



Policy Paper

***The Emerging Role of
PPP in Indian Healthcare Sector***

Prepared By



In collaboration with 

Contents

Executive Summary	1
1 Overview	3
1.1 Indian Healthcare Sector	3
1.2 Demographic Changes	4
1.3 The Burden of Disease	5
1.4 Health Infrastructure	6
1.5 Financing Mechanism	7
1.6 Social and National Objectives	8
2 Key stakeholders in Healthcare PPP	10
2.1 Stakeholder Roles	10
2.2 Public vs. Private	10
2.3 Managing Stakeholder Interests	11
3 Key Thrust Areas for Healthcare PPP	15
3.1 Infrastructure Development	15
3.2 Management and Operations	16
3.3 Capacity Building and Training	18
3.4 Financing Mechanism	19
3.5 IT Infrastructure	19
3.6 Materials Management	20
4 Models in Healthcare PPP	21
4.1 Dimensions of PPP in Healthcare	21
4.2 Existing Frameworks	21
5 Evaluation of PPP Models	24
5.1 Evaluation Framework	24
5.2 Risk Allocation and Sharing	29
6 Recommendations	31
6.1 A simplified PPP model	31
6.2 Operationalization Next Steps	32
7 Conclusion	34

List of Tables

<i>Table 1- Structural snapshot of Indian healthcare system</i>	3
<i>Table 2 Stakeholder roles in a Healthcare PPP</i>	10
<i>Table 3 Public vs. Private Providers in Healthcare</i>	10

<i>Table 4 Public vs. Private Financing for Healthcare Payment</i>	<i>11</i>
<i>Table 5 Public vs. Private participation in ICT in Healthcare</i>	<i>11</i>
<i>Table 6 Dimensions of a Healthcare PPP</i>	<i>21</i>
<i>Table 7 Different types of PPP models</i>	<i>22</i>
<i>Table 8 Evaluation Parameters for PPP models</i>	<i>25</i>
<i>Table 9 Evaluation of Healthcare PPP in Tamilnadu, India</i>	<i>27</i>

Executive Summary

With the rapid growth of the Indian economy in recent times and the changing demographics and socio-economic mix of the Indian population, there has been an immense change to the healthcare requirements in the country. Over the years, the public and private sectors have helped in addressing the health needs of the country and made good India's progress on key health indicators like life expectancy and infant mortality. Today, the healthcare system in India faces a challenge in raising the service quality and ensuring equitable access to people while simultaneously gearing up its capabilities to tackle the changing disease incidence profiles. This challenge needs to be addressed through a concerted effort of both public and private sectors by their agreeing on suitable public policy initiatives which incentivize financing and provision of healthcare, and thereby increase healthcare access to the people. The role of an effective public policy is critical here, since it is the public policy which influences the manner in which a nation's healthcare resources and funds are collected, allocated and utilized as well as the extent to which the services are developed, distributed and accessed.

In this context, this policy paper is the outcome of extensive and exhaustive deliberations by a Healthcare Sub-Committee constituted by the CII National Committee on Healthcare involving leading stakeholders in the Healthcare Industry. The recommendations in this document are based on a specific mandate provided to the sub-committee, which was to study the avenues of collaboration between the public and private sectors of the healthcare industry, and to recommend public policy initiatives that would foster Public Private Partnerships (PPPs) and stimulate investment in healthcare sector to shape the future of Indian Healthcare Industry.

The observations from the study indicate five major thrust areas where a Public-Private-Partnership could be evolved as a synergistic model to combine both the social objectives of universal healthcare access and the business objective of running a profitable healthcare facility. The five areas where private sector contribution can prove very beneficial are:

- 1 Infrastructure Development - Development and strengthening of healthcare infrastructure that is evenly distributed geographically and at all levels of care
- 2 Management and Operations - Management and operation of healthcare facilities for technical efficiency, operational economy and quality
- 3 Capacity Building and Training - Capacity building for formal, informal and continuing education of professional, para-professional and ancillary staff engaged in the delivery of healthcare
- 4 Financing Mechanism - Creation of voluntary as well as mandated third-party financing mechanisms
- 5 IT Infrastructure - Establishment of national and regional IT backbones and health data repositories for ready access to clinical information
- 6 Materials Management - Development of a maintenance and supply chain for ready availability of serviceable equipment and appliances, and medical supplies and sundries at the point of care

In each of the above areas, there are different capabilities and drivers for the public and private sectors in a PPP arrangement. For example, the government is the largest provider of healthcare in the country especially at the primary and secondary care levels, and the government is also

the largest buyer of healthcare services at the tertiary and quaternary care levels. The private sector investments in healthcare have been driven by free market economy, and the pricing of healthcare services has been largely influenced by investment cost. Consequently, these services have remained out-of-reach of a large majority of our population due to cost consideration. In order to make PPP as a sustainable common ground for both public and private sectors and to evolve successful PPP models, it is essential to have clarity of the public and private sector positions and develop unambiguous criteria for assessing PPP models. An evaluation framework proposed in this document brings out four key principles on which any PPP model must be assessed

- 1 **Effectiveness** or the ability to meet program objectives
- 2 **Efficiency** or the financial efficiency in transfer of ownership and associated risks
- 3 **Equity** or the ability to accrue the benefits of the program to the poor people
- 4 **Financial Sustainability** or financial viability of the model

An example of the usage of the evaluation framework in India highlights some key issues that need to be identified thoroughly before signing a PPP agreement.

As a recommendation, the PPP model proposed primarily assumes a facilitator role for the public sector by way of offering support and aiding the private sector's role of managing the service delivery and quality of care. Specific policy initiatives recommended for increasing private sector interest and participation along the key thrust areas include:

- 1 Providing help in infrastructure set-up especially in areas like land acquisition
- 2 Offer equity participation where possible or extend subsidized debt and other fiscal benefits
- 3 Provide budgetary grants for capital and operating expenses of the PPP systems
- 4 Ensure a non-compete policy within a predefined geographical limit of the PPP facilities
- 5 Buy-back a share of capacity for government identified beneficiaries

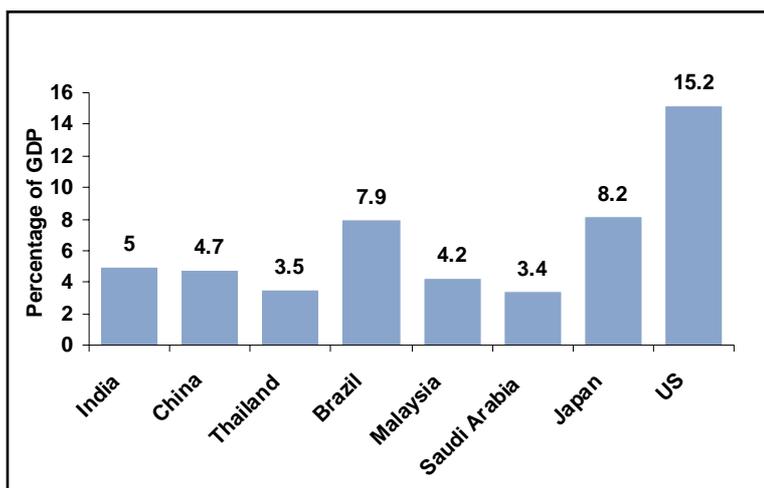
In the following sections, a case for PPP in Indian healthcare is presented with a detailed discussion on stakeholder roles, thrust areas, PPP frameworks, key recommendations and next steps for the governing body.

1 Overview

1.1 Indian Healthcare Sector

At over 8 percent GDP growth in recent years, India is one of the fastest growing economies in the world in terms of GDP and is expected to be the third largest economy by 2050. Healthcare services which are critical to the growth in economy have seen vast improvements over the past few years in India. Yet, India's total expenditure in healthcare as a percentage of GDP is still one of the lowest in the world. Though

Figure 1- Total Expenditure on Healthcare in 2005



the public health services infrastructure is widespread, starting with sub-centers, primary health centers, community health centers, secondary level district hospitals, up to medical colleges, the quality of these are not uniform and subject to regional vagaries. The table below provides a structural snapshot of the Indian healthcare system.

Table 1- Structural snapshot of Indian healthcare system

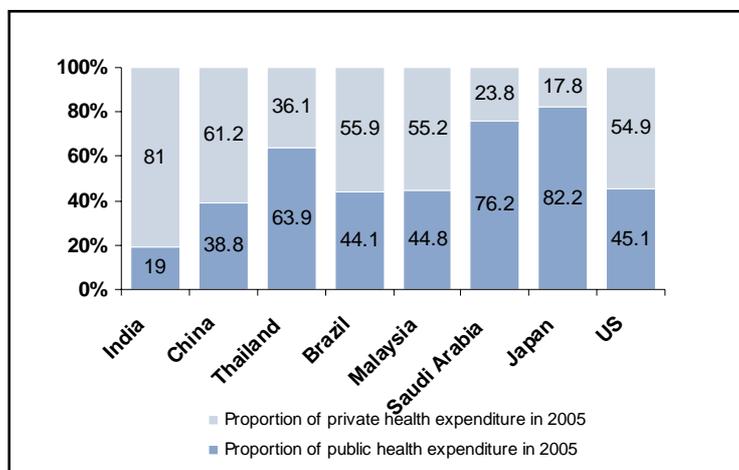
Stage of Healthcare	Demand of Healthcare
Primary Care	The basic healthcare facilities for common and minor ailments and where prevention is most effective; Demand is the highest in this sector
Secondary Care	Healthcare facilities that require constant medical attention including short period of hospitalization; Demand is moderate
Tertiary Care	Conditions requiring care from specialized clinicians and facilities; Demand requirements are highly specialized and thus minimal

Contribution of Public and Private sector in Indian healthcare sector

In India, the public sector accounts for only around 20 percent of the total healthcare expenditure, representing around 1 percent of the GDP – among the lowest in the world (Figure 2). India's public healthcare is under-funded and small in size to meet the current health needs of the country. Items like public health, hospitals, sanitation, etc. fall under the state government, while items having wider ramification at the national level (food and drugs, family planning, medical education, and vital statistics) come under the central government. It is mostly through national health programmes that the central government pumps in around 15 percent of the total funds in the healthcare sector. The Government Health Projects are implemented through the states, with the Department of Health facilitating access to external aid. The contribution of private sector in healthcare expenditure in India is around 80 percent

and is one of the highest in the world. Almost 94 percent of this amount (which covers both financing and provision aspects) comprises of out-of-pocket expenditure on health. The remaining 6 percent is the expenditure on provision, which accounts for the private sector contribution to 60 percent of all in-patient care and 78 percent of total number of visits in outpatient care¹ in India. In addition the private sector today provides 58 percent of the hospitals and 81 percent of the doctors in India². Adding to the challenge is also the changing demographics and lifestyles of the people. Dealing with these challenges requires the resources and expertise of public and private sector combined.

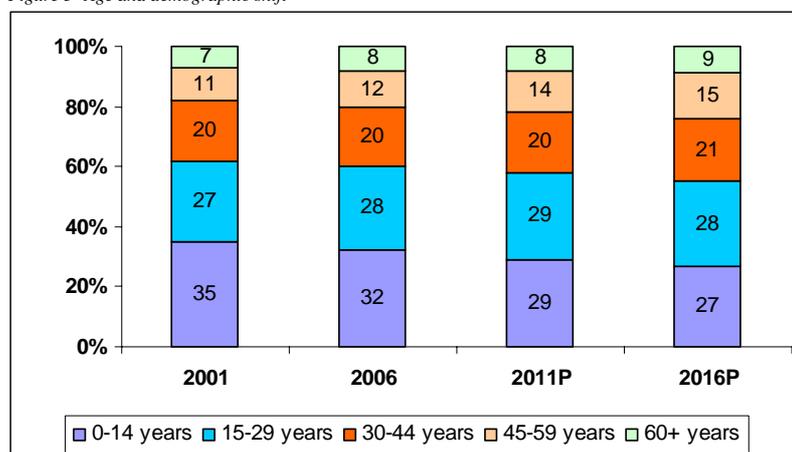
Figure 2- Health expenditure distribution between public and private sector



1.2 Demographic Changes

Better facilities and overall improvement in healthcare has led to increase in life expectancy and the population is expected to touch 1.27 billion by 2016. This would put a lot of stress on the existing healthcare infrastructure in the country. In addition the changing demography and socio-economic mix are altering the population's disease profile and increasing the incidence of lifestyle diseases like diabetics and cardiac ailments. Although a large section of the population is still poor, there has been a rapid increase in the middle class and rich segments. The urban middle class segments accounts for a majority of healthcare expenditures in India; hence with their numbers on the rise, coupled with surge in income levels, the per capita expenditure on healthcare is expected to increase. The demand for quality healthcare will also be driven by the improvement in health awareness.

Figure 3- Age and demographic shift



¹ NSSO Survey 2008

² Report by the Task Force on Medical Education constituted by the MoHFW, GOI

From 52 percent in 1991 the literacy rate in the country has increased to 65 percent in 2001 and this has resulted in better awareness and hence the need for quality healthcare facilities.

1.3 The Burden of Disease

Focus on maternity and child health has shown results and needs continued focus

³India's economic progress over the last few decades has brought with it some resultant improvement in basic healthcare metrics. With focus on primary healthcare in the past in India, the life expectancy and mortality ratios have improved over the years (Figure 4), though there is further scope for improvement when compared with other countries of the world (Figure 5, Figure 6).

⁴When compared to the South Asian Region averages on life expectancy and mortality (Life Expectancy: 64 years, Infant Mortality: 52 per 1000, Maternal Mortality 4.5 per 1000) India is just about at the average level on these parameters. While focus in this area needs to be continued, there are other emerging areas of focus that merit attention.

⁵As seen in the previous section, changes to the age demographics mix of the Indian population indicate an increase in the working age group population (Figure 3). This has also brought with it a change in the disease profile and an increase in the incidence of diseases to which the population in the working age group is more prone towards.

Figure 4 Increasing Life Expectancy at Birth in India

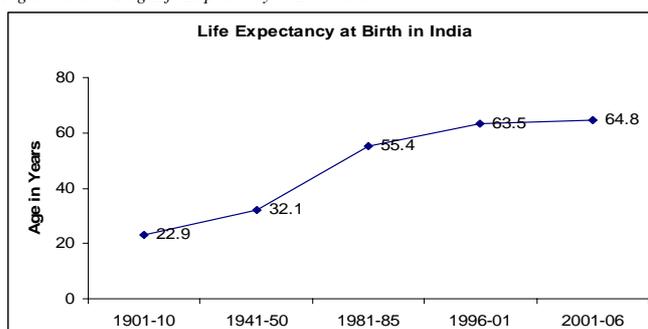


Figure 5 - India life expectancy comparison

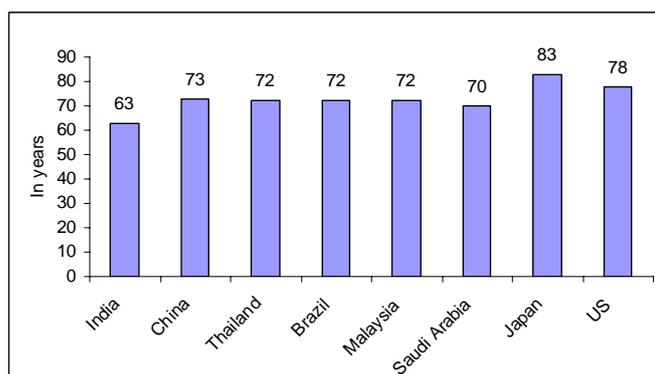
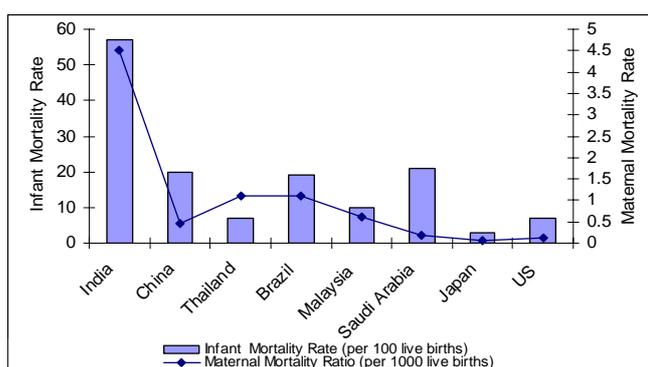


Figure 6 - India mortality rate comparison



Today, focus is needed to tackle increase in non communicable and lifestyle diseases

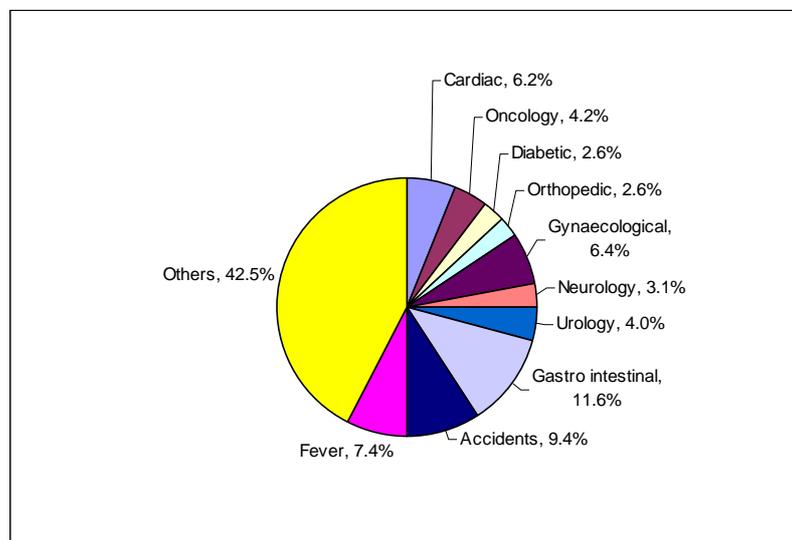
³ World Health Organisation report on World Health Statistics, 2008

⁴ World Health Organisation report on World Health Statistics, 2008

⁵ World Health Organisation report on World Health Statistics, 2008

Non Communicable Diseases (NCDs) have evolved as major health problems and accounted for 53 percent of all deaths in the age group 30-59 years in 2005. It is projected that by 2015, 59 percent of the total deaths in India would be due to NCDs. While NCDs are usually expected to occur in old age, their peak occurrence in India is a **decade earlier than western countries**. Hence, the issue is not only the burden, but also its

Figure 7 - Hospitalized cases in India, 2006

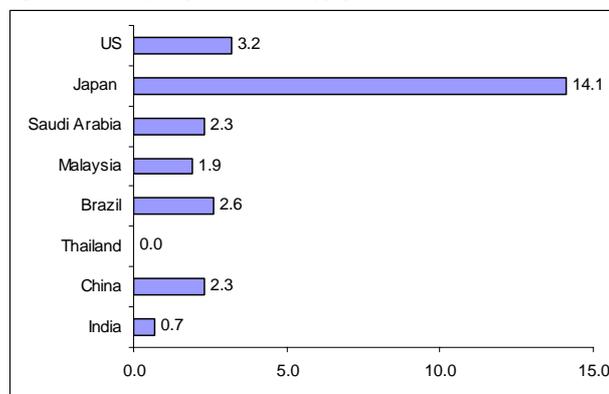


prematurity and the resulting socioeconomic consequences. With changing socio-economic mix in India, the share of lifestyle diseases is likely to surge. Figure 7, indicates that lifestyle diseases like Cardiac ailments, Oncology and Diabetes accounted for about 13 percent of the total hospitalization in 2006. Projections for these diseases in the future indicate that the share of these might rise to more than 15 percent by 2011 on account of a change in dietary habits and a more sedentary lifestyle led by people. These lifestyle diseases are more expensive to manage and control. Participation from private players who possess access to quality medical staff with super specialization facilities will be critical to manage the rising demand in the category of lifestyle diseases. In addition to this, the objective of increasing the share of the population which is covered under financially sound and competitive insurance schemes should become a national priority.

1.4 Health Infrastructure

Providing for quality healthcare services is highly capital intensive where the cost of building a secondary care and tertiary care hospital could be as high as 25 lakhs and 40 lakhs per installed bed, respectively⁶. The industry also requires highly skilled resources ranging from doctors to other medical support staff like nurses, lab technicians, pharmacists etc. India faces a severe resource shortage on both capital invested and manpower as shown. India suffers from an acute shortage of hospital beds with a bed ratio of 0.7 per 1,000 of population. Regional variations exist with some areas in economically advanced states having excess capacity, but shortage in

Figure 8 Number of hospital beds/1000 of population



⁶ CRISIL report on Hospital Industry in India, 2008

other regions contributes to the shortfall at a national level. This is very much below the average ratio of 1 bed per 1,000 among the low income countries (as defined by WHO). To reach to the average level of 1 bed per 1,000, India needs about 3 lakh beds as additional installed capacity. At an average cost per bed of 25 lakhs for a secondary care hospital, the total investment required amounts to INR 75,000 crores.

Figure 9 - Number of physicians/ 1000 population

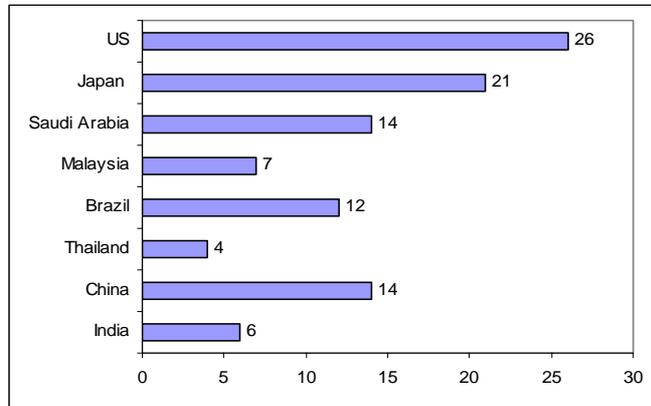
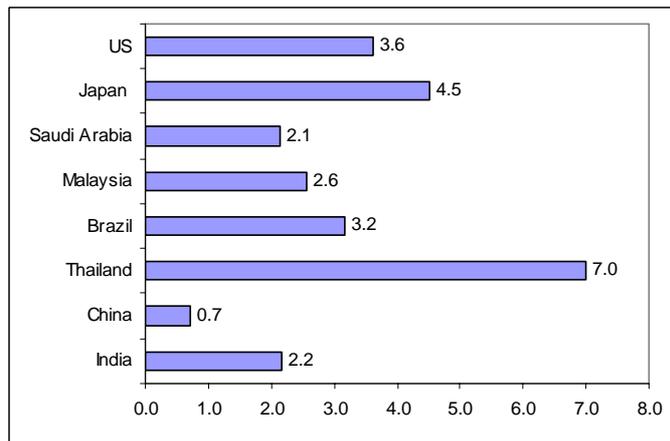


Figure 10 Nurse to Physician Ratio



In setting up and running a healthcare unit, capital costs form significant proportion of the total costs. Land and building development accounts for 40-65 percent of capital invested, with land accounting for 15 percent and building development for the remaining 50 percent. Government help in land acquisition helps to significantly reduce project costs and the benefit of the same can be incorporated into the costing of services to reduce the financial burden of the beneficiary. Equipment costs form the other major component in the project cost with tertiary hospitals typically importing 75-80 percent of their equipment. Maintenance and operation of these specialized and high-end medical equipments requires skilled management and personnel where involvement of private parties can be sought.

1.5 Financing Mechanism

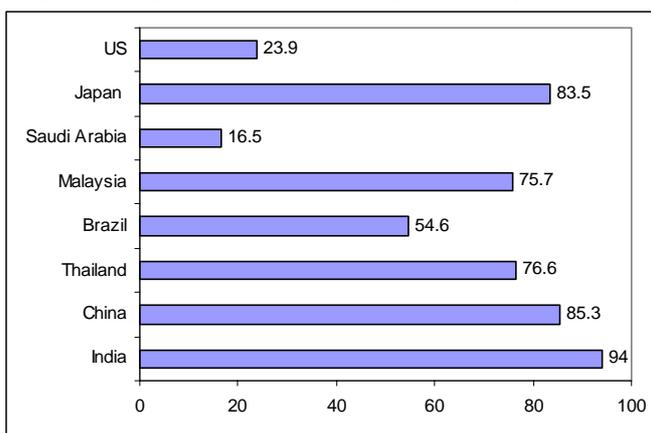
As mentioned in the earlier section the public sector spends only 1 percent of the total 5 percent of GDP on healthcare expenditure while private sector accounts for the remaining 4 percent. Considering the huge investment in infrastructure required the government needs to identify mechanisms for further increasing private sector participation through incentives.

During 1991-2003, private out-of-pocket expenditure on health grew at 10.9 percent per annum in real terms, whereas per capita income grew only at 3.8 percent during the same period. Out-of-pocket expenditure as a percentage of total private expenditure on health is at 94 percent in India and one of the highest in the world. This level of expenditure poses problems for families who cannot pay, which includes not only the poor, but also the middle class, forcing them into debt and leading to a poverty trap. On average, the poorest 20 percent of the Indian population is 2.6 times more likely than the richest population to forego medical treatment when ill, due to

financial reasons. According to NSSO survey 2004, financial constraints among all other reasons, led to almost 28 percent of the total people with ailments in rural areas; to leave their ailment untreated. Government

subsidy is not a direct answer to the situation as the poorest quintile uses only 10 percent of the total net subsidy while the richest uses three times that figure⁷. Even if the government provides free or nearly free services, poor households spend a significant part of their income on transport and informal charges though drug expenditure occupies almost 70% of the total out-of-pocket expenditure.

Figure 11 Out-of-pocket Expenditure as percentage of Private Expenditure on health



The growth of private sector, especially the for profit corporate sector has been substantially influenced through the introduction of medi-claim hospital insurance policy in 1983 by the four public sector general insurance corporations with a provision of tax exemption. Although all the general insurance corporations incurred losses in meeting the claims of the policy holders, it was an initiation of transfer of social responsibility to the private sector by making a certain small premium to cover a large uncertain health risk.

Although the health insurance market covers just 10 percent of the population, it has helped growth of the private sector by free market economy. A large part of this is covered by schemes for those employed by the public sector and entitled to health coverage has contributed to the growth of private sector with privileges of cost reimbursement or cash less transactions through CGHS, ECHS and other similar schemes covering employees of the government and public sector undertakings. Unfortunately, the remaining 90 percent of the population remains outside the scope of the above coverage. In this context, sectors like Micro insurance, which targets the low income segment for various types of health, life and general insurance coverage is a fast emerging area attracting many private players.

1.6 Social and National Objectives

Although access to healthcare is not a fundamental right, it is an obligation on part of the government to facilitate universal access to basic health services and to provide access to continuum care to all sections of the society. The Union Government's National Health Policy 2002 and the 10th Five-Year Plan aim at achieving an acceptable, affordable and sustainable standard of good health and an appropriate health system. The key aspects of the policy include

- Desire to utilize private sector resources for addressing public health goals
- Liberalization of the insurance sector to provide new avenues for health financing

⁷ Public-Private Partnerships: Managing contracting arrangements to strengthen the Reproductive and Child Health Programme in India, A WHO-IIMA report, 2007

- Redefining the role of the state from being just a provider, to being both provider and a financier of health services

The focus is on reorganization and restructuring of the existing health infrastructure at primary, secondary and tertiary levels to reduce inequities and regional imbalances in the health sector. This includes delegation of powers to local bodies. The National Rural Health Mission calls for a holistic approach to health development, supported by relevant human resource capacities, convergence, integration, and public-private partnerships. The scheme provides an opportunity for promoting equity, serving the under privileged, and empowering communities in a sustainable manner. India is striving to achieve the Millennium Development Goals, and the expectations to attain various targets are variable.

2 Key stakeholders in Healthcare PPP

There are five key stakeholders in any healthcare service system as shown below. Implementing a healthcare PPP will have an impact on all these stakeholders and the PPP itself can be structured along any of the roles where private sector participation is applicable.

2.1 Stakeholder Roles

Table 2 Stakeholder roles in a Healthcare PPP

	Participant Type	Role Description
Provider	Public or Private	Entity providing the core services of designing, building and operation of healthcare units
Payer	Public or Private	Entity or person paying for the service rendered to the end user. Out-of-pocket expenses where the end user pays for himself/herself still forms a large part of this segment in India. Formal sector consists of insurance players both in public and private sectors where the end user comes under medical cover.
Beneficiary	Neutral	End user or the ultimate recipient of the healthcare service. Currently impacted by high costs as percentage of income and significant vagaries in quality of service across the country
Regulator	Public	An apex body governing the formal healthcare market in the system. The role of a central regulator will be key to monitor the expansion and sustainability of a scaleable PPP model
IT infrastructure	Public or Private	Resource, expertise and management provider for connectivity and sharing of data on patients, specific medical cases, diagnoses and treatment techniques is an area of development that can bridge the quality and accessibility gap across regions in the country.

2.2 Public vs. Private

In the roles of provider, payer and the area of IT infrastructure, there are significant advantages as well of areas of concern between the public and private sector as discussed below

Table 3 Public vs. Private Providers in Healthcare

Provider	Public	Private
Advantages	<ul style="list-style-type: none"> - Motive of improvement in overall health of population drives growth and expansion strategy - Potential for economies of scale can be realised both within a unit as generally facilities are large and across units due to extensive network - More equitable in outlook 	<ul style="list-style-type: none"> - Efficiency in management and operations with a thrust towards employing technology and latest best practices - Increased access in areas of operation and availability of round the clock services - Increased flexibility and responsiveness
Areas of concern	<ul style="list-style-type: none"> - Efficiency issues in management and operations hamper the system from realizing complete potential - Inflexibility and issues in responsiveness - Customer satisfaction and quality perception is low 	<ul style="list-style-type: none"> - Financial sustainability without government support restricts expansion into all regions - Quality of service can suffer in areas of low competition and lack of regulation - Higher costs exclude large sections of the poor population

--	--	--

Table 4 Public vs. Private Financing for Healthcare Payment

Payer	Public	Private
Advantages	- Sheer size of reserves and financial position of public sector players like United India Insurance and New India Insurance gives room for foraying into microinsurance segment at initial stages	- Efficiencies in process and innovative strategies make private players as strong candidates to enter the BOP (bottom of pyramid) market with customized solutions that will financially sustain
Areas of concern	<i>Regulatory</i> - IRDA policy on microinsurance still at a nascent stage and entry into BOP markets will not be at full steam until a policy framework is finalized	

Table 5 Public vs. Private participation in ICT in Healthcare

IT infrastructure	Public	Private
Advantages	- Extensive network of PHCs which can provide better services if connected through ICT. Public sector successes in connectivity include notable ones like CARD, the e-governance initiative in Andhra Pradesh	- Significant knowledge and management expertise available to manage ICT projects on a large scale
Areas of concern	- Training of existing government staff to manage and operate the equipment	- Operating equipment in remote locations may not be financially viable without government support for manpower and training modules to impart operating knowledge to staff

The policy goal of PPP in healthcare would be to bring out the synergies in key stakeholder interests between the public and private sector and at the same time have a strong regulatory mechanism of maintaining quality along with equity in service. Any model of healthcare PPP that is implanted and the framework used in evaluating it will need to accommodate for the key concerns raised in the above discussion. PPP models will vary in design and implementation based on structural, regional and goal differences. Yet a framework for evaluating such models will try to ensure that the PPPs are setup for success rather than failure

2.3 Managing Stakeholder Interests

The key to success in PPP initiatives lies in effective management of the public sector and private player interests across different stakeholder roles. PPP experience from different sectors indicate some key implementation aspects of PPP which need upfront clarity and have to be kept in mind by concerned parties before initiating PPP projects in healthcare

- 1 *Defining and differentiating scope of free services at PPP hospitals* – Free service implies access to healthcare to the beneficiary free of charges. However, there is a cost to the service provider which has to be met either through a global budget or through cross subsidy out of revenue from paying patients. While the qualitative aspect of the core service of the patient’s medical care must be equitable irrespective of the socio economic background of the beneficiary, there could be difference in catering to the patient’s personal conveniences for those who are able to and willing to pay for such services. The quantitative aspect of free

service can be determined on the basis of the built up facilities with maximum capacity utilization, or alternatively on the basis of the actual service provided.

In order to establish clarity of objectives upfront in any PPP project, it is recommended that the MoUs or SLAs define the complete scope of “Free Services” and include the following:

- Determination of “Free Services” to be provided at the PPP Hospital
- Definition of the scope of “Free Services” to be provided at the PPP Hospital
- Definition of the eligibility of patients to avail the “Free Services”
- The Quality charter of “Free Services”
- Differentiation of facility’s infrastructure for “Free” & “Paid” Services

- 2 Tariff Determination - It is essential that pricing strategies and service tariffs of the ‘free services’ are determined on mutually agreeable platforms. The government is the third party payer covering the cost of services for the private sector service provider, on all ‘free services’. But the government generally does not have a mechanism to administer financing and provision of care through pre authorization of rendered services as is the case of insurance or employee benefits. Hence it is invariably a matter of conflict to estimate and compensate the quantitative aspect of care. Therefore in most successful PPP models, tariff determination actually works top downwards from a global budget based on built up capacity and capacity utilization. Global budget on utilization is also auditable and therefore fits into the public accountability. Based on mutual understanding this global budget figure can be determined, based on the cost of reimbursement or on a cost plus basis should there be an incentive provided in the PPP model. It can also lower than cost of operation if cross subsidy is part of agreement. The value of assets provided by the government could be considered as contribution in which the government can expect certain returns in the form of return on capital employed or dividend on equity.

In general, the service tariffs should be determined on the basis of the following criterion while entering into the partnership agreement between government and private sector:

- Inflation (current & projected)
- Project Operational Expense
- Project Capital Expense
- Project Profitability
- Public Sector partner’s obligation
- Periodicity of tariff change
- Agreeability by both partners

3 Role of advisors to the PPP

In most PPP initiatives, the public sector partner identifies the management and financial consultants to advise on the projects. It is important that the appointed advisors should develop the contractual clauses after discussion and in mutual agreement of both the public and private sector interests. This would enable a better business projection and incentivize the bottom-line objectives of the project.

4 Regulatory Role in a PPP setup

PPPs are looked upon as bringing the best of both public and private sector world practices and benefits together to provide better healthcare. At the same time, a strong control mechanism is

also needed to ensure that the public and private players operate within their defined roles and do not transgress boundaries that may undermine that larger industry context. While self-regulatory mechanisms are an option for enforcing quality controls through professional associations, such a mechanism might still need some time to evolve in India. An independent regulatory watchdog is needed in dealing with dispute resolution to maintain the business viability of the PPP as much as it is needed to ensure equitable access to all sections of the population. Some of the areas where the regulator could contribute are:

- 1 **Consumer Rights Protection** – Ensuring that the poor are not worse off if PPPs are set up to serve remote areas of India. A clear policy on rights of consumers in a PPP-type of arrangement, and patient rights in case of a PPP failure are genuine concerns that need to be addressed in any policy framework and have to be employed by the regulator to manage PPPs.
- 2 **Litigation issues** - Litigation has been a source of concern to the private sector. One of the key instruments used by governments to encourage PPPs is subsidizing inputs (mainly land), and the common property element of such inputs makes them vulnerable to public scrutiny and litigation, which can be detrimental. While there is clearly a case for opening such decisions to public litigation, governments need to identify correct procedures and the regulator needs to ensure some amount of protection to the private partners so that they can be assured of the continuation of PPPs unhindered by the constant threat of litigation. Keeping these in mind, it is necessary that even at a contractual stage, a “Scope of Protection” of both the partners is clearly documented in the MoU of the PPP.

The “Scope of Protection” of the partners’ and partnership’s interests (both financial and brand image) need to be clearly specified in the agreement. Moreover, litigations arising out of public outcry need to be fundamentally cleared at inception to avoid any debate in the future. Specifically, the Scope of Protection should cover the following:

- Operational issues
 - Manpower Planning in terms of issues like
 - Local employment generation,
 - Outsourcing requirements, and
 - Specialist requirements
- 3 **Ensure timely decisions** – In some of the cases the delays in decision making from the side of the government has been a significant challenge in the successful execution of the PPP model. The regulatory body which looks into the PPP aspects should be well empowered to take decisions and act as a speedy channel to address the various issues.
 - 4 **Exit options for private providers** - In deciding on a PPP, private providers not only look for attractive economic returns but also look for a hassle free exit strategy in case a partnership goes wrong. There is little evidence on what kinds of exit clauses have been included in PPP contracts in India so far. Penalties and compensation issues must be clearly outlined in the MoU whether the public sector or the private party wants to exit the contract. MoUs must clearly and objectively define the necessary exit options that can be exercised by the partner along with the rights of the partner at the time of exercising such rights. The MoU should clearly provide for necessary exit clauses and exit events which can be

exercised by the partners anytime after the expiry of the stipulated lock-in period. The exit clause should also clearly define the necessary conditions which will deem and affect the expiry of an existing partnership. The MoU should also provide scope, in case of any financial fall-outs, the rights of the partners, to seek regulatory intervention and to appoint an “arbitrator” towards resolution of issues and concerns before seeking legal recourse. In such cases, the role of a regulator becomes critical to ensure that the process is fair to both state and private sector, while the interests of the beneficiaries is not compromised

To summarize, the role of the regulator is seen as a neutral operator between the public and private sectors whose primary interest is the benefit of the general public benefiting from the system, but is also aware and active in mitigating potential sources of conflict within PPP arrangements.

3 Key Thrust Areas for Healthcare PPP

The scope of PPP initiatives in India has spanned disease surveillance, purchase and distribution of drugs in bulk, contracting specialists for high risk pregnancies, national disease control programs, social marketing, adoption and management of primary health centers; collocation of private facilities (blood banks, pharmacy), subsidies and duty exemptions, joint ventures, contracting out medical education and training, engaging private sector consultants, pay clinics, discount vouchers, self- regulation, R&D investments, telemedicine, health cooperatives, and accreditation. While these have been spread out in time and space and occurred on an ad-hoc basis, the idea of PPP as a scalable and long term solution to Indian Healthcare brings up some key thrust areas along which private sector participation will have the maximum impact.

Opportunities for private player participation in PPP models in Indian healthcare system can be broadly classified along the following key thrust areas

- Infrastructure Development
- Management and Operations
- Capacity Building and Training
- Financing Mechanism
- IT infrastructure development for Networking and Data Transfer
- Materials Management

This section covers the background context and the private player role in each of these opportunities.

3.1 Infrastructure Development

The participation of private sector in healthcare infrastructure development is expected to bring innovation strategies thereby quickly bridging the resource gap in infrastructure for healthcare. The following are some areas where energies could be focused to extract workable solutions

- Planning, Design and Development of healthcare facilities in whole or speciality wise
- Owning and Operating diagnostic services for public health systems
- Own and operate other services like mobile clinics

For more than 90 percent of the population in India today, modern healthcare facilities are still unaffordable. As pricing is a direct function of the costs incurred there is an urgency to introduce measures to bring down the cost of providing healthcare. PPP could offer the solution for this problem if sound public policy initiatives are introduced by the government which

would make private healthcare investments an attractive proposition. Some of the aspects that can be considered to provide affordable healthcare for the people would include

- Providing land at a subsidised rate for building healthcare infrastructure facilities to keep the overall project cost low. The land provided can be part of the equity provided by the government
- An other measure to keep the land prices in check would be to reduce the land registration charges and the other applicable duties specifically for the healthcare sector
- In case of financing, government can provide public institution finance at a reduced rate of interest. Government can also facilitate lending by commercial institutions by giving priority sector status to healthcare industry where, by reserve, a fraction of the overall lending is to fund healthcare development projects
- Provide budgetary grants for capital and operating expenses of the systems covered under the PPP where possible
- Ensure a non-compete policy within a predefined geographical limit where the PPP facilities operate to ensure growth and sustenance of the model
- Government can also consider providing duty exemptions on import of capital goods which are essential for providing quality healthcare

3.2 Management and Operations

The huge infrastructure of the Indian public health system lacks in realizing its complete potential partly due to inadequate expertise in managing the operations of the units, be it PHCs or large hospitals. In response to the situation, private sector has grown over a long period and gained significant experience in addressing the needs of the clients of the system. A case in point is that most outpatient primary care (about 60-70 percent) is now provided in private clinics and health centres in both rural and urban India.

In this context, PPP can help in contracting-in models which involves the hiring of one or more agencies to provide a multitude of services like

- Infrastructure maintenance and upkeep
- Key service delivery of medical treatment
- Hospital Management including Housekeeping, Catering etc.
- Medicine store and inventory management
- Medical equipment purchase and maintenance

- Transportation
- Security

Hiring medical staff and specialists for some days in a week could also be part of such arrangements. The fundamental aspects that the private party can bring in to the arrangement are

- Technical efficiency
- Operational economy
- Quality in delivery of healthcare

Government buy back schemes are the most viable way of structuring PPPs in India

On financial structuring of PPPs, it is important to realize that any contract between the government and the private parties cannot be on individual line items like the American CPT system where cost of every x-ray, scan or other treatment procedures is fixed. Such a system cannot be adapted to the Indian context which has significant vagaries in quality of healthcare across regions and may attract non-serious operators whose quality credentials will be questionable. Such a scheme also inherently allows for over provision of services by the provider. Instead, a buy back arrangement on capacity (percentage of beds) or throughput (percentage of patients treated) must be considered in management and operations contracts where the government hands over a facility to private parties. The government must support such a capacity sharing arrangement through budgetary grants. The usage of these grants will be tracked and must be auditable by the government or any other third party.

The incentive for private parties can be structured on any of the following lines for operating that share of total capacity which falls under the buy back arrangement from government:

- Government pays cost X per bed under buy back portion plus a defined margin on costs while the remaining capacity is operated by private parties at market rates
- Government pays costs X per bed under buy back portion while allowing the private party to operate the remaining capacity at market determined rates
- Government pays a percentage of costs X per bed under buy back portion which will be cross subsidized by the private parties using profits from the remaining capacity managed at market rates

The public sector and private parties may decide on any of the above schemes at the time of structuring the PPP depending on factors like the region where the healthcare unit is setup and also based on the allied market demand in that region. To determine the cost X in any of the above schemes, an independent third party audit can be done to determine the total cost of operating a bed.

3.3 Capacity Building and Training

Comparative statistics of Indian healthcare sector (in terms of number of available medical staff per 1000 of population) with other countries as discussed in earlier sections highlights the magnitude of shortage India faces in skilled health care professionals. Although the government's initiative to increase the number of medical colleges in the country is commendable, there is a country wide issue in relation to sector skills gap and indicates an urgent need for augmenting the medical staff graduating from formal training programs.

In this context, private players can play a key role in capacity building and training through PPP modes by working with the public sector to better utilize the infrastructure of government hospitals. Government district hospitals will be appropriate in terms of size and availability of clinical material (for in-patient and out-patient care), for providing training to nurses and other auxiliary medical staff. Such an arrangement integrates well with other PPP arrangements like on management and operations contracts to private parties, since private party offering management services will be able to tightly integrate the training program to the service delivery. Though such an integrated arrangement between management and training would not be mandatory, it would help in increasing the efficiency and quality of training.

In addition to the formal training segment, there is also a large requirement for informal programs in the form of continuing healthcare education in India. There are a large number of registered medical practitioners (who may not be qualified), para-professional and auxiliary staff and other healthcare functionaries who need to be trained on a continuing basis to improve the quality of healthcare. Private players can contribute to this segment too, by utilizing the district hospital infrastructure of the state to run continuing education programs for the network of healthcare functionaries. Such training programs need not be only in medicine, but can be in allied technical fields too.

In addition to these PPP models, the government can generate private sector interest through initiatives at a policy level as follows:

- 1 Provision of tax incentives to encourage private sector investment in healthcare capacity building, education and training. For example, the benefits accruing to a training institute in India under Section 10 (23C) of Income Tax Law, currently applying to not-for-profits could be expanded to for-profit private players also.
- 2 Allowing corporate entities to venture into healthcare education (which is currently restricted to trusts and societies in private sector), will generate private sector interest and have an immediate impact in increasing training capacity.
- 3 Increasing stipulated annual limits on student seats to a reasonable level for optimized use of resources. For example, a medical college with a 500 bed capacity could produce 150 students annually, instead of the 100 as per the current MCI norms

To summarize, capacity building and training initiatives by the government need sharpened focus not only for a quantitative increase in trained manpower but also for improving the effectiveness of existing methods in training. Private participation can directly help in improving the technical and counseling skills of medical practitioners, especially in rural areas, to improve the quality of service.

3.4 Financing Mechanism

The partnership between the public and the private sectors in healthcare is important for several reasons including equity and for promoting economic development. Currently, 76% of total healthcare expenditure in India is for out-of-pocket costs, and this component as a proportion of per capita income has doubled since 1961. The increase in this ratio has been from 2.7% in the 1960s to 5.5% at the beginning of the current decade. Private health expenditure has grown at a much faster rate than per capita income in the intervening period.

During 1991-2003, private out-of-pocket expenditure on health grew at 10.9% per annum in real terms, whereas per capita income grew at 3.8% during the same period. This level of expenditure poses problems for families who cannot pay, forcing them into debt and leading to a poverty trap. On average, the poorest 20% of the Indian population is 2.6 times more likely than the richest population to forego medical treatment when ill, due to financial reasons⁸. Even if the government provides free or nearly free services, poor households spend a significant part of their income on transport and informal charges.

Covering payments for healthcare through insurance is still at a low penetration level compared to international standards and a large part of the population that is more prone to financial burden on incurring healthcare expenses, is largely uninsured. In this context, policy changes in allowing greater private participation and the establishment of the IRDA as a regulatory body has catalyzed the formal insurance segment with private players contributing to increased sector efficiency. Microinsurance, which targets the low income segment for various types of health, life and general insurance coverage, is a fast emerging area attracting many private players. Packaged with a good micro credit system, it helps to improve the economic independence of the poorer sections. Models in India for health microinsurance covering various categories of inpatient and outpatient illnesses have evolved over the years. Some of them include VimoSEWA in Gujarat and Yeshaswini in Karnataka. With greater impetus from IRDA on this front, corporate players like ICICI are partnering in various micro health insurance initiatives.

3.5 IT Infrastructure

Quality of health care provision in India is inconsistent in terms of level of access and quality of service delivery leading to massively disparate outcomes among States and even districts in the country. In many States, ineffective management of healthcare is a greater concern than the quality of infrastructure. There has been an involvement of NGOs in managing provision of healthcare in remote and rural areas but capacity and the accountability are key concerns in involvement of NGOs. Accessibility and coverage in rural areas, given the diversity in geographical terrain, provision of health care services (hard and soft) are difficult. Also the inaccessible areas also tend to be the most backward areas and therefore the need to extend medical services to such challenging areas.

Given the context, networking the existing facilities through ICT and telemedicine facilities will immensely help in reaching out to even a remote PHC. Availability of demographic and clinical information at the point of care can significantly influence the choice of clinical intervention and consequently the clinical outcome, and therefore development of regional and national data

⁸ Public-Private Partnerships: Managing contracting arrangements to strengthen the Reproductive and Child Health Programme in India, A WHO-IIMA report, 2007

repositories accessible through web based smartcards applications or an IT Backbone, where feasible would immensely benefit the standard of healthcare services across regions. Private players with expertise and managerial experience in deploying huge ICT networks to link the healthcare units across the country can significantly contribute to increasing the access and improving quality of healthcare across India.

3.6 Materials Management

Management of materials used in healthcare delivery is critical and forms the vital link enabling last mile delivery of healthcare. That ready availability of serviceable medical equipment and appliances and medical and allied supplies and sundries at the point of care significantly influence clinical effectiveness and quality in the delivery of care. The materials comprising of replaceable and durables (beds, sterilization units, other medical equipment etc.) as well as consumables (medicines, syringes etc.) can managed efficiently by the private parties in a holistic way by offering the following services

- Centralized purchase of all consumables for scale advantages and quality standardization
- Warehousing of materials for supporting an efficient distribution network, especially for consumables
- Establishing and managing a distribution network including PPP in areas such as operating a pan India network of general medicine shops

The objective of such a setup would be to optimize costs and at the same time ensure the timely replenishment and supply of materials at the points of service delivery. This in turn will be critical to ensure that no person needing healthcare assistance is turned away or made to wait due to lack of medicine or other materials required for treatment.

4 Models in Healthcare PPP

4.1 Dimensions of PPP in Healthcare

The following structure shows the variations that are possible in the PPP models in healthcare sector along the identified dimensions⁹.

Table 6 Dimensions of a Healthcare PPP

Type of Private Partner	Content of PPC	Process or Service	Time range of commitment	Contribution of private partner	Form of PPC	Level of Care	Area	Type of Public Partner
Profit Oriented	Infrastructure	Core process or Service	Long Term	Finances	(Partial) Privatization	Tertiary	Urban	National
	Service				Contracting Out			
Non Profit Oriented		Management	Support Process or Service	Expertise and Finances	Outsourcing	Secondary	Rural	State
	Innovation	Management Process or Service				Primary		Community
Idealistic or Altruistic			Short Term	Expertise	Procurement			

Among these the scope of the discussion is on certain specific features. For example, the type of private partner in the PPPs is for profit only, as mentioned earlier. Similarly, to build sustainable and scalable partnerships, it is necessary that the time range of commitment to the partnership is long term. The private participant brings in not only an expertise in managing the healthcare system but also a financing role in case of equity participation along with the public sector. Also, for sheer economies of scale and for making an impact on a wide scale, it is necessary that the PPPs involve public participation at a central or state government level.

4.2 Existing Frameworks

PPP is increasingly seen as an alternative to traditional procurement through the EPC contracting route whereby the public sector conducts competitive processes to create separate contracts for the design and construction elements of the capital project like building of roads. In most cases, the public sector retains ownership of the asset and is responsible for financing the initiative. PPP allows the public sector to harness the private sector management and delivery capability along with raising additional finance to deliver specified services.

PPP arrangements vary across a risk-return spectrum depending on the degree of private sector involvement, use of private finance and risk transfer. The figure and table below describe the different PPP modalities¹⁰

⁹ Adapted from *Opportunities for Public Private Collaboration in the Lithuanian Healthcare System*, Prof. Dr. Oec. Bernhard J. Güntert, University for Health Sciences, Medical Informatics and Technology, 2006

Figure 12 PPP Modalities and Trends

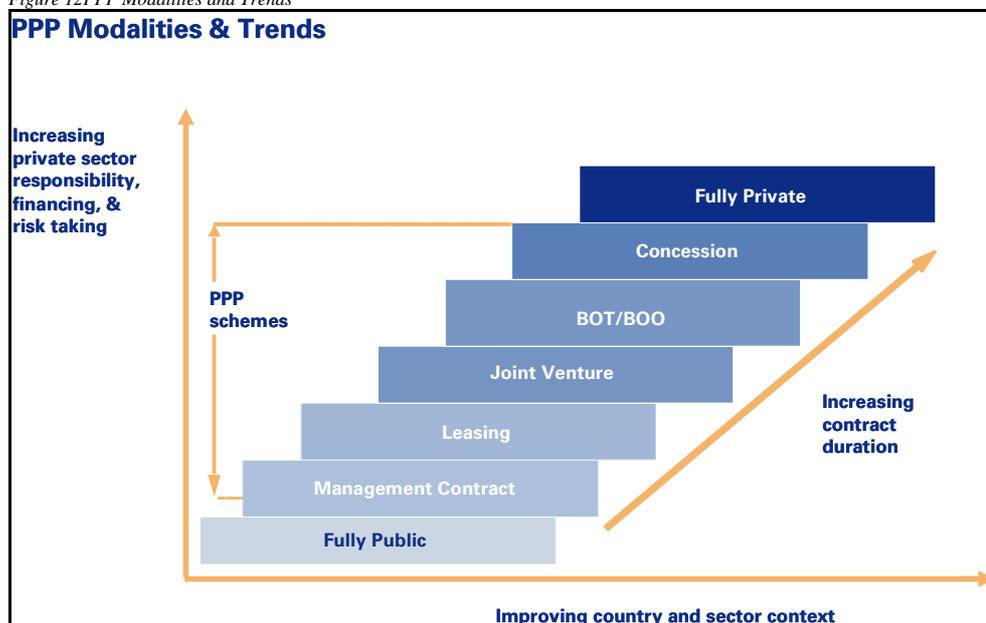


Table 7 Different types of PPP models

Management Contract	The infrastructure is owned by public sector with private participation in operating and managing the facility typically for a fee typically to improve quality with the contract period defined and linked to quality of service
Leasing	Public sector infrastructure is on a short to medium term lease to private players who operate the facility with specific buy back arrangements from the government during the lease period in the form of a percentage of beds or other subsidies on capital expenditure ¹¹
Joint Venture	Generally formed as a legal entity or an SPV, with equity participation from both the government and the private players. Government contributions can vary from upfront capital infusion into the SPV, land lease, or financial concessions on capital infused by private player. Equity objectives can be achieved through specific arrangements like a buy-back by government on a certain % of beds
BOO/BOT	<p>The public sector contracts with a private entity to design, build, and operate the capital asset. The public sector remains responsible for raising the required capital and retains ownership of the facility. This type of PPP is also called “Build Own and Operate” BOO</p> <p>The private sector is assigned all aspects of the project. The ownership of the new facility is transferred to the private sector – either indefinitely, or for a fixed period of time. This type of arrangement also falls within the domain of PPP. This arrangement is also referred to as Build Operate, Own, Transfer (“BOOT”).</p>
Concession	This works more like a long term lease where a private player takes over the management of a state owned enterprise including significant investment risks. The ownership and investment decisions during the lease period no longer remain with the state. Government regulation may stipulate a certain percentage of services on identified demand segments through schemes like prepaid vouchers.

¹⁰ Asian Development Bank report on PPP in Health and Education Sectors in India, April 2008

¹¹ Public-Private Partnerships: Managing contracting arrangements to strengthen the Reproductive and Child Health Programme in India, A WHO-IIMA report, 2007

Among these frameworks, the one that is most likely to work in any Indian context is when there is a good balance of private and public sector interests. At an implementation level, any of these frameworks could be taken up and adopted at different levels of central or state government participation or across different regions in India, with suitable customization to suit all stakeholder interests.

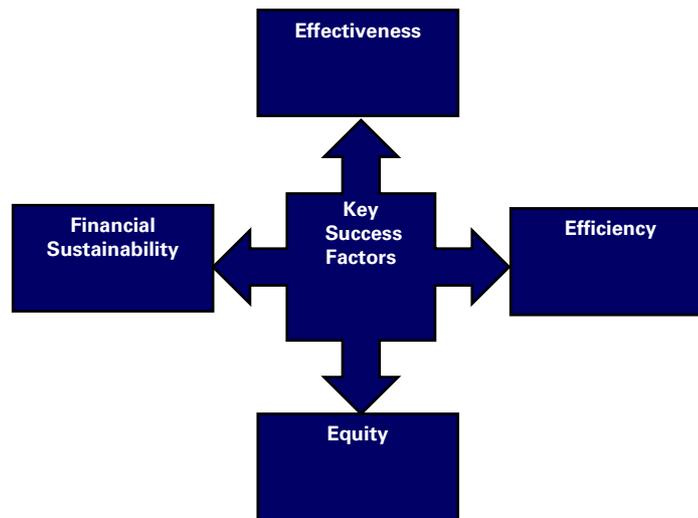
5 Evaluation of PPP Models

While adopting any PPP framework for customization into a model, it is necessary that the model's viability is evaluated upfront before the private and public sector participants proceed with the PPP planning and implementation. For any model, there are some key success factors upon which it has to be evaluated and a framework for the same is discussed in the following section.

5.1 Evaluation Framework

The proposed evaluation framework uses the following four considerations to assess the success of a Public Private Partnership model.

Figure 13 PPP Evaluation Framework Model



- 6 **Effectiveness:** The ability of the program to meet the objectives it was originally set out to achieve. An important element of this assessment is clarity of the objectives laid down by the program and ability to measure the success through identified and measurable outcomes.
- 7 **Efficiency:** This section evaluates the cost efficiency of the program in achieving its objectives. It evaluates the financial consequences to the public sector vis-à-vis risk transfer achieved.
- 8 **Equity:** This relates to evaluating whether the benefits of the program accrue to the low income/ below the poverty line/ targeted sections of the society and does not subsidize the cost of service provision to richer sections of the country.
- 9 **Financial Sustainability:** This section deals with the financial viability of the program including bank-ability and private sector appetite in delivery of the program.

The Evaluation Framework has been further elaborated in the table below, with various questions and issues that the public sector should consider while evaluating its model.

Table 8 Evaluation Parameters for PPP models

Evaluation Parameters	Questions to be considered
A. Effectiveness	
Level of success in meeting its objectives	<ul style="list-style-type: none"> • Has the procuring authority set out clearly the outcome it would like to achieve through the program and the standards for the service provision to be delivered? • Is there a fit between the needs of the sector to be addressed and the outcomes proposed to be achieved? • Has there been an improvement in the achievement of outcomes set out at the outset of the program? What is the level of improvement in the outcomes?
Effectiveness in monitoring the delivery of the program	<ul style="list-style-type: none"> • Does the program describe the service provision in clear, objective, measurable output based terms? • Can the service provision be assessed against an agreed standard and are there mechanisms to evaluate the same on a regular basis? • Is the payment mechanism structured to incentivise the private sector for delivery of the service to standards? • Is the private sector responsible for achieving the improvement in outcomes?
Scalability	<ul style="list-style-type: none"> • Does the program look at whole life costing i.e. construction cost, operating and maintenance cost? • Is there sufficient private sector appetite for building a pipeline of projects under the program? • Does the public sector have enough financial and management capability to procure more projects under the program? • Does the program provide an economic return to the private sector under the program?
Local stakeholder buy in	<ul style="list-style-type: none"> • Does the program involve the local stakeholders such as Panchayats in the procurement of the private sector party under the program? • Is there a consultation process before and during the procurement to incorporate and address the concerns and requirements locally?
B. Efficiency	
Value of Money analysis	<ul style="list-style-type: none"> • Does the current model provide an effective way of risk transfer to the private sector, particularly for time and cost overrun risks in case of large construction projects? • How does the program compare with other options available to the public sector? • Is there enough operational flexibility (at an acceptable cost) in the contractual structure over the lifetime of the contract?
Affordability (public sector support)	<ul style="list-style-type: none"> • Is the program within the procuring authority's spending allocation and expected future allocations from Centre and State levels?
Cost of developing the monitoring mechanism	<ul style="list-style-type: none"> • Does the public sector require a wider monitoring mechanism outside the contract to be able to monitor progress under the program?
C. Equity and political considerations	

Evaluation Parameters	Questions to be considered
Ability to benefit the poorer and not subsidize the rich	<ul style="list-style-type: none"> Does the program benefit the sections of the society targeted by the program i.e. below the poverty line or rural communities? Does the program subsidize the public service provision to higher income groups and thereby crowding out the availability of the service to poorer sections?
Political Resistance	<ul style="list-style-type: none"> Is there sufficient political will to undertake the reforms that will be required to implement the program? Does the program affect large sections of unionized or organised groups?
Need for wider public sector reforms	<ul style="list-style-type: none"> Are there any regulatory or legal restrictions that affect the service provision under the contract? Does the program require wider sectoral reforms related to finance and accounting, transfer of personnel, and introduction of user charges?
D. Financial sustainability	
Economic return to private sector	<ul style="list-style-type: none"> Do the revenues accruing to the private sector allow for economic return on its capital invested? Is it possible to generate third party revenues alongside the payments received from the Government for management of public services? Is there the financial return to the private sector commensurate with the risk transfer proposed in the program?
Financing risk	<ul style="list-style-type: none"> Is it possible for the private sector to raise financing for participation in the program?
Private sector appetite and capability	<ul style="list-style-type: none"> Is there adequate financial, technical and management capability within the private sector to deliver the services envisaged under the program? Has the private sector shown interest in working with the public sector on this program?

It is recommended that the above Evaluation Framework be visited regularly while developing any PPP model. Furthermore, as the public sector progresses on the developing its business case for the PPP model under consideration, it would be in a position to evaluate the above questions in more detail and in some cases quantify (affordability and performance standards) outcomes.

A sample case study where this evaluation framework has been used is provided below. The evaluation is for the PPP initiative in state of Tamilnadu in India, which covered specific arrangements as listed below, between the state government as the major provider of services and other private parties.

1 Outsourcing contracts for soft facilities management services in hospitals

In order to enable Government hospitals to have more efficient and economical administration, the State Government has outsourced support services such as sanitation, security & catering. This has been undertaken in small scale at individual hospital levels on annual contract basis.

2 User fees for specified diagnostic procedures

Fees for diagnostic services such as laparoscopy, laparoscopic sterilisation and laparoscopic minor investigation have been introduced. Further services like laboratory, nursing, paramedical and sanitation have been outsourced for paying wards; and the charges are met from the fees

collected. This has been a fairly successful model that has been used within the State. However, drugs and diet requirement of patients in paying wards is met from the regular hospital services. Rates for minor, major and special investigations have been fixed. These charges are levied only from patients staying in special class maternity wards.

3 Primary Health Care adoption schemes with voluntary sector

The Government has a scheme for adoption of rural primary health care centres by NGOs for corporate social responsibility action. The service provision included maintenance of existing infrastructure and supply of doctors and support staff for management of the health centres. This is being done on not-for-profit basis and the NGO network enables the Government to provide local support system for its health provision. The State Government pays an annual / monthly fee for the adoption of primary health care centre.

4 Management and operation of ambulances under NGOs for providing emergency obstetric services

The Government pays an annual cost to the NGOs for maintenance and operation of ambulances including provisions for driver and health staff. The ambulances are owned by the State under this scheme.

Table 9 Evaluation of Healthcare PPP in Tamilnadu, India

Evaluation Parameters	Option 1 Ambulance and Motor Operations	Option 2 Diagnostic Services	Option 3 Facility outsourcing and management contracts	Option 4 PHC Adoption Scheme
A. Effectiveness				
Level of success envisaged in meeting its objectives	Medium Due to the accessibility issues, the potential for success of this initiative appears to be good	High This is likely to improve utilisation of public diagnostic facilities	Medium The success of this initiative largely depends on effective monitoring	High As this project will be financed primarily by the private sector – in a small scale scenario this project will work. Scalability to cover the State is not possible
Effectiveness in monitoring the delivery of the program	Medium IT systems and human supervision may to be used for monitoring	Medium IT systems may be partly used for monitoring	Low Manual supervision is largely required	Low Manual supervision is largely required
Potential scalability	Low State will be required to make significant investment in hard assets to increase scalability	Medium The scheme is more scalable in urban areas	Low The smaller size of rural hospitals might dampen private appetite for such projects	High Not many Private Sector donations / NGOs may be available to scale up the scheme
Local	Low	High	High	Low

Evaluation Parameters	Option 1 Ambulance and Motor Operations	Option 2 Diagnostic Services	Option 3 Facility outsourcing and management contracts	Option 4 PHC Adoption Scheme
stakeholder buy in required	Some buy-in from local communities required	Active buy-in and sponsorship from local Panchayat and communities is essential	Active buy-in and sponsorship from local Panchayat and Unions is essential	Some buy-in from local communities
B. Efficiency				
Value of Money	Medium	Medium	Medium	Medium
	The health coverage in rural areas will increase significantly	The utilisation of public diagnostic facilities will increase once doctors are required to refer patients only to public diagnostic facilities	The scheme could potentially result in better services for the same amount of money spent	The scheme could potentially result in better services for the same amount of money spent
Affordability (public sector support)	Low	Medium	Medium	Low
	The initiative is likely to require significant public sector support	The initiative is likely to require significant public sector support	The investments required will be mainly for labour and training	The initiative is likely to require significant public sector support
Cost of developing the monitoring mechanism	Medium	Medium	Low	High
	Monitoring would be mainly IT based	Monitoring could be partly IT and partly manual supervision based	Monitoring likely to be manual supervision based	Monitoring likely to be constant manual and IT supervision based
C. Equity and political considerations				
• Ability to benefit the poorer and not subsidize richer sections	Medium	Medium	Low	Medium
	Targeted service is possible	Targeted service is largely possible	Targeted service is not possible	Targeted service is largely possible
Political resistance to current initiative	Low	Low	High	Low
	Political resistance would be low in absence of user charges	Political resistance would be low in absence of user charges	Unionism of public employees could be an issue	Political resistance would be low in absence of user charges
Need for wider public sector reforms	Low	Medium	Medium	Low
	Major public sector reforms not envisaged	Might require polices mandating doctors to refer patients only to public diagnostic facilities	Major changes not envisaged. However, public sector buy-in required	Major public sector reforms not envisaged

Evaluation Parameters	Option 1 Ambulance and Motor Operations	Option 2 Diagnostic Services	Option 3 Facility outsourcing and management contracts	Option 4 PHC Adoption Scheme
D. Financial Sustainability				
Current ability to generate third party revenues	Low A not a profit model – unlikely to generate any third party revenue	Medium Low/moderate levels of income at current scale	Low Low levels of income at current scale	Low Low levels of income at current scale
Financing risk	High High given investment and demand risk.	Medium Moderate given investment and but lower demand risk.	High High given potential political resistance.	High High given investment and demand risk
Private sector capability	High Private sector capability is high; however, some expertise in similar operation management will be helpful	High Private sector is strong in this segment	Medium Private sector is strong in this segment. However, some experience in hospitals will be helpful	Medium Private sector is strong in this segment. However, some experience in Primary Health Care will be helpful
Private sector risk appetite	Medium The Private sector risk appetite likely to be moderate, given the financing risk involved	Medium Moderate financing risk	Medium High financing risk partly offset by lower level of investments	Medium The Private sector risk appetite likely to be moderate, given the financing risk involved

The above example outlines the evaluation consisting of a rigorous analysis on various stakeholder capabilities, risks and expected trends that help to communicate the assessment effectively between the private and public sectors.

5.2 Risk Allocation and Sharing

One of the key parameters for evaluating PPP programs is the degree of risk transfer they achieve through the contractual structure. The basis of the risk transfer is that the risk is borne by the party that is best able to manage the risk. Following are some of the key risks involved in any PPP arrangement.

- Design risks
- Construction and development risks
- Performance risks

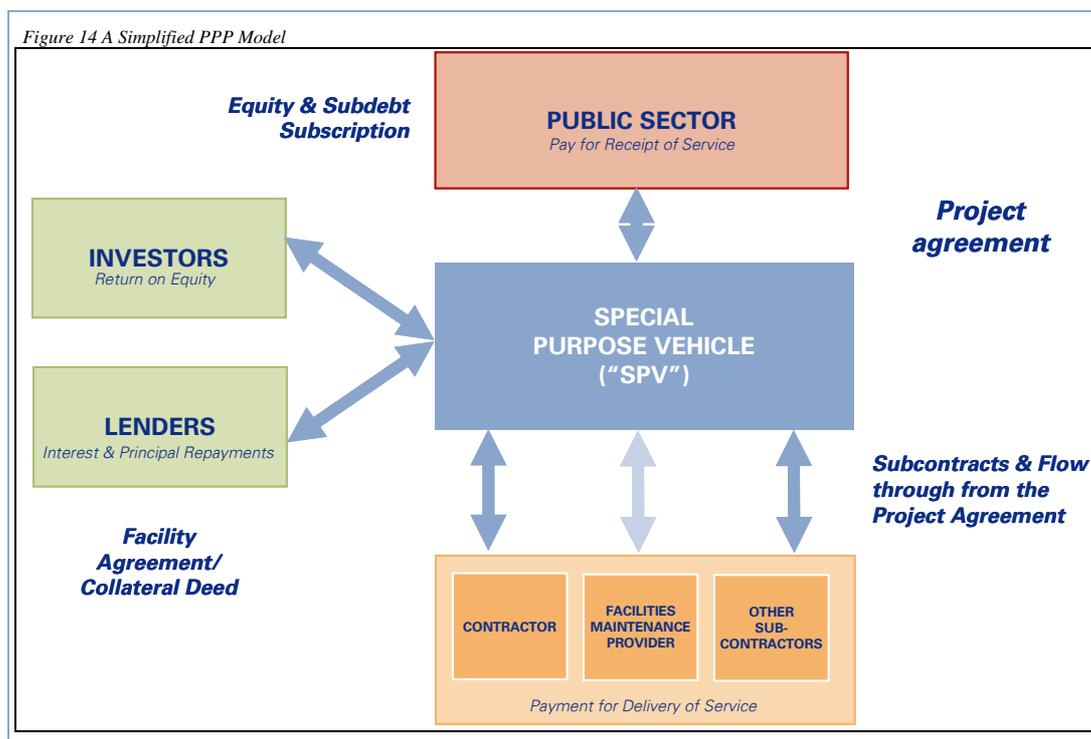
- Operating cost risks
- Variability of revenue risks
- Termination risks
- Technology and Obsolescence risks
- Residual risks

As the blueprint for the PPP is developed, it is essential that both the public sector and private participants discuss the following risks and develop a detailed list of all specific items under the above heads. A clear picture of the above risks will serve as a vital input for the evaluation framework used for evaluating the PPP model.

6 Recommendations

6.1 A simplified PPP model

Any model derived from the framework discussed earlier needs to have good balance between the public sector objective of providing equitable healthcare services with the private sector perspective of building a scalable and financially sustainable business model. The diagram below is a simplified PPP model represented with some essential features.



Source: KPMG research

In such a model, an SPV is formed for a specific period and for a specific purpose clearly stating the healthcare business objectives of both private and public sector players. Private sector involvement can span across roles such as investing, lending and operations management. **Public sector involvement provides for maximum impact and benefit when it is along the following cardinal principles:**

1. Providing help in infrastructure set-up especially in areas like land acquisition. Healthcare must be reachable by the beneficiaries within a reasonable time and distance, and therefore prime land at subsidized rates could reduce the investment cost and consequently the price of healthcare services
2. Structure the PPP specifically through equity participation where possible or infuse debt at subsidized cost of borrowing and provide an extended tax holiday
3. Provide budgetary grants for capital and operating expenses of the systems covered under the PPP where possible

4. Ensure a non-compete policy within a predefined geographical limit where the PPP facilities operate to ensure growth and sustenance of the model
5. Have complete control of furthering the policy objectives of increased and equitable healthcare through buy-back arrangements where a percentage of beds in units are reserved for beneficiaries identified by the government. In these cases, the government will pay for the services received, and the payment will be structured based on the larger financial context of the PPP where the government may have subsidized capital or costs as mentioned in the previous points

For a private player in such a PPP, it is important to adhere to the following cardinal rules for building a scalable and sustainable business model in healthcare:

1. Identifying the need for the project and establishing project objectives clearly
2. Identifying and sharing all risks associated with the PPP upfront and risk ownership roles clearly defined
3. Defining Performance Measurement metrics or Key Success Factors for evaluating the performance
4. Developing and communicating a clear strategy for growth and increasing scale
5. Maintaining clear and frequent communications to all stakeholders
6. Extensively using technology to plan, implement and communicate¹²

Within this PPP model, specific innovations can be achieved in the implementation leading to different models of building the healthcare industry in the country.

6.2 Operationalization Next Steps

While it is important to have a robust model for the PPP initiatives it is equally important to develop an execution framework. In most of the cases where the PPP models have failed the reason for failure has not been the model but it was more to do with the execution. In the Indian context for a health care PPP initiative to succeed some of the following aspects needs to be in place

- **Private Sector participation in the PPP governing body** – The governing body in the Health Ministry with a mandate to oversee PPPs currently does not include private sector participation. For ensuring equitable representation of both private and public sector interests, it is necessary that the governing body includes members nominated from the private sector also.
- **Identify priority sectors and regions** – Government should study the breadth of the healthcare landscape and benchmark the standards with other developing and developed

¹² PPP in Healthcare – Models and Options, KPMG presentation to CII, 2008

countries and identify critical areas and gaps. These needs to be done keeping in mind the regional disparity that exists. The government can then look at involving private participation for addressing some of these gaps.

- **Identify level of participation** – The PPP governing body needs to evaluate the PPP model recommendations and identify the right level of participation on areas like funding and equity stakes. There needs to be clarity on what each party would bring in and what controls each can exercise.
- **Run pilot campaigns** – Pilot projects can be implemented to test the viability of the model before a full scale implementation. While this will enable to address any gaps in the model it will also help in translating the benefits of PPP in a tangible form.
- **Adopt measures for scalability** – The models also need to be evaluated on the scalability dimension. To ensure scalability the following aspects can be looked at
 1. Standardization of process should be achieved maybe through some form of accreditation mechanism.
 2. The regulatory and government bottlenecks which exist in expanding across states needs to be addressed.
 3. Provide for long term funding through options like creating a special reserve, project financing etc
 4. Run national campaigns to educate the public and internal staff on the merits of PPP
- **Advocacy** – Transparency and information flow on PPPs assume even more critical importance in India because of concerns about political patronage and favoritism, in addition to the general public's fear about PPPs being a façade for privatization. Because of the asymmetrical growth of the private sector in health in India, the ability of governments to direct the growth of PPPs for the larger public good is in doubt. The central and state governments must reassure the public about the PPP process. Information on subsidized inputs, the process and criteria of choosing partners, monitoring standards and consumer rights must be out there in the public domain. This will not only secure the trust of the public, but also establish a fair competing ground for private providers wanting to partner with the public sector.¹³

¹³ Legislative and institutional framework for public-private partnerships in India, Transatlantic Partners

7 Conclusion

There is an air of optimism surrounding PPPs in India. Used judiciously and fitted to local circumstances, they clearly have the potential to drastically change the healthcare landscape in India. PPPs will survive only if the interests of all stakeholders are taken into account. This means detailing specific roles, rights and responsibilities, establishing clear standards, providing training for public sector managers, active dissemination of information, and constantly refining the process to make the system more efficient. The public sector has to lead by example, and be willing to redefine itself and work with the private sector. The latter must in turn be willing to work with the public sector to improve mutual cooperation and understanding.