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The private sector's role in achieving Universal Health Coverage in India

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With 93% of all health facilities in India belonging to the private sector, it would be a missed opportunity not to have it on board

Summary

- India's current public healthcare spending and infrastructure is currently well short of what is required to fulfil its ambition of achieving universal health care. Given that the majority of all healthcare in India is provided by the private sector, it will have to play a major role.
- The Indian government has been attempting to achieve universal healthcare since independence in 1947, although the private sector did not begin to grow rapidly until the National Health Policy of 2002. From 2004, the government began to provide incentives to the private sector to cater for the poor, and since then PPPs have been viewed as a sustainable way of providing healthcare.
- Although there are several examples of PPPs successfully providing care to Below Poverty Line patients, there are also many examples of failure. The literature suggests that many failures stem from insufficient autonomy granted to the private partner.
- PPPs have the potential to help India achieve its healthcare ambitions, although the government should refrain from using its power to dominate the partnership, and will have to allow private partners greater scope both to plan and manage.

Introduction

India has experienced an impressive growth trajectory since 1991, witnessing a GDP growth rate of around 7 per cent consistently over the last decade, even during the recession years. This growth has been largely fuelled by the increasing outward orientation of the Indian economy. The healthcare industry in India has emerged as a major driver of this growth, growing at more than 13 per cent per annum over the last decade. The outward orientation has played a major role in the sector as well, with India's share in the global medical tourism industry reaching around 3 per cent by the end of 2013 (HCI, 2011). The health industry accounted for 6.1 percent of GDP in 2012, providing employment to around 9 million people.

This impressive health sector story masks a rather more unpalatable reality: for the majority of the Indian poor, healthcare is either entirely inaccessible or of a very low quality. The government has recognised the failings of the healthcare sector, and is currently considering a

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major package of reforms to achieve 'Universal Health Care'.

The respective roles of the public and private sectors in achieving Universal Health Care is a matter of major contention amongst policymakers, with a large body of opinion supporting a far more activist role for government, particularly in the creation of new health infrastructure. But given that 93 per cent of all health facilities in India belong to the private sector, it would be a major missed opportunity not to have the private sector on board.

The government has to an extent recognised this reality, and has for the last decade been undertaking a number of Public Private Partnerships (PPPs) in order to scale-up health infrastructure. How successful have they been, and what promise do they hold for helping to achieve Universal Health Coverage?

This paper gives a brief overview of the history of Indian PPPs, a critical analysis of the government's handling of the partnerships, and suggests some areas for reform.

How 'developed' is India's Healthcare Infrastructure?

Despite rhetoric to the contrary, the Indian government has historically not been able to allocate adequate financial resources to the goal of providing universal health coverage. Public health expenditure in India is low compared to other emerging markets such as Malaysia, Thailand, Brazil and Mexico, all of which have increased health spending rapidly in recent years. India has a very low per capita spend on healthcare compared to peer countries, which has resulted in a very poor international performance on health infrastructure measurements such as numbers of hospital beds per 1,000 people. As a result of these weaknesses in health infrastructure and spending, the vast majority of Indian patients are forced to pay out of pocket for healthcare (Figures 1 to 4).

Public Private Partnerships and healthcare for the poor – a brief history

Since independence in 1947, universal healthcare has been considered a major responsibility of the government.

In 1983 the Indian government launched the National Health Policy which aspired to provide comprehensive public healthcare to poor people with the promise of 'Health for All by the year 2000'. Though the policy led to an expansion of the hospital and medical personnel network (both traditional and non-traditional medicine) to some extent, and was somewhat successful in controlling tropical diseases, there was substantial scope for further improvement. Since the document was conceptualized in the pre-liberalization period, pro-market reforms and medical

Figure 1: Comparison of public expenditure on health, as % of GDP.

Country	1995	2000	2005	2010
India	1.22	1.27	0.93	1.18
Philippines	1.36	1.63	1.43	1.28
Indonesia	0.64	0.72	1.00	1.28
Malaysia	1.43	1.67	1.85	2.44
China	1.79	1.77	1.83	2.72
Thailand	1.66	1.91	2.29	2.91
Mexico	2.17	2.36	2.64	3.09
Brazil	2.86	2.89	3.28	4.24
World	5.48	5.34	5.70	6.52
Japan	5.71	6.25	6.56	7.83
European Union	6.76	6.58	7.01	8.06
United States	6.09	5.79	6.70	9.49

Source: World Development Indicators

Figure 2: Comparison of Health Expenditure Per capita (Current US $)

Country	1995	2000	2005	2010
India	1.22	1.27	0.93	1.18
Philippines	1.36	1.63	1.43	1.28
Indonesia	0.64	0.72	1.00	1.28
Malaysia	1.43	1.67	1.85	2.44
China	1.79	1.77	1.83	2.72
Thailand	1.66	1.91	2.29	2.91
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Source: World Development Indicators

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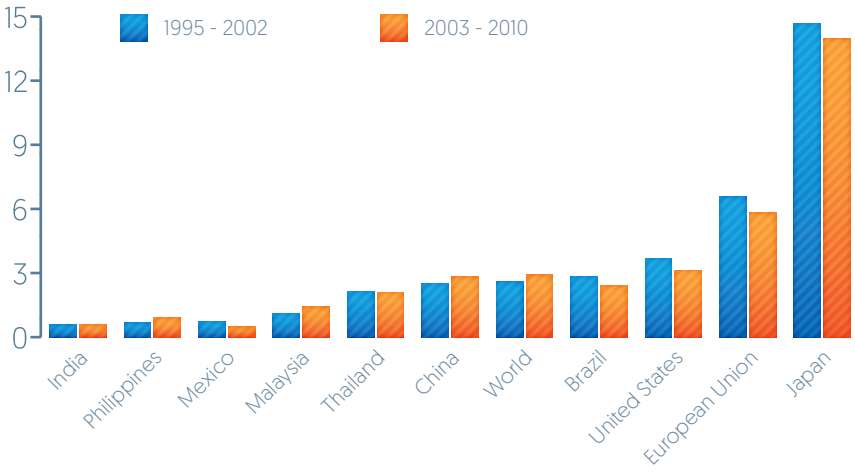
service export were not included within its purview.

Fiscal mismanagement and resulting budget constraints during the late 1980s forced the government to rethink its healthcare policy. During the Sixth Plan period (1980-85) a greater role for the private sector in securing a deeper reach of healthcare to citizens was proposed for the first time. In line with the changed focus of the government, in 1986 the hospital sector was recognized as an industry, thereby enabling hospitals to raise capital from public financial institutions. Moreover, customs duties on high-technology medical equipment were reduced, which consequently improved the quality of healthcare in Indian medical providers (Thomas and Krishnan, 2010).

After the start of the structural adjustment programme in India from 1991 onwards, economic philosophy underwent another round of transformation. Health sector reform received a strong push in 1992 when the concept of free medical care was revoked, while the commitment for free or subsidized care for the Below Poverty Line (BPL) population was retained. Moreover, user charges were also introduced in the hospitals. However, while the government paved the way for private sector involvement, the number of private players taking up the challenge grew quite slowly. As a result, the expansion of private health network fell short of government expectations.

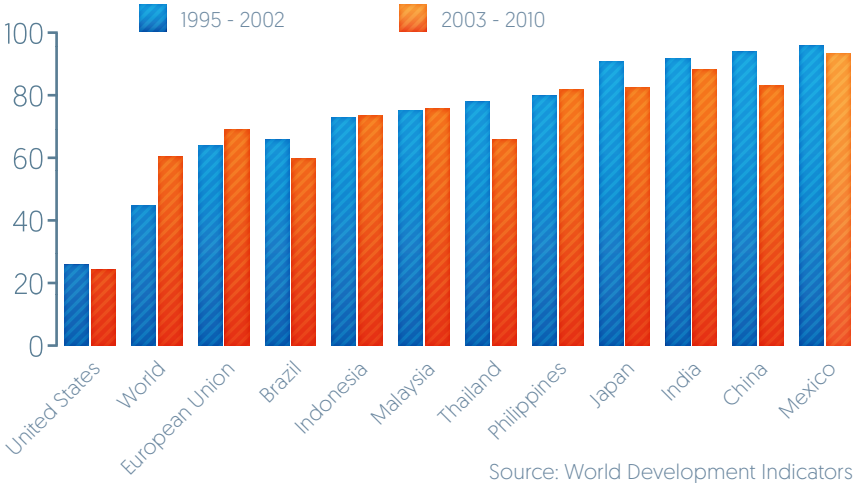
The stagnating healthcare framework forced the government to move towards yet another policy shift when the National Health Policy (2002) was introduced to bring Indian health network in line with Millennium Development Goals (MDGs) agenda. In particular the document was pragmatic in terms of encouraging the outward orientation of the healthcare sector, as it strongly encouraged export of health services by servicing overseas patients, in order to capitalize on comparative cost advantages. It also promised that "providers of such services to patients from overseas will be encouraged by

Figure 3: Comparison of Hospital beds (per 1,000 people)



Source: World Development Indicators

Figure 4: Comparison of Out-of-pocket health expenditure (% of private expenditure on health)



Source: World Development Indicators

extending to their earnings in foreign exchange, all fiscal incentives, including the status of 'deemed exports', which are available to other exporters of goods and services." Furthermore, in line with the liberalization drive, the participation of the civil society, namely that of the NGOs as well as domestic private sector, was strongly advocated by various sections of the document. Consequently, several options were highly recommended by the document, including privatization of existing public hospitals, creation of new private initiatives and subcontracting of public health centres to NGOs etc.

These private initiatives led to the creation of new outpatient and inpatient facilities. Such entities promoted by single owners or partners (generally doctors) with between 5 to more than 100 beds emerged both in towns and cities as well as in peri-urban and rural areas (Baru, undated). The reforms helped a number of private big hospitals like Wockhardt Group and Apollo to gain prominence, which catered to the needs of foreign patients as well. India's healthcare services exports increased given its ability to provide quality healthcare solutions in advanced fields at competitive price, due to presence of skilled healthcare professionals. Foreign patients came mostly from South and West Asia and

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Africa, while non-resident Indians (NRIs) from various parts of the world also came back home for treatment. Foreign Direct Investment (FDI) inflow from abroad contributed significantly in fueling this outward orientation, as observed from select examples noted in Table 1.

Nevertheless, the government had to maintain a fine balance between the commitment to reform and social commitments. When the NDA government was defeated in 2004 general election, and the same was considered to be a mandate against hasty reforms, the succeeding UPA government was quick to follow the path of social commitments. The subsequent decisions taken through National Common Minimum Programme (NCMP) to increase public spending on health to at least 2-3 per cent of GDP over the next five years, and stepping up public investment in programmes to control all communicable diseases etc. need to be viewed in this light.

In 2004, the Planning Commission agreed that private players should be provided with land and other incentives in return for free or concessional treatment of the poor and in 2005 the National Rural Health Mission (NRHM) was introduced, which was given the responsibility of bridging the healthcare gaps and ensuring decentralized healthcare. The idea was to ensure affordable healthcare in rural areas, which had historically been understaffed. NRHM (2005-12) was introduced in 18 Indian states for ensuring a network of one ASHA (Accredited Social Health Activist) per 1000 people. The NRHM goals included reduction in Infant Mortality Rate (IMR) and Maternal Mortality Ratio (MMR), universal access to public health services (e.g. women and child health, immunization, nutrition), prevention and control of communicable and non-communicable diseases etc. NRHM focuses on strengthening of existing Primary Health Centres (PHC) and upgrading of 3222 existing Community Health Centers (30-50 beds) to 24-Hour First Referral Units (NRHM Mission Document).

Table 1: Select Approved FDI Hospitals by DIPP

Sl. No.	Date	Indian Company	Country of foreign investor	Foreign equity (millions)	
				Rs.	US $
1	Dec 2002	Sir Edward Dunlop Hospitals, New Delhi	Canada	1,282.25	26.71
2	Jan 2004	Max Healthcare, New Delhi	Mauritius	316.21	6.63
3	Jan 2000	Dr. Ramayya's Pramila Hospitals Ltd., Hyderabad	UK-NRI	15.00	0.35
4	Oct 2001	Malabar Institute of Medical Sciences Hospital Ltd., Calicut	UAE	133.61	2.97
5	Aug 2004	Add Life Medical Institute Ltd., Sterling Hospital Building, Ahmedabad	USA	326.24	7.07

Source: Quoted from Chanda (undated)

Since then, PPPs have been viewed as a sustainable model for providing healthcare to the poor, and government partnerships with leading private players like Apollo deserves mention. On several occasions foreign players have partnered with Indian government and domestic private players for delivering healthcare services.

Public-Private Partnership in India: How Effective?

PPP partners are generally selected through a process of competitive bidding and competitive negotiation. PPPs in India can be categorized under several heads, namely: increasing access (mobile health units), affordability (community health insurance), efficiency (functional autonomy to hospitals), financing (joint ventures), outreach (partnering with grassroots organization), risk transfer (contracting) etc. (Rajsulochana and Dash, 2009).

The PPPs have spanned over hospital maintenance outsourcing, maintenance and operation of data centres at state and district levels, diagnostic services (radiology and pathology), physician consultation as well as surgical operations etc. Under the PPPs, user charges for patients have been introduced, though they are much cheaper than the corresponding private sector charges.

Below Poverty Line (BPL) households are required to pay a nominal fee and specialist physicians are paid a per unit fee as an incentive.

Several successful PPP models have emerged over the last few years, and two of them deserve special mention:

- Rashtriya Swasthya Bima Yojana (RSBY), launched in 2008, has been successful in enhancing health coverage for BPL households in India. The insurer receives a premium for each enrolled household, while the hospital is paid per beneficiary treated. The private sector contributes to the system by helping identify BPL households and getting paid for their services.
- In Maharashtra a viable model has been introduced by the collaboration between Municipal Corporation of Greater Mumbai (entrusted with services and infrastructure provision), the

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community (problem identification and monitoring of the project), ICICI Centre for Child Health and Nutrition (funding), the Centre for International Health and Development (input design, evaluation and dissemination) and SNEHA (implementation and monitoring). A considerable degree of health infrastructure has been created and referral links with hospitals have been established (Shende et al, 2009).

Despite the success of these two andother PPPs, several have failed as well. There is a need to understand the underlying reasons behind the failures. Raman (2009) notes that PPPs formed after mutual consultation have performed better vis-à-vis competitively selected partners. However, Mukhopadhyay (undated) notes that the NGOs have enjoyed limited say during the health planning stage. Raman (2009) also observes that as the government lacks the requisite technical and managerial skills to run successful PPPs, 'visionary' individuals have played crucial roles. The government policy of periodic transfer of officials therefore has often hurt the operation of successful PPPs.

Other reasons behind failures include: hasty planning; untimely budgetary devolution from the government; mismatch between grassroots needs and government agenda; government inefficiency and red tape; greater emphasis on achieving the quantitative target, rather than ensuring the quality of the service; political interference; and failure to devise sufficient in-built incentives (Gupta, 2011; Sewa Rural Team, 2004; Elamon, 2004; Kapadia, 2004; Sen, 2004; Raman and Björkman, undated; Mukhopadhyay, undated).

The Future

The poor performance of several PPP initiatives begs the larger question of whether the government considers PPPs as a 'private initiative supported by the public sector' or a 'public initiative supplemented by the private sector'. This distinction is crucial, because if the former is the underlying motive, then the government role will be reduced in the long term to a mere facilitator, and efficiency will automatically be augmented with increasing operational flexibility of private partners. However, if the government views itself as the dominant partner in PPPs, they will always prioritise their own political requirements and agendas over the efficient running of the PPP. This could fatally undermine the viability of many PPPs.

It must therefore be recognised the PPPs and indeed the entire healthcare sector will benefit from a more liberal policy regime. This will help India on both the domestic and international front on several counts:

- First, the PPPs have made a considerable contribution already to India's healthcare infrastructure. But as indicated earlier, their potential for better delivery is often undermined by management failures on the part of the government partner. Greater understanding from the government is greatly needed to secure the best output from existing collaborations. Crucially, the government must grant greater autonomy to the private partners at all stages (planning, execution as well as assessment). Only then can an optimal outcome from the PPP initiatives be expected.

- Second, it is a good time to let efficient private players in the healthcare sector grow and enhance their efficiency levels. Only hospitals above a certain standard of operation can hope for accreditation by Joint Commission International (JCI) / Joint Commission for the Accreditation of Hospitals and Healthcare Organizations (JCAHO). These standards are based on all health related criteria, including quality of patient care, accessibility, personal and equipment hygiene, etc. Apollo Hospitals group was the first Indian entity to receive JCI accreditation, and several other Indian hospitals have followed. Allowing a greater role for large reputable private players can expand the list further. Collaboration with foreign entities, through FDI and other forms of collaborations, would have a crucial role in increasing much-needed healthcare infrastructure in India. This segment will cater to domestic demand on one hand and medical services exports on the other.

- Third, increased instances of medical tourism and lack of portability of medical insurance for foreign patients have forced Indian private players either to enter into tie-ups with foreign insurance players or actively advertise in various media in India and abroad. The deepening of the health insurance schemes offered jointly by Indian and foreign players (e.g. Birla Sun Life health insurance, ICICI Prudential health insurance) is another example of market based solutions on this front. Also a number of tour operators have come forward to take advantage of this development (e.g. Kuoni - Apollo, Cox & Kings - Dr. Batras, Vedic India etc.) and easing foreign participation in this segment will also be important. The insurance sector needs reform so that India can leverage its comparative advantage in medical tourism, and thereby attract greater levels of FDI.

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- The views expressed by the author are his own.

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