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ANALYSIS

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Public-Private Partnerships in Health Care: China and India

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Public-private partnerships (PPP) as an idea are not new to the developed and developing world and have been one of the main forms of reforms in many sectors – including the health sector – in lower and middle-income countries. Given the lack of revenue in the government to invest in health services, these partnerships with the private sector are viewed as a way out, providing a source of greater investments and filling gaps in delivery of clinical and/or non-clinical services. These partnerships – seen to be improving the 'efficiency and effectiveness' of the health services – have to be viewed as a continuation of the process of commercialisation of the health sector. The rationale and logic for these partnerships are informed by the principles of the new public management approach that formed the basis of the health sector initiatives of the 1990s.

In May 2016, the Shanghai Health Development Research Center (SHDRC) organised a workshop to present the different models of PPPs being piloted in the tertiary public hospitals in China. The Center was also keen on learning from the Indian experience as China is a late entrant to experimenting with the idea of PPP. Partly, the reason for the late entry is that the private sector is not very mature and government policy has been careful in opening the social sector to foreign investment.

There are varied definitions of PPP in the research literature. A frequently used definition of PPP is: 'a long term contract between a private party and a government entity, for providing a public asset or service, in which the private party bears significant risk and management responsibility, and remuneration is linked to performance' (World Bank 2015). This definition does not hold for many PPPs in middle- and low-middle income countries like China, India and a number of Asian countries. In many of these countries, these partnerships are varied and may not strictly adhere to the standard definition. This is because these partnerships are not merely technical, managerial or administrative interventions; the socio-political and institutional contexts in

which these partnerships are forged make each case unique.

The question of power relationship and dynamics between the partners raises potential contradictions and sometimes conflict that is an important determinant of the functionality of the partnership.

PPPs in Health Care in India

India has a longer history of PPPs in health with most of the National Health Programmes partnering with non-profit and for-profit organisations from the 1st Five-year Plan itself. The government sought these partnerships in order to generate demand for services, impart health education and to a lesser extent to deliver services.

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A large number of the PPPs were at the primary level care. The Family Welfare Programme offered subsidies to NGOs to create demand for sterilisations during the 1970s. Later on, they partnered with private nursing homes and specialists to offer sterilization services in order to meet the targets set by the government. Another important area of partnerships was centred around the immunisation programme. Here again, there was both demand generation and service delivery. Several disease control programmes initiated partnerships with the non-profit and for-profit sectors. These were simple partnerships with the government playing a dominant role and the private sector a minor role. The PPPs gained greater legitimacy in the 1990s and underwent significant changes. The architecture of these partnerships ranged from simple to complex type with the simplest involving individual private practitioners, from both the informal and formal sectors. The nature and complexity in terms of design of these partnerships varied across levels of care.

The more complex partnerships were prevalent at the primary and secondary levels with multiple actors. There was a clear splitting of role, authority and power between the partners. The Revised National Tuberculosis Control Programme (RNTCP) and the Reproductive and Child Health Services encouraged the forging of a number of PPPs. Analysis of these partnerships showed that the government set the terms and duration of the contract. It was during the 1990s that PPPs were institutionalised in the health sector with a plurality in the architecture across India. The major form of partnership was contracting-in and contracting-out of services. The other forms were social marketing and social franchising which were fewer in number but more complex and at the primary level. The latter became important parts of PPP designs.

The contracting-in or -out of services at the primary level was restricted to interventions like health education, limited curative services and also of primary health centres to private (mostly non-profit) entities. At the secondary and tertiary level, PPPs were restricted to contracting-out of non-clinical services like laundry, diet, drug stores and diagnostic services in hospitals. The structure of such partnerships could be described as simple and linear involving not more than two or three actors (Baru and Nundy 2008).

There was much variation in the outcomes of these partnerships and what was fairly clear is that the government played a dominant role in setting the terms and monitoring. Considerable amount of corruption was seen in the selection of partners, awarding and extension of contracts. The euphoria over PPPs has now reduced in India partly due to the uneven results; there were also constraints in building these partnerships due to lack of adequate players.

A prerequisite for building partnerships is that there should be free and fair competition in the selection of partners. In several instances, there were so few players that the pool was not large

enough to choose potential partners. This has been well documented in the case of non-clinical and clinical services from both developed and developing countries. The success of the partnership depended on the optimal functioning of all partners, commitment and trust between the partners being a necessary condition (Baru and Nundy 2008).

PPPs in Health Care in China

In contrast to the PPPs in the health sector in India, China has introduced PPPs in the hospital sector only more recently. The piloting of PPPs has been in the tertiary hospital sector. As a strategy it is a continuum of the health sector reform initiatives and a course correction to autonomisation of public hospitals. In 1992, the Ministry of Health granted substantial financial autonomy to all public hospitals, which allowed hospitals to charge for services (World Bank 2010). Newer organisational forms like the State-Owned Enterprises (SOEs) were initiated in the health sector in order to augment financial revenues by introducing mechanisms like user fees, charging for drugs and diagnostics. Hospitals were made responsible for their survival. Autonomisation of public hospitals had resulted in the adoption of perverse revenue generation by individual institutions. This resulted in rising out-of-pocket expenditures and irrational provider behaviour.

The first step towards correcting this was to increase public investment but this could not fully solve the revenue gap. PPPs were seen as a possible way forward. This suited both the government and private sector, because the former was not able to take a firm policy position regarding the direction of hospital reform. This impasse was due to a deeply divisive debate within the Communist Party as well as within the public at large, regarding the future of health reforms. There were those who took a pro-market stance while others saw health as the responsibility of the government. For both ends of the spectrum of this debate, PPP was a viable compromise. Given the policy impasse in the government, private capital was insecure and did not want to venture investment in the health sector.

Private capital perceives the health sector to be a 'high risk' venture with many risks and uncertainties compared to other sectors in the economy. The risks and uncertainties in the hospital sector stems from the fact there are technical, managerial, administrative and human dimensions that need to be addressed. A simple input-output model of financial investment and returns does not hold in the health sector. Therefore, PPPs are a safer option for private capital and the autonomised public hospital that gives enough time to test and ready the waters for a transition from commercialisation to privatisation.

> *In China, PPPs are seen as a safer option for private capital to gain entry and test waters.*

From the case studies presented at the workshop, PPPs in the hospital sector in China are dominated by big capital – pharmaceutical, technology, infrastructure, finance and insurance – fulfilling all the essential features of a medical industrial complex.PPPs will not only fulfil the resource gap but private capital will have to invest in preparing the culture of public institutions to bring about a shift in values for the market. It will partner with public hospitals of repute and work with the senior leadership of these hospitals to bring about the required attitudinal change to the needs of private investment. Two models that were discussed brought out the contours and complexities of the design of PPPs. These are being piloted in Beijing, Shanghai and extended to other first- and second-tier cities. One is an 'entrusted management model' and the other, a 'franchise model'.

Entrusted Management Model

The entrusted management model involves the furthering of reforms in public hospitals. Here, a private entity or big capital gets the management contract to provide support in the functioning of the hospital. In Figure 1,

Phoenix Health Care, a domestic investor provides management support to public hospitals in Beijing.

In addition, Phoenix also has a supply chain business and provides technology/equipment and pharmaceuticals through its supply chains, which ensures profit and consolidates its hold over the hospital.

Despite the differences in the design of these partnerships, both these countries have to grapple with the tension of reconciling the opposing values of the public and private sectors.

In another complex model of 'entrusted management' in Shanghai (represented in Figure 2), the public hospital creates a limited company that is an intermediary. This company gets investment from a private equity firm and capitalises on the public hospitals know-how, success and pool of talent. The group of experts, who are senior doctors from tertiary public hospitals associated with the company visit hospitals in other provinces and train hospital staff on management issues and know-how.

Franchise Model

In the franchise model, on the other hand, tertiary hospitals become franchisers and lend their name to franchisees. Investments are made by a private equity firm that capitalises on the public hospital's name to create franchisee hospitals and provides professional training and management support while ensuring quality.

Contrasting PPPs in India and China

As seen in the sections above, there are contrasts in PPPs in India and China. In the latter, the private sector capitalises on the reputation of public hospitals and there is a commercialisation of the intangible assets in terms of values, reputation and knowledge of the public sector. These partnerships are at the tertiary level and involve big capital.

This is unlike the PPPs in India where these partnerships are mostly at the primary and secondary levels of care. There is a plurality of actors within the private sector as partners. There are both non-profit and for-profit actors. These include a range of community health organisations, individual private practitioners, clinics and hospitals. This is an important contrast to the Chinese context where it is the SOEs that become the 'private' partner, and one could argue whether it is appropriate to term these emerging partnerships in China as a PPP. This is especially so when public hospitals are essentially behaving like private entities, where they are the franchisers. The public hospital is, in essence, a government-created private entity that partners with both domestic and international private capital. This is clearly very different from the Indian scenario.

Contrasting the two different contexts of PPPs, one can discern the variations in design and the levels at which these PPPs have emerged in India and China. To summarise, in India majority of the PPPs are at the primary level that includes private individual practitioners, clinics, small nursing homes and community health organisations.

In China, these partnerships are with tertiary levels multi-speciality hospitals. The design of these partnerships is complex and involves multiple actors and intermediaries. Despite the differences in the design of these partnerships, both these countries have to grapple with the tension of reconciling the opposing values of the public and private sectors. While the former represents the values of equity and social justice, the latter is motivated by profits. It would be interesting to watch how China deals with these tensions as they experiment with PPPs.

Figure 1:

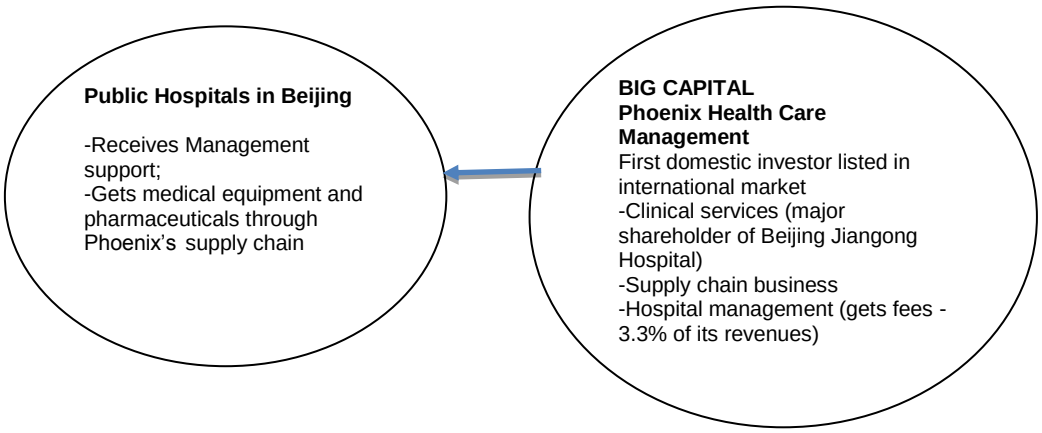


Figure 2:

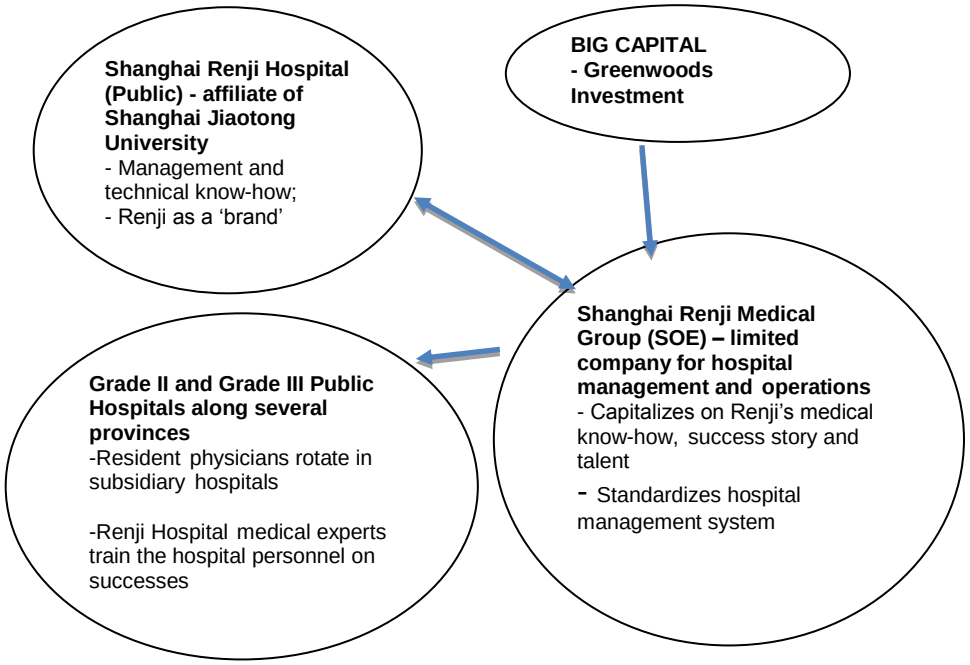
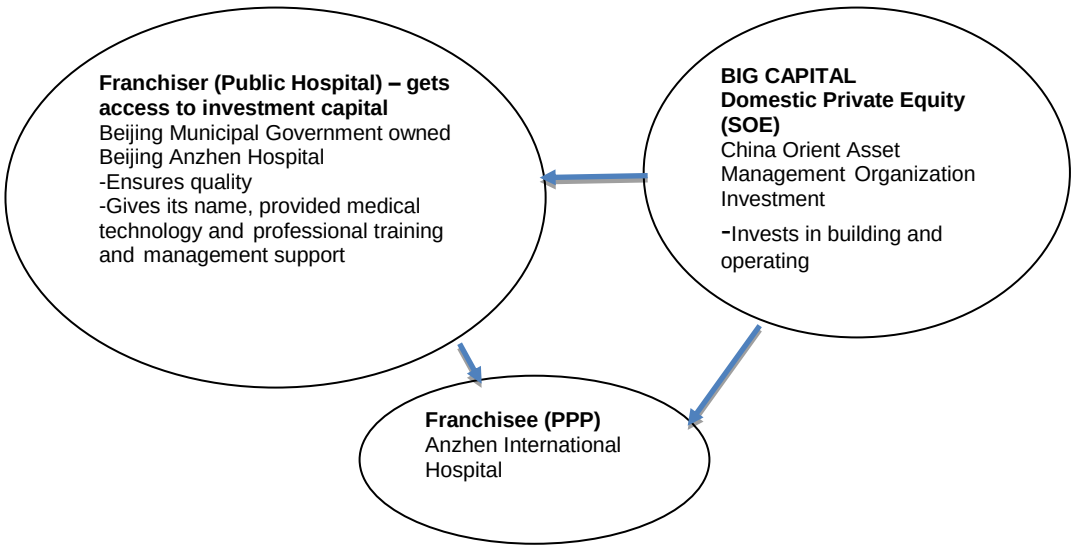


Figure 3:



Endnote

The analysis on China is based on the authors' participation in the seminar on Public-Private Partnerships in Health Care: India and China organised by the Shanghai Health Development Research Center (SHDRC), Shanghai in May 2016 and interactions with public health scholars in Shanghai. The SHDRC is a collaborative partner of the Institute of Chinese Studies; School of Social Sciences, Jawaharlal Nehru University and the School of Public Health, Fudan University.

REFERENCES

Baru, Rama and Madhurima Nundy. 2008. Blurring of Boundaries: Public-Private Partnerships in Health Care, *Economic and Political Weekly*, Vol. 43, No. 4, p. 62-71.

World Bank. 2010. *Fixing the Public Hospital System in China*, World Bank: Health Population and Nutrition, East Asia and Pacific Region, available at http://documents.worldbank.org/curated/en/947791468242107797/pdf/584110NWP0V20P10No21Hospital0Reform.pdf (accessed on 23 September 2017).

World Bank. 2015. *What are Public Private Partnerships*, http://ppp.worldbank.org/public-private-partnership/overview/what-are-public-private-partnerships (accessed on 2 July 2017)

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