their legitimacy, such activities may raise ethical questions.
- **Budget anomalies** – Individual Government Departments have to return their unspent funds back to the Finance Department. Unspent funds mean lower allocation to the respective department in the next budget. Hence, Government Departments have an incentive to inflate bid base prices, collude with specific private partners and share the gain.

Case Study: Delhi Airport Privatization

The mother of all bidding projects, for the privatization of Mumbai and Delhi airports finally took place in 2005, nine years after the privatization had been first proposed by the Airport Authority of India.

The evaluation committee announced that two consortia had cleared the technical evaluation and scored more than 80% marks and declared one of them stronger than the other.

The Evaluation Committee report was objected to by a Planning Commission member. He alleged bias in the eligibility criteria and in the evaluation of the same. Also, allegations of conflict of interest of the financial consultants were raised. The financial partner had named both the qualifiers in the bid amongst its own top five borrowers

The Attorney General opined that there was no conflict of interest.. An Empowered Group of Ministers (EGOM) was constituted to resolve the matter. A cabinet note prepared for

the EGOM stated:

“A majority of the evaluation criteria, as stipulated in the RFP documents, are necessarily subjective in nature and therefore it would have been difficult to allocate a purely objective marking across all bidders....” The note also expressed concern about the way the marks were allotted and weightage given to different parameters. The system of awarding marks by 'consensus opinion' rather than by working out averages of marks given by individual evaluators was also questioned.

The weightage of the sub-factors in the RFQ had not been pre-specified making the evaluation process subjective, nor had minimum passing criteria been declared for each parameter.(Rekha Jain ,2007)



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THE ROLE OF TRANSACTION AND LEGAL ADVISORS

There has been a demand from some of the State Governments and its agencies in different forums, for assistance in short-listing Transaction Advisers. In response to this demand, the Government of India has established a panel of pre-qualified Transaction Advisers for assisting the PPP Sponsoring Authority for implementing the PPP. This panel of transaction advisors is required to have the following characteristics:

- Panel members have adequate skills and experience to provide both commercial/financial and legal services in support of PPP transactions (depending on the sector in which PPP is being sought).
- Where specialist technical advice related to the sector concerned is required, this should be separately procured.
- Moreover, the panel applicants have already been assessed by the Department of Economic Affairs as capable of providing transaction management services. Subsequent appointment by the Central, State and Municipal Government Agencies should be on the basis of a financial proposal, against a defined scope of work.
- This panel of advisors is a common pool available to all central, State and Municipal Governments, who are undertaking or intending to undertake PPP transactions.
- However, it is advisable to procure financial, legal and technical expertise separately in the case of large projects where the project cost is very high.

Basic Requirements of a Transaction Advisors

- ✓ Interaction with the market, conducting formal market assessments, to confirm decisions on scope, timing and packaging of the transaction
- ✓ Preparation of bid documents including but not limited to the Request for Proposals and the Contract for Services (Concession Agreement)
- ✓ Preparation of supporting information to assist bidders in preparation of their bid, and where relevant creation of a database and management of access to the database



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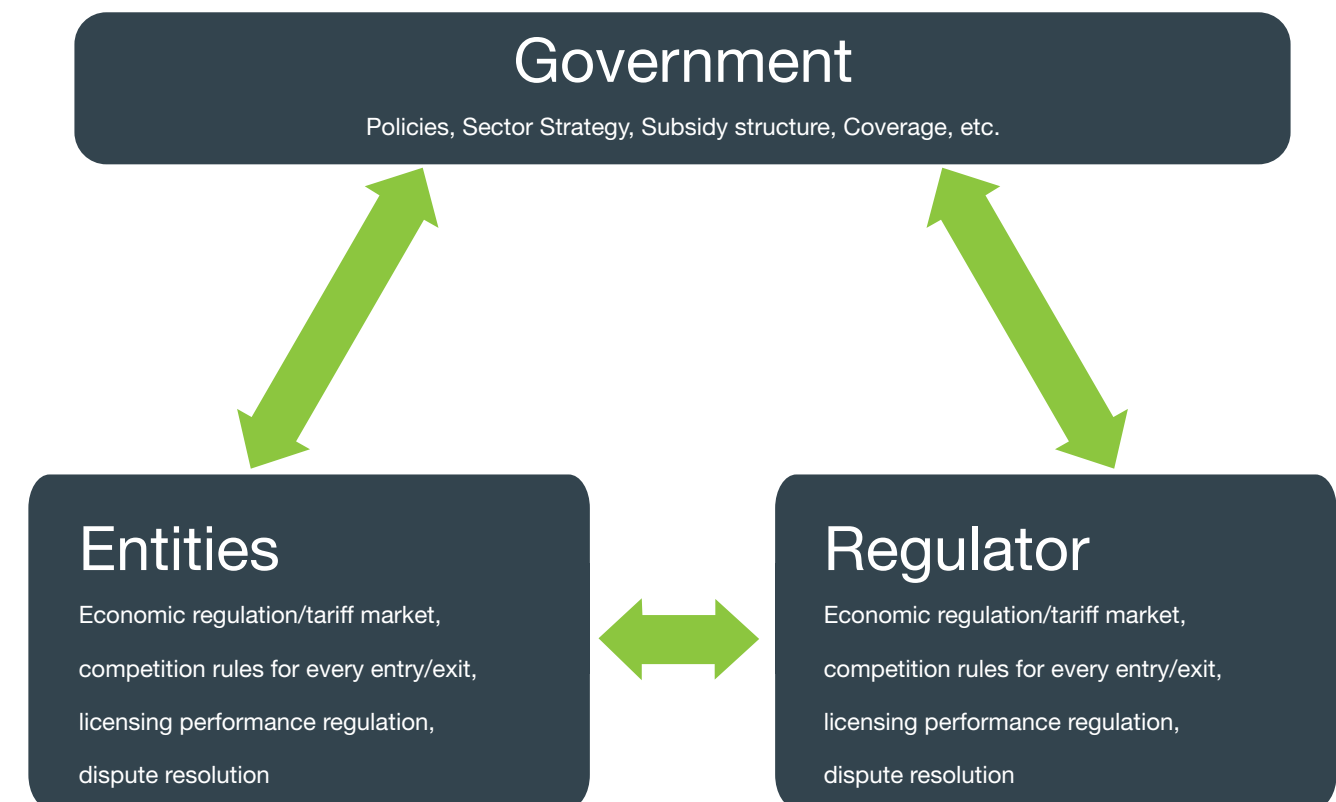


Fig.1. Government-Regulator-Private Integration

Source: PPP Cell, Deptt. Of Economic Affairs, Ministry of Finance, GoI, 2010, Criticality of Legal Issues & Contracts for Public Private Partnerships. Perspective. Finnish Road Enterprise, Helsinki, 2002.

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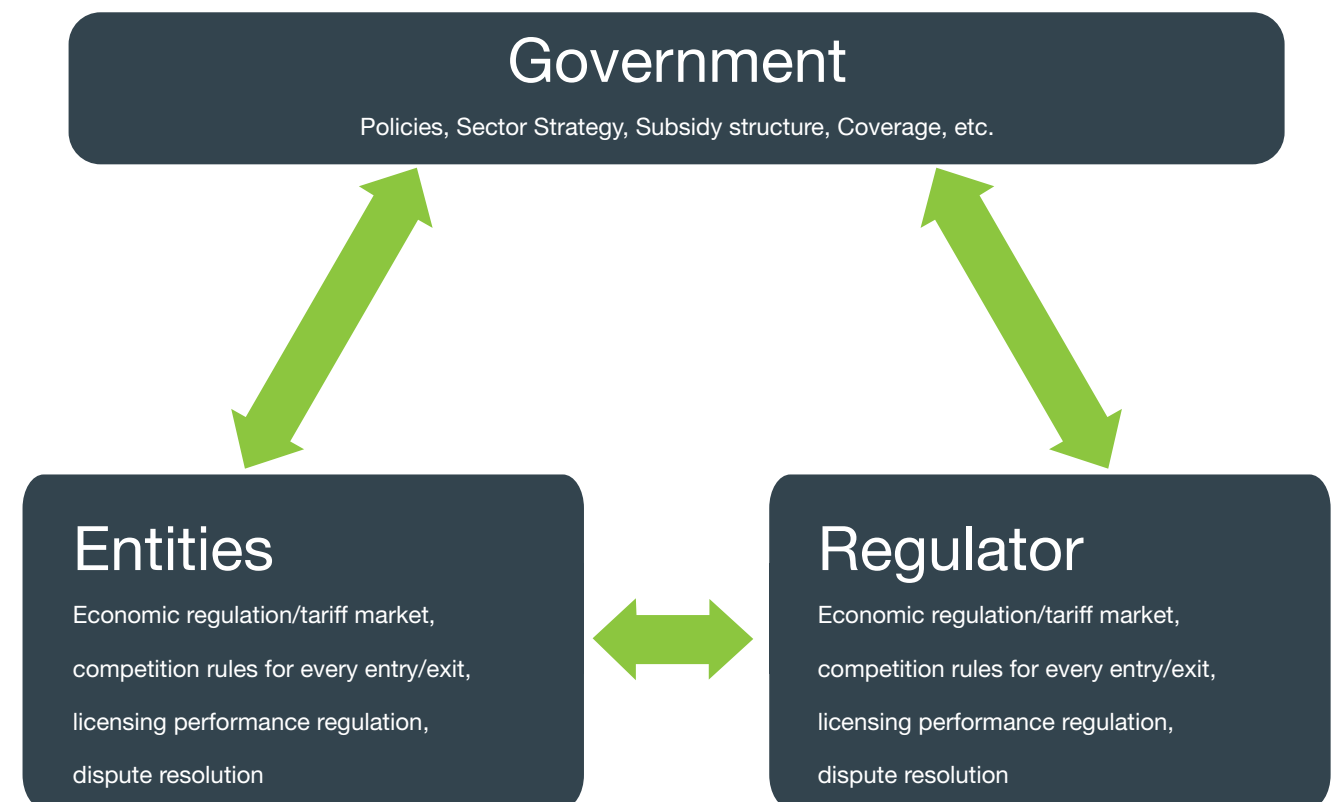


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Choice of Private Partner

One of the largest components of the private sector is non-qualified rural medical practitioners in the informal sector in India. A conservative estimate puts the number of these practitioners at 1.25 million. It is as inadvisable to partner with it as to ignore it.

Not-for-profit organizations have special concern for reaching the poor and the disadvantaged but, in many states, they account for less than one percent of all health facilities (World Bank 2004). Their sustenance depends on philanthropic donations or external funding. As a result, their interventions remain ad hoc, and their scalability remains doubtful. However, they provide good quality care, need little regulation or oversight from government, are able to attract dedicated staff, and cater to the needs of those otherwise excluded from mainstream healthcare. Moreover, they are also willing to undertake healthcare challenges that the for-profit sector is unwilling or unable to take on. Given their non-profit motives and grass-root level presence, NGOs can play useful oversight roles in the system. Their size and flexibility allows them to achieve notable successes where governments have failed.

Opinion is divided on the motives of the (for-profit) private sector, ranging from outright distrust to strong support for close co-operation with it. One extreme view is that the private sector is primarily motivated by money and has no concern for equity or access. Bennet et al. (1994) identified five main problems associated with private-for-profit provision of health services.

They are related to the use of illegitimate or unethical means to maximise profit, less concern towards public health goals, lack of interest in sharing clinical information, creating brain drain among public sector health staff, and lack of regulatory control over their practices. Rosenthal (2000) cites similar concerns towards involving the private sector in delivering public health services. However, Bloom, Craig and Mitchell (2000) suggest that the private sector is neither so easy to characterize nor easy to neglect. Its strength is its innovativeness, efficiency and learning from competition.

Management standards are generally higher in the private (for-profit) sector. The private sector can play an important role in transferring management skills and best practices to the public sector. In India, the formal for-profit sector has the most diverse group of facilities and practitioners. Since it accounts for the largest proportion of services and resources in the health sector, it is argued that future strategies to improve public health should take into account the strengths of the private sector (World Bank 2004).

However, it is to be accounted for that the private for-profit sector has its own strategic vision and defined priorities.

Only a few PPPs shall fit into that vision. Also, the depth of the for-profit sector providing cost effective quality care is finite, there are, as we described a while ago, aspects of market failure there too.

Nonetheless, it is the only sector that is providing state-of-the-art 21st century care. It has to be listened to, given its space and partnered with, as long as there is no direct clash of vision and interest.



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The pros and cons of partnering with each subgroup in the private sector are identified in Table below.

Table 1. Pros and Cons of collaborating with the private sector in Health

Subsector	Pros	Cons
Informal	Accessible Client-oriented	Poor quality care Difficult to mainstream Low cost Poorly educated
Not-for-profit	High quality Targeted to the poor	Small coverage Lack of resources Low cost Involves the community Cannot be scaled up Ad-hoc interventions
For profit	High quality (in select disciplines)	Ad-hoc interventions High cost Huge outreach Variable quality Innovative Clustered in cities Efficient

Adapted from World Bank 2004



POST CONTRACT BLUES

For those on the work-ground, the PPP is a sea of change. There are basic cultural differences and work practices built over careers, in ecosystems poles apart, a potential for a clash is imminent every minute. How is common ground to be sought?

The only way is adaptation; we have to treat adaptation as the priority; as the main efficiency purpose of the new organization. The organization is to consciously and purposefully adapt to a new hierarchy and the hierarchy should keep space for perpetual spontaneous adaptation to the external market; both the purposeful and spontaneous adaptations are equally important.

(Williamson, 2009)

The organization has to ensure that there is a single, unified administrative command and control and at the very top, one common head, chosen, if possible, by consensus.

Also, it is important to remember that contracts are only frameworks, they cannot be complete and perfect; no contract in the world can account for every eventuality, especially in a complex arena like healthcare.

The major importance of a legal contract is to provide a framework which almost never accurately indicates working relations, but affords a rough relation around which such relations vary. It is an occasional guide in cases of doubt, and a norm of ultimate appeal when relations cease infact to work. (Karl Llewellyn, 1931) The more elastic concept of contract as framework that assists, not bound rules that constrict. It supports a cooperative exchange over a broader range than a strict legal rules construction.

However, the main clarity required in the contract is Performance Indicators which can be objectively measured. This is the key to generate efficiency in a PPP.

Infact by the Holmstrom-Milgrom model of incentives, PPP should be entered into only for functions for which measurement of performance is objective and simple.

Rewards linked to measurable efficiency gains incentivize ideal behavior, and if performance is not measurable, there is as much incentive for the partner to cut costs and compromise on quality. (Hart, 2002)

Renegotiation on various other aspects is allowable, and inevitable; some degree of flexibility is ideal for long term contracts.



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THE ROAD AHEAD

PPP Expert Insights

We spoke to two renowned PPP experts on their immediate concerns about Healthcare PPPs.

The interviews yielded interesting insights into the actual current situation and concerns.

Excerpts:

Dr. A Venkat Raman
PPP Expert & Associate Professor,
Faculty of Management Studies,
University of Delhi.

Dr. JN Srivastava
PPP Expert & Senior Consultant,
NHSRC, New Delhi.

The basic dichotomy of the NGOs and for profit private sector is that of the visions of taking healthcare to the masses.

While private sector wants to recover its costs and make certain amount of profit for its growth, majority of NGOs and charitable organizations want to provide healthcare services to the neglected sections of the society and at a more programme implementation and management level, as it aligns with their organizational vision and mission.

Private sector's vision, on the other hand, is naturally aligned to that of providing secondary/tertiary care and curative services. As far as finances of the operation of these agencies are considered, NGOs are heavily dependent on donations, funding by philanthropic organizations and/or subsidies from government.

Apart from that private sector generates its own funds and deploys it in ventures that are aligned to its vision and mission. This has led to a situation where private sector is unwilling to go to sub-district level due to lack of basic infrastructure (roads, transportation, electricity, availability of clean water, etc.), and the NGOs do not have enough funds to fully take over the complete healthcare delivery.

These reasons have led to a distinct dichotomy in the way healthcare is provided to the population by non-governmental players – for-profit sector focusing on towns/cities and the not-for-profit sector aiming at basic healthcare services primarily due to resources constraints. This dichotomy has to be resolved by the government by ensuring that basic infrastructure is in place, and improving its governance by making agreement as transparent as possible to ensure fostering of mutual trust and respect for both the parties in a Public Private Partnership.



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NEW POSSIBILITIES PUBLIC-PRIVATE PARTNERSHIP

Suggestions for areas of partnership and for effective governance are as follows:

- There are nearly 100 backward districts – where socio-economic and infrastructure development is required. Industrial Houses could partner with district administration in adopting one district each. Excepting mine-townships, very few PHCs have been taken up by private sector. Incentives should be provided to the industrial houses partnering in such development initiatives (concessional water, electricity, import and export of products/raw materials).
 - Pharmaceutical Industry should manufacture cheaper drugs for the masses, donate drugs for HIV-AIDS, viral Hepatitis, Malaria, TB and other chronic diseases. Firms like LoCost should be encouraged.
 - India has largest number of teachers of primary, middle, high school and college teachers from village to state level. These teachers should be given responsibilities, territorial jurisdictions and the groups to educate, and monitor the implementation of the programmes.
 - Non-formal leaders in rural and urban areas could be trained – carpenters, barbers, blacksmiths, preachers of all religions, shop keepers, and women leaders could be trained for health education programmes. Successful initiatives have been made in Punjab and Himachal Pradesh. Give details here too.
 - Medical Colleges, Nursing and Para-Medical schools, public health training institutions could be extensively involved in organizing camps, early diagnosis, referral, and health education and awareness programmes.
 - Large number of training institutions, chapters of Indian Medical Association, Nursing Associations, and management schools could be involved in training programmes. The Indian Society of Health Administrators (ISHA) has trained over three lakhs personnel in various fields, particularly representatives of voluntary organizations, medical colleges, nurses, doctors working in the Central Government Health Scheme, and senior executives working in the Central Government Public Sector Enterprises.
- PPPs in preventive healthcare are minimum; corporates should sponsor preventive healthcare campaigns promoting ideas like breast feeding and other health promotion activities.



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THE WAY FORWARD

The centre should focus more on creating an enabling environment and capacity of various stakeholders to foster and develop the public-private partnerships relationships. Lot of work is required to address various systemic issues such as development of accountable and performance oriented system, ensuring financial autonomy and decentralization, delegation of authority, building trust and accountability in the system, effective integration, managing discontinuities and fostering true sense of partnership between the state and non-state sector.

The centre should play catalytic role focusing on creating knowledge base in these areas, and help the states to design and develop appropriate policies. There is lack of proper classification in PPPs especially with regard to those Below Poverty Line (BPL) and Above Poverty Line (APL). Cross subsidizing would prevent BPL patients from being excluded from receiving health care.

Source: Public-Private Partnerships: Managing contracting arrangements to strengthen the Reproductive and Child Health Programme in India, A WHO-IIMA report, 2007

HOW TO GO THE PPP WAY...

- PPPs are possible when both the sectors genuinely commit themselves to a common goal.
- The soft and permissive attitude towards private sector in tertiary care ensures that integrated Primary Health Care is overlooked, as for it to improve it requires inputs from other governmental agencies and ministries/departments and not just health and family welfare ministry/department.
- Institutions should either have differential fee structures through in-built cross subsidies or provide free care to the poor.
- State demand that mutual give and take strategy, pooling of information, standardization of therapeutic strategies, and cost of treatment for common diseases, especially those covered under the national program, would have to be compulsory.
- The recommendations are that proper regulatory mechanisms and monitoring for both private and public sector institutions and self-regulation within private sector are necessary. The positive experience of some of the PPPs in different states can be taken as examples for replication.



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RECOMMENDATIONS

- It emerged from the deliberations that PPPs could improve accessibility, quality of health services and result in relaxation of bureaucratic procedures and red tape. PPPs are seen as 'win-win' arrangements in which diverse actors with varied motivations and philosophies work together, albeit with different motivations, and are able to contribute to health of the people and development of the country.
- The role of the GOI should be proactive and it should identify areas in National Health Programmes, diagnostic and curative services where partnership is possible by suggesting area specific models. The basic premise should be patient-centric approach with people at the grass root level taking part in the decision making as partners. This dramatically improves the success rate of the PPP.
- GOI should develop working guidelines based on successful experiences of different states. MOUs/ contract agreements, control mechanisms, monitoring and evaluation, feedback system etc. should be designed to oversee the implementation of PPPs with regulation mechanisms in place.
- GOI should come up with specific guidelines for viability gap funding to serve medical colleges.

Within the current MCI guidelines, private medical colleges find sustainability difficulty in PPPs unless they indulge in malpractice, or compromise on the student quality. Medical education has a bearing for the future, and the Sikkim-Manipal model of a fixed viability gap per bed can be piloted and institutionalized.

- Tamil Nadu Medical Service Corporation is a public sector corporation with an excellent procurement and supply chain for drugs. Such a corporation can lend its services even to the private sector for drug procurement and supply. Pharmacy purchases have leakages frequently even in private hospitals and an assured, transparent supply chain can be beneficial to both sectors.
- Monitoring and evaluation should be strengthened by means of PPP cells as the nodal agency. Random quality checks by state level officials: qualitative and quantitative benchmarks for performance should be developed. Self-monitoring and peer-review networks of professionals can also be one of the innovative monitoring and evaluation strategies. Management Information System (MIS) should become the mandatory management tool for assessing the trends and making assessments about the efficacy of the PPP system.
- The Unspent Budget of the Ministry of Health should not be returned at the end of the year but kept in a special account to facilitate large scale capital investments in healthcare.

- The elements of profit-making of the private partners should be kept taken into account. Government should involve at least one 'for-profit' and one 'not-for-profit' actor. Due diligence study (SWOT analysis) should be done before embarking on any PPP initiatives.
- Guidelines for implementing any PPP arrangements by hospital societies like RKS may be developed.
- Quality guidelines should be framed with assistance from professional organizations, which already have experience in preparing quality assurance tools. These guidelines can form the basis of accreditation as well as of benchmarks and performance-based indicators. There should be proper guidelines for selection of NGOs based on recommendations from donors, credibility based on documentary evidence and certification by opinion leaders of the area, field appraisal procedures.
- In the case of a PPP being unable to break even, there should be an exit policy for the private sector.
- PPP cells at central and state level should be made functional at the earliest to undertake to site visits (in other states) where successful PPP models are under implementation.
- Mapping of dysfunctional Primary Health Centers/Community Health Centers and private sector health facilities would provide an updated account for partnership feasibility. Tracking the number of health practitioners available in the state would help in assessing specialties and availability for their involvement in the initiatives.
- Cost and economic considerations are imperative in undertaking partnership schemes for which the government may work out the operational cost per unit service. Allocation of funds in the state health budget for innovative schemes would ensure a dedicated fund for the PPPs. User-fee should be utilized locally. Price may be fixed on the basis of operating cost.
- Efforts involving national leaders, well acclaimed professionals in the field and other luminaries would provide consensus and an environment to generate demand for PPPs. Politicians, policy makers, administrators at state and district level may be sensitized about mechanisms and benefits of PPPs. Campaign approach is required, especially in bigger states like UP to reach the masses. Education should be given through entertainment and use of folk media for reaching out to people in the Four Cs of partnership are required, namely: Communication, Consultation, Coordination and Collaboration.



About CII

The Confederation of Indian Industry (CII) works to create and sustain an environment conducive to the growth of industry in India, partnering industry and government alike through advisory and consultative processes.

CII is a non-government, not-for-profit, industry led and industry managed organisation, playing a proactive role in India's development process. Founded over 115 years ago, it is India's premier business association, with a direct membership of over 8100 organisations from the private as well as public sectors, including SME's and MNC's, and an indirect membership of over 90,000 companies from around 400 national and regional sectoral associations.

CII catalyses change by working closely with the government on policy issues, and enhancing efficiency, competitiveness and expanding business opportunities for industry through a range of specialised services and global linkages. It also provides a platform for sectoral consensus building and networking. Major emphasis is laid on projecting a positive image of business, assisting industry to identify and execute corporate citizenship programmes. Partnerships with over 120 NGO's across the country carry forward our initiatives in integrated and inclusive development, which include health, education, livelihood, diversity management, skill development and environment, to name a few.

CII has taken up the agenda of 'Business for Livelihood' for the year 2010-11. Businesses are part of civil society and creating livelihoods is the best act of corporate social responsibility. Looking ahead, the focus for 2010-11 would be on the four key Enablers for Sustainable Enterprises: Education, Employability, Innovation and Entrepreneurship.

While Education and Employability help create a qualified and skilled workforce, Innovation and Entrepreneurship would drive growth and employment generation.

With 64 offices and 7 Centres of Excellence in India, and 7 overseas in Australia, China, France, Singapore, South Africa, UK, and USA, and institutional partnerships with 223 counterpart organisations in 90 countries, CII serves as a reference point for Indian industry and the international business community.



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About HOSMAC

HOSMAC India Private Limited has carved a niche for itself in the field of Hospital and Healthcare Planning & Management Consultancy. Soon after its inception in 1996, HOSMAC evolved into an unmatched centre of skill sets that attend to the various facets of a healthcare facility, ranging from architecture and engineering to hospital management, Public Health Consultancy (PHC), healthcare training and information technology (IT).

The healthcare industry, unlike others, is extremely complex in terms of its wide spectrum of specialties, technologies and skilled manpower. Only a smooth interplay of these factors would lead to an eminent healthcare organization. Against this backdrop, HOSMAC provides an invaluable range of Total Solutions to suit the elaborate requirements of its clients. Giving precedence to quality service and an ISO 9001:2008 certification, it has strived to exceed client expectation. Being one of the most comprehensive healthcare consultancies in the world, HOSMAC understands the vision and sentiment behind building a healthcare facility. It has designed and coordinated hospital projects worth more than eight billion INR, spanning over six million square feet of hospital space.

HOSMAC has provided full-fledged technical assistance to hospitals in India and abroad. Its portfolio already encases 350+ diverse projects dealing with the hospital and healthcare industry. With the head office in Mumbai, three regional offices in Gurgaon, Kolkata, Bangalore, and an international office in Dubai, UAE, the organization can efficiently engineer projects in any part of the world.

With the foremost objective of Perfecting Healthcare, the HOSMAC team is constantly streamlining their efforts to turn their vision into reality. These professionals are the mainstay of the organization, enduring to further strengthen HOSMAC's confidence in being able to cater to the multifarious needs of the healthcare industry.

As a CSR venture of HOSMAC India, HOSMAC Foundation was registered in 2005. The Foundation, a non-profit organization, was built with a vision; to build a networked and sustainable healthcare community by providing innovative solutions to address critical issues in the domain of healthcare. It emphasizes on improving the healthcare delivery system by making pertinent contributions in the domain of capacity building.



Contact Us at CII

Mr. Prakash R Boga

Confederation of Indian Industry (CII)

105 Kakad Chambers, 1st Floor

132 Dr A B Road, Worli

Mumbai 400 018, India

Tel: +91 22 66611692(D) / 24931790 Extn 438

Fax: +91 22 24939463 / 24945831

Email: prakash.boga@cii.in

Website: www.cii.in

Contact Us at Hosmac

Head Office

120, Udyog Bhavan,

Sonawala Road,

Goregaon East,

Mumbai – 400 063

Tel: +91 22 6723 7000

Fax: +91 22 2686 3465

Website: www.hosmac.com

Dr. Vivek Desai

Managing Director

Hosmac India Pvt Ltd

Tel: +91 22 67237004

Email: vivek.desai@hosmac.com



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