Public Private Partnerships

Reflecting on 20 years of theory and practice

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Health Policy Primer - 4
Public Private Partnerships : Reflecting on 20 years of theory and practice
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Background: PPPs in the discourse of Health Sector Reform and Universal Health Coverage:

One of the big hopes and directions of health sector reform over the last three decades have been the Public Private Partnerships (PPPs). PPPs have been used in India's health-system since 1995. The nation thus now has over 20 years of experience of implementing PPPs in health-sector. So there is a need to reflect back on this experience with PPPs.

The discussion on PPPs has a renewed importance at a time when Universal Health Coverage has become the main framework within which goals, directions and processes of health systems are discussed. Officially international organizations insist that Universal Health Coverage does not imply any one road- map and nations are free to choose their own road map. But three features characterize the discourse that comes along with this UHC concept:

a) It dismisses any discussion of what can be done to strengthen free or subsidized care by public providers; and equally important fails to discuss how health sector reforms promoted as part of a neo-liberal understanding were at least in part responsible for the poor performance of the public sector.

b) It insists on shifting the role of the government from being a provider to a purchaser of health care services. It argues for separating the Government's role of purchaser from that of being a provider. Purchasing is supposed to replace the traditional role of 'planning', give government the levers of

financial incentives for improving performance and build competition or contestability between public and private providers so as to make use of market mechanism for improving efficiency.

It believes that competition and choice is essential for ensuring quality of care and efficiency in services, but acknowledging that there is market failure, calls for governments to make the purchase, on behalf of the users, from public and private providers or provider networks.

		Who is the Provider of Health Services	
		Govt. Provider	Private Provider
Who is the payer for health services	Government Pays	A. Govt. hospitals providing free care. Most Govt. hospitals are like this.	B. Private hospitals paid by Govt. on behalf of patient
	Private Payer (individual or family)	C. Govt. hospitals whose main source of funds is user fees	D. Private hospitals paid by individual patients. Most private providers are like this

If we categorize all hospitals and health care facilities into four groups A to D as done in the table above, then we can understand that currently most hospitals are either in category A (if they are government owned) or Category D if they are private. The direction of reform is to enlarge the category B. Category B is obviously 'purchasing'. But health economists like to call the category 'A' also to be part of 'purchasing'. A part of the above discourse further recommends Government to 'purchase' from its own efficient facilities by entering into contracts with them.

How is purchasing done? One route is insurance- where private hospitals are empanelled, and after a patient has visited the hospital. He or she is billed, but the bill is paid for by the government, usually through an insurance company, but it could be directly as well. The other is through what are called public private partnerships, where government has a contract with a private agency, and the contract specifies how much they would pay for the services that the agency provides. These services may range from just some part of the care provided- like ambulance services or diagnostics, or it may be for all aspects of care.

Much of this was part of the earlier health sector reforms of the 1990s also. Promoting health Insurance was mooted by the World Bank as a form of promoting private markets in healthcare. Public private partnerships were promoted as a form of shifting from public to private providers. In the usual forms of privatization, payment is left to the consumers, but in these partnerships it is government who is the main or even sole payer.

What is new now is this term 'strategic purchasing'.

Strategic Purchasing: A new term and its multiple meanings:

In what way does strategic purchasing differ from passive purchasing? There are many ways that this is explained. Some call paying public providers directly as passive purchasing, and all the rest as strategic purchasing. Others use it to denote- that the purchasing is not done keeping only the current market rates and structure in mind- but meant to influence the structure and functioning of the market and/or achieve other strategic goals. Thus within India's National Health Policy 2017, itself there is more than one definition of what is 'strategic purchasing'. In paragraph 13.6 of the Policy it is described thus:

"The health policy recognizes that there are many critical gaps in public health services which would be filled by "strategic purchasing". Such strategic purchasing would play a stewardship role in directing private investment towards those areas and those services for which currently there are no providers or few providers. The policy advocates building synergy with "not for profit" organizations and private sector subject to availability of timely quality services as per predefined norms in the collaborating organization for critical gap filling." (National Health Policy, 2017, section 13.6, pg 63),

The above description emphasizes government's role in directing investments of commercial private sector towards 'critical gaps' in healthcare as the 'strategic purchasing'. But in the earlier part of the same policy, the 'strategic purchasing' is explained as follows:

"The policy envisages strategic purchase of secondary and tertiary care services as a short term measure. Strategic purchasing refers to the Government acting as a single payer. The order of preference for strategic purchase would be public sector hospitals followed by not-for profit private sector and then commercial private sector in underserved areas, based on availability of services of acceptable and defined quality criteria. In the long run, the policy envisages to have fully equipped and functional public sector hospitals in these areas to meet secondary and tertiary health care needs of population, especially the poorest and marginalized. Public facilities would remain the focal point in the healthcare delivery system and services in the public health facilities would be expanded from current levels." (National Health Policy, 2017, section 3.3 pg 11)

The presence of above seemingly contradictory and at the same time overlapping definitions of strategic purchasing in the same policy is not an error. It is reflective of one of the most contested

areas in health policy, which is the question of the extent and scope of government as a purchaser of services as compared to government as provider.

In this note, we shall be considering the experience with different forms of contracting private sector to provide public services, which is what is usually referred to as Public-Private-Partnerships. We will not be considering insurance and other forms of demand side financing, as that is covered in another accompanying paper.

Theoretical Expectations of PPP (Public Private Partner ship):

Public Private Partnerships are meant to close critical gaps- that much is clear. There is however much variation in what is called a gap and the extent of the gap, and therefore the scope of PPPs. To those who for reasons of ideology do not believe that public systems will or should *ever* deliver, PPPs are only a form of slowly and steadily shifting all healthcare, or as much of it as possible, into a "private-provisioning, government purchasing" mode. To others who think that public sector performance can be improved, PPPs can become an important route to ensure performance of public health systems.

The question for the latter is: "Why should the government ever choose to contract a private agency when it could have organized the services with its own workforce." There are many explanations for this:

a) *"Incentive Environments" that "align agents with principal":* PPPs are expected to perform better because they are governed by explicit contracts. In this understanding the main reason why public systems are dysfunctional is because public provider and the manager of a public facility

get their salary irrespective of outcomes. They have no incentive to perform better, and indeed they may get into trouble if they try to innovate. Further there may even be poor clarity about what are the desired outcomes. The functioning of an organization and individuals within it is analysed as made up of principals (for whose benefit the organization is run) and agents (those who carry out the necessary functions). In healthcare system, the principal is the public, or service user. The principal is also the government, especially if the government is the payer. The agent is the hospital or healthcare manager. The manager is expected to work in the best interests of the beneficiary or the payer, but in reality the organization or its managers may have their own self- interests and priorities, which may overshadow the interests of the principal. The contract makes explicit the outcomes that the principal wants and then the terms of the contract are written such that payment is organized that the interests of the agent are now better aligned with the interests of the principal. Or in the language of this framework- the incentive environment is created that aligns the interest of the agent with the principal. The contract will offer rewards if the performance is good and impose penalties if the performance is poor or terms of the contract are breached.

b) *Efficiency*: A related set of reasons to argue for PPPs relates to the notion of efficiency. Here the belief is that if the private agency to provide the services is selected by competitive bidding, then we can get the lowest possible rate for the same level of outcome. Private agencies can do the same job as a public agency at a lower cost, because (i) their managers will make the workforce work harder and better and (ii) private agencies innovate- they can find new

ways of doing the same job for less funds (iii) the behavior of providers and overall quality of service will be better and therefore they would attract more patients for the same level of funding.

c) *Organizational Capacity*: A completely different reasons for PPPs is to say that the government does not have the capacity to organize a particular service and therefore it expands its own capacity to hire in private agencies which can play that role. The lack of capacity could take the form of lack of persons with requisite skills and technical knowhow, or it could take the form of the presence or absence of enabling framework of rules and regulations for recruiting staff, for managing funds, for procuring technologies or commodities, for monitoring staff and so on. This reason is more consistent with the understanding of purchasing or PPPs for 'critical gap closing.'

d) *Human Resources Gaps- especially specialists:* One argument for PPPs has been that close to 80% of specialists and even doctors are in the private sector- and we will need PPPs to harness their skills to achieve public health goals. *Because it is there: Another persuasive argume*nt for engaging with private sector is simply 'because it is there.' (Sir Edmund Hillary when asked why he climbed Mount Everest, is said to have replied: because it is there.) When clos*e to 70% of patient* care is from the private sector, government policy cannot ignore its presence and its impact on people's lives. Also within the private sector, there are many ethical providers who are making an effort at relief of suffering and the reduction of mortality. So there is a need to construct ways of engaging with private providers- and PPPs could be one important way.

Other ways of engaging with the private sector so as to support the ethical care provider and shape markets are regulation, insurance and through supportive training and guidelines.

Recognizing the multiple expectations and roles of public private partnership, the Peoples Health Movements evolved an understanding on PPPs that it presented to the National Health Assembly – II held in March 2007, in Bhopal. To quote:

" JSA is opposed to privatization of public health services but recognizes that "the private sector is here to stay for decades to come and that it contributes the major share of all health care provision, and that it is therefore essential to engage with it to ensure that it also contributes to public health goals……The two forms in which popular pressure is forcing the government to move into is an opening up of health insurance programs and a pressure to reimburse expenses of treatment incurred in the private sector. A number of poorly worked out schemes have emerged in this area – most of which would not be viable if scaled up and fully utilized.

Recognizing these pressures, the people's health movement proposes a framework that enshrines the following eight principles:

1. Clearly demarcate the commercial private sector from the not-for profit voluntary sector in health care provision and treat them differentially.

2. Quality and Cost Regulation of service delivery and a transparent system of monitoring would have to be in place and these should be structured such that it can be expanded into a system where all private and public health facilities are eventually so monitored. The systems of contracting have to be friendly to such monitoring and have the ability to prevent inappropriate care and costs.

3. That the mechanisms of access to the poor are clearly defined and there are mechanisms of enforcing its adherence. These could be through social security/insurance options or other demand side financing options or it could be through reimbursement to the hospitals for their management of the poor.

4. That PPPs should supplement and strengthen public sector but not substitute or weaken existing public health care services.

5. Expanding/bringing in investment working for the public health goals: Which would mean no transfer of assets and resources from public ownership into private hands. This should be acceptable, as the efficiency of private sector is critically dependent on it having to invest its own capital in it.

6. Prompt payment with dignity for the private sector partners so that ethical low budget proprietary services in smaller towns are favoured;

7. Ensuring that efficiency is based on better management practices and not based on unfair wage structures and compromised social security benefits, especially for women health care providers like ANMs and nurses;

8. Exclusion of private nursing homes where government servants are providing services from such a framework – to avoid a conflict of interests. "

It is worth noting that some of these principles had made their way into official government documents as well, especially the report of the task force on PPPs that came out at the time of initiation of the NRHM.

However as reviews of PPPs in India have stated, there has been considerable lack of clarity within governments on the policy framework for PPPs in (a) terms of objectives and scope of the services to be delivered, (b) costing of the services, (c) performance indicators including indicators for quality, (d) payment mechanisms, (e) contract management, and (f) ensuring equity for the poor. In terms of performance a small body of research has emerged, but most of these are in the nature of documentation of specific PPPs, often commissioned by their funding agencies. There is little information on effectiveness in terms of health outcomes, or in terms of efficiency, or on longer-term sustainability. There is also little information on the impact of PPPs on public sector – draining away public health staff, or otherwise weakening or strengthening public sector provisioning. There is so much variation between different PPP models that is difficult to generalize.

The scope of this review:

In the year 2005, the lack of understanding was understandable, but now with more than 20 years of PPP experience, governments should have a greater clarity. But when it comes to PPP, it is always a call for pushing ahead, not even a serious engagement with past failures to improve future PPP designs. One specific barrier for governments in developing clarity is the lack of institutional memory, in a political context where PPPs have to be pushed (a) as the great solution to all public service delivery problems and (b) as providing space for private sector to participate. The latter objective, which is laid bare in the NHP 2017 (in section 13.6), is a form of economic stimulus and support to private sector by using public funds... Paradoxically, this policy it is often referred to as being "inclusive" which is confusing for activists who have always used the word inclusive to mean ensuring that the poor are not left out of benefits of

public expenditure, and not that the corporate sector is not left out of public expenditure.

Even within Peoples health movements it is time to reflect on what we have learnt from PPPs and what should be its demands in accepting, resisting or shaping such schemes in the coming years.

This paper therefore presents 5 case studies- each of which can be said to constitute a category of PPPs. After presenting each case study we overview the extent of PPPs belonging to that category, and then reflect on what governments have learnt and what they have failed to learn, and the plans for expansion in this area. Based on this understanding a set of peoples demands are formulated.

PPP Category -1: Outsourcing Primary Level Health Care:

Case Study: The Rajasthan PPPs for outsourcing Primary Health Centers:

In Rajasthan in year 2015, initially 30 and then 99 PHCs were outsourced to a number of NGOs and private providers. Initially the outsourcing was all done through a NGO called WISH Foundation, which is an NGO set up as part of a CSR action. WISH Foundation was to help in selection of providers and managing contracts and making payments to them for running PHCs. The 99 PHCs have been distributed amongst 20 NGOs and private agencies, many of whom are local.

Essentially these are management contracts where the entire infrastructure is handed over to the private agency for managing the human resources and the organization of services. Drug logistics remains with the government. User fees are present – but to services outside the selective package of RCH services that government-run PHCs are also focused on.

As is typical of PPPs, there was considerable excitement in the first stage, and in the first year itself there were plans made to expand these services very widely. Outsourcing of another 300 PHCs was planned, but soon had to be given up because of both internal doubts and external pressures.

Two years after the launch of this project, it is not clear what advantages it has conferred. In the choice of the PHCs, no particular effort was made to identify poorly functional PHCs as different from better functioning ones. There were no base-line measures and therefore no proof of any improvement of service delivery, much less health outcomes. There is no evidence of any innovation, or increased efficiency or effectiveness. There is no evidence that they are able to attract or retain or get better performance from their human resources.

The overview of PPPs in outsourcing Primary Care:

Outsourcing Primary health centers to private agencies is not a new idea. It is a repeatedly tried approach over the last 25 years. One of the first efforts was in taking the help of industries to improve the functioning of PHCs in the areas where they were located. This took place even before this was mooted as a reform or made part of a policy. It usually led to a beautification of the local PHC which was also providing healthcare to its workers, but seldom went beyond this.

Then under the sector investment programme, run with European Commission's support, there was a systematic effort to outsource urban PHCs to NGOs and private agencies. This went to scale across many states, Andhra Pradesh, Assam, Orissa were some of the better known models. Since urban areas had little or no primary care provision by government, this could have been a useful supplement. However little of this has survived.

Under the NRHM, there was encouragement to outsource PHCs in remote areas, and under this a number of PHCs were outsourced. Some of these have survived. These have also attracted considerable student research and funding agency sponsored evaluations, which are more in the nature of an analytic documentation. The numbers that started up and closed down are much higher, but little documentation exists of this. We know for example that Bihar went through at least two rounds of outsourcing PHCs in the last decade and after a period of one year or two years, the effort would be abandoned.

Currently 446 PHCs are outsourced across the country, most of which could be in remote areas (reply to a parliamentary question, 7th August, 2018). This is less than 2% of the entire country. Of these there are 99 in Rajasthan, 32 in Odisha (along with 182 sub-centers), 24 in Meghalaya, 16 in Arunachal Pradesh, 5 in Manipur, 2 in Nagaland and 1 in Mizoram. Except for Rajasthan, all the rest are in remote areas.

Under NRHM another area where PPP was encouraged was in the management of Mobile Medical Units. Here the trend is that almost in all states it was initiated as a public private partnership- but over time they relapsed into government organized activity. Currently in only 8 states are MMUs largely under PPPs. In 18 states the MMUs are organized directly by the state department of health. And within these in three states there is minor PPP contribution. In Uttar Pradesh, Uttarakhand and Himachal Pradesh, they started up as PPPs but could not be sustained and are now non-functional. Chhattisgarh, not learning from failure of its previous PPP, has engaged another private operator to run MMUs.

A specific variant of the MMU, are the boat clinics of Assam (15 operational), which serve seriously underserved, and remote islands on the Brahmaputra. These boat clinics are reporting relatively better results.

A third type of primary care PPPs is to support a few not for profit run hospitals to provide primary health care in the area under their program. These are exceptions and there is no effort to generalize from this experience. There is little information on their value addition and most represent a form of public recognition to NGOs which are doing good work.

One very different type of attempt is the sky clinics of Bihar (and Uttar Pradesh). This is a social franchisee network organized by World Health Partners (WHP), an international NGO and funded in a major way by Bill and Melinda Gates Foundation (BMGF). This program had recruited, unqualified health care providers who have set up shop and providing medical care in rural areas of Bihar. The recruits are provided training, supported by a built up brand image, and linked to a telemedicine hub in Delhi which has a number of call center operators with varied quasi-medical qualifications providing online advice. It was seriously pushed in 2012- but one hears very little of it now, and by all indications it has been a non-starter. The WHP team were to ruefully accept that without partnership a primary care model is not economically viable and were looking for a government bail-out, which fortunately did not come. There is so far that the government can be persuaded- and no further.

Yet another social franchisee approach is the Marigold chain of health care facilities in Uttar Pradesh. The agency to which this is outsourced is Hindustan Latex Limited (HLL), a public sector company. And the best that can be said about the best of these is that they survive and a very modest level of performance.

PPPs for Primary Level Care- the theory-practice interface

After 20 years of continued efforts, PPPs for primary level care remain an exception rather than the rule.

Even with the best of the PPPs, all that we can assert is that they were able to survive. There is also no evidence that there is any improvement in services vis a vis the routine government managed PHC. The quality and quantity of services across individual service delivery units is varied- and the variation is much like what is seen in government managed PHCs. In remote area, that these agencies can keep running services is itself seen as an achievement. But it is no better or no worse than government providers.

There is therefore no evidence that any of the advantages of contracting making a positive difference to service deliver outcomes, let alone health outcomes. Contracts have little in the way of incentives and even less room for innovation.

Competition in selection of agencies shows no benefits. The selection of the agency is by tendering- but this brings little competition into play in selecting agencies. Often agencies that are selected have no track record of running services, much less a record of delivering services with quality or more efficiently. It is hard pressed to find any commercial players who are willing to engage, and often those contracted are agencies with considerable social networking presence.

As a mechanism for closing critical gaps in particularly remote areas using dedicated non-commercial NGOs, it may have some role. But they seem to work best by providing a benchmark for services that government providers have a pressure to emulate. In Arunachal Pradesh and Meghalaya, non-functional PHCs were outsourced. But once they became functional, there was pressure on other government providers to also do better. But that did not

lead to outsourcing more PHCs since NGO availability was limited and the existing NGOs could not handle more. Existing NGOs in Arunachal Pradesh, for example would constantly have a high turn-over as whenever government positions were advertised, the nurses and other staff working with the NGO would apply and the get the government appointment.

One caution about PPP outsourcing to close critical gaps in remote areas is about the terms of hiring staff. If the model is reducing salaries of the working team, especially of the nurses- and shifting that to administrative costs, it is hardly a model to support even for such remote areas.

In one of the publications in this series, we have discussed nine barriers that are an impediment to public sector strengthening- investment, human resources, quality of care, selective package of care, governance issues and so on. None of these PPPs have been able to address any of the problems. That is not a reflection on the private agency. Rather it is a reflection on bad theory. Theory that advocates such PPPs had identified ownership of the facility as the key cause for the dysfunction. But we now know that changing ownership does not help, since the obstacles remain. Rather new problems get added on.

These lessons are important when the country goes into health and wellness centers in the Ayushman Bharat mode. In the section 13 of the NHP, there seems to be a high expectation that commercial healthcare players would be able to enter and play a significant role in managing HWCs. Despite letters to states from the center, reminding the states to bring in private players, as yet no state reports any show of interest from commercial sector.

What has corporate sector and its support base among external aid agencies learnt from this experience. One current strand of thinking is that the problem is that these PPPs have been tried on

too small a scale. If it were a large area that was outsourced or a large network that was contracted that could do better. The BMGF has therefore in partnership with Uttar Pradesh government floated a tender to outsource a number of blocks in Uttar Pradesh to corporate agencies. That is over a year ago, it has not proceeded further since then, but by all accounts the BMGF has not lost hope.

In another effort USAID has given a bank guarantee to Healthsprings to take a loan to organize a network of primary care providers largely catering to urban middle class. The idea is to build a business model that can work for primary health care. There are many other private corporate players also entering this market. Very few of them are thinking of themselves as a PPP option. Rather it is one of the attractive private equity financed options. The reports are that these models are either struggling, or that the costs of care are rising steeply.

In the external aid sector, especially in BMGF, there is a lot of expectation that if some of these business models of primary healthcare are successful, then the HWCs could be outsourced to such corporate agencies. However that does not seem to be happening. The one that went furthest was the sky-clinic model- but that could not sustain either. However the USAID, World Bank, BMGF triad has not given up hopes and the situation may change.

PPP category - 2: Outsourcing the Secondary Care Public Hospital

Case Study: The Uttarakhand CHC outsourcing model:

In May 2013, a PPP for outsourcing of community health centres was initiated through a Memorandum of understanding (MoU) between the Directorate of Health & Family Welfare

(Government of Uttarakhand) and two private sector parties. Technical Assistance in this instance was by the Department of Economic Affairs (DEA), Government of India and Asian Development Bank (ADB) for promotion of PPP in the State. Earlier PPPs have had USAID or World Bank Support. All these PPPs clearly draw inspiration from the theories of contracting, incentive environments and principal-agent alignment. Selection is by tendering, bidding is based both on experience of provider but also on the financial bid, there are rewards for performance and penalties for non-performance, not one but cluster of CHCs were to be outsourced, the contract duration was for five years and so on. Clearly the highest quality of technical thinking had supported the preparation of the tender document.

The MoU outsourced 12 selected CHCs. One immediate reason stated for the outsourcing of the CHCs was to help closing the human resource gap in the rural facilities, where the government had failed consistently to provide medical staff, especially the specialists required for emergency obstetric care. The selection process was by open bidding. Two private parties Rajbhra Medicare Pvt. Ltd, New Delhi and Sheel Nursing Home Pvt. Ltd, Bareilly (UP) won the bid for 4 and 8 CHCs respectively. These 12 CHCs are spread over 13 districts of the 2 divisions - Kumaon and Garhwal. One agency had extensive experience in running MMUs over 4 states and the other managed a nursing home and a private university in the neighboring state.

One notable feature of this model was that the primary health centers and the sub-centers in the CHC area were not part of the contract. They remained with the government. National Health Programs that the CHCs were to perform also remained with the government. Only the hospital's curative services- both ambulatory and in-patient were outsourced. They were to be paid a flat rate for each CHC based on their bid- and since the

CHCs were of different specifications, the bidding was per square foot of floor area. Then based on four performance indicators which included institutional deliveries, diagnostics done, they were to be paid incentives. Some of the CHCs were very near urban areas and some were far- so as to give the private agency a good chance of success. Another interesting feature of the model was that user fees were allowed for many services, but this would be collected by a government worker- and not handed over to CHC. Since most of such user fees were around diagnostics, the agency anyway got an incentive for doing more diagnostics.

The PPP was officially launched in May 2013. By May 2014, this was being praised and other states were being welcomed to come and see the success story. By December 2014 there were complaints made mainly related to inflating output figures so as to earn more incentive. There were also complaints that the agreed number of specialist staff were not there. Then complaints from the public arose regarding poor service. By about August 2015, the state stopped payments and in December 2015, just 30 months after signing the MOU, the contracts were formally terminated. But the story did not end there. The private agencies went to Supreme Court and by August 2016 got a stay order, but by November 2016, the court allowed the contract of one of the parties to be terminated with payment of dues. Then the program was all but abandoned.

The core of the problem was this. All that the CHC was able to provide was services which were about par with the government managed CHCs. Officers of the government monitoring the programme were quick to point out that the agency was failing on its core deliverables, viz. to position a number of specialists and deliver a certain range of secondary care services of which emergency obstetric care was the most important. By terms of the contract such a gap could attract penalties but not cessation.

But when the gaps were large the government felt justified in ending the contract. Supporters of outsourcing could argue that other CHCs also had such gaps. But then what was the case for outsourcing and what happens to the theories of how contracting would remedy poor functionality of facilities. To supporters of PPPs, the answer was to write better contracts. But we would hold that the problems why government CHCs were sub-functional, continue to act even when the ownership or management is transferred to private hands. If government was unable to attract specialists to remote areas, private agencies with temporary appointments will also not be able to attract or retain them. Thus among the few specialists that the agency recruited were some retired officers and some interns.

In fact the usual problems of CHCs became worse with a private management. There were more problems of coordination with the PHCs below and the district hospitals above, and there were more problems in support and referrals. There was also a clear gaming of the system with greater consumption of services attracting incentives while critical secondary care services that were really the need of the patients, were still not becoming available.

But did the government learn any lesson? Did the technical assistance teams learn any lesson? Now after a two year wash-out period there are reports that a fresh effort at outsourcing CHCs is beginning. Earlier cycles of failures are being dismissed as consequent on individual factors and personality issues.

Overview of Outsourcing Secondary Care Hospitals:

There has been a relatively less intensity of effort to outsource community health centers and district hospitals (secondary level hospital care), though private agencies often express interest in the same, and there are repeated attempts from policy makers as

well. Important examples of this are the outsourcing of two district hospitals in Karnataka.

This case study described above conforms to the general pattern is of an early declaration of success, followed by the rise of complaints at about 2 years and a slow down or cessation after three to 5 years- a pattern that we described with Primary level care outsourcing. But these repeated failures are inadequately documented and largely forgotten.

An interesting variant of this theme which has had relatively better success is the Memorandum of Understanding (MoU signed between the Deepak Foundation and the Government of Gujarat (GoG) in 2006 for operating the Mother and Child Care Centre in the Jabugam CHC, which is near Vadodara. This PPP has now been in existence for the past ten years. It is important to note that this PPP only caters to the maternal and child services, while the general outpatient and inpatient services provided in the same CHC is the responsibility of the government.

There are many differences between this model and the Uttarakhand model. The private agency brought in capital investment to build infrastructure as part of its CSR work. Initially even HR costs were shared, but now most of it is by the government, but with Deepak Foundation paying a top up salary to retain the sole gynaecologist that they have been able to recruit. The aim was to provide emergency obstetrics and new born care at the CHC level. And this it does, but with increasing difficulty in providing emergency services. It has been unable to secure a paediatrician. There was no process of tendering, no complicated contracting or expectation of contracting, no space for profit maximization. It just provided space to a private CSR agency to strengthen a public service. This is a niche contribution and they have not been able to scale it up.

Recently the NITI Ayog has renewed attempts to find possibilities for outsourcing district hospitals and Uttar Pradesh, as always, been a soft target for such efforts. However the private agencies seem interested in only the best running, most central hospitals- like the Dufferin hospital and most reluctant to go to more peripheral districts where the hospitals really need help. And the state government has to hesitate because the political and economic costs of outsourcing the good hospitals will be high. This experience has been reported from many other states in the past. Though private agencies are interested in taking over district hospitals, to establish medical colleges, this is talked about but seldom materializes.

One curious failure is the lack of efforts to harness the capacity of mission hospitals to provide hospital services and a very good range of secondary care services. The capacity of mission hospitals is estimated at about 60,000 beds and may equal that of all the district hospitals combined. They have a very good dispersal and many of them are in rural areas. They should require less monitoring. Some of them have joined in government insurance schemes. PPPs with them are very patchy- almost non-existent. One important example of a relatively successful case is the Ramakrishna Mission Hospital in Narayanpur, a remote tribal district in Chhattisgarh. But these are exceptions.

Lessons to be learnt:

Outsourcing public hospitals on management contracts is not working. And efforts at outsourcing district hospitals is likely to find that private agencies will accept only the more functional hospitals and for managing this they may need to be paid much more to run the same level of services- with no gains in either

efficiency or quality of care. When it comes to more remote areas, the same problems that affect the performance of government management will affect the private agencies and they would have even less capacity to manage these.

PPP Category - 3. PPPs for Tertiary Care hospitals:

Case Study: Apollo Indraprastha Hospital and the Delhi Government.

One of the earliest prototypes of the standard model for PPPs with private corporate hospitals was the PPP with Apollo Indraprashtha Hospital, New Delhi.

In 1986, the Delhi Administration invited proposals to establish a multidisciplinary, super-specialty hospital on "a no profit no loss" basis. Two years later, the government leased a prime property to the Apollo Hospital group on a token payment of one rupee a year, to set up the Indraprastha Hospital. The hospital is a joint venture with the Delhi government. By the terms of the

Agreement, the hospital was to provide free services to patients occupying at least one third of its 600 beds and to 40 per cent of those seeking outpatient care. In return the government provided 15 acres of land, and Rs 16 crore to set up the hospital.

Much later, a panel constituted by Delhi High Court in response to a PIL, found that the hospital had failed in its obligations. And this despite the fact that this was never seen as a philanthropic act, rather as a legal obligation to provide certain clearly specified services to people in return for a substantial financial subsidy to the company.

The underlying logic of such a PPP is quite different from the usual ones. Or else why choose the center of Delhi already replete

with both public and private hospitals to support with public funds such an initiative. As one article in Indian Journal of Medical Ethics puts it:

"The media image of Dr Prathap C Reddy, the founder of the Apollo Hospitals Group, which has been in large part carefully crafted by the group itself, credits him with having brought modern multidisciplinary super specialty care to India for the benefit of patients."(IJME, Jan-Mar 2010)

Clearly what is at work here is the desire of the Indian elite to have a world class medical facility which they can access without experiencing the crowds and the hassles of the leading government tertiary care institutes.

Overview of the super-specialty Hospital PPP

Apollo was the first, but there have been many after that. Government using the public land acquisition act acquires the land. Modest compensation has to be paid to the landowners. But since many in urban slums, may have no legal title to the land, even payment could be avoided. Then it gives it to the private hospital owners, almost always corporate hospitals at throwaway prices. In return free services have to be provided for anywhere from 10% to 40% of patients in different agreements- but this never materializes. Fortis, Escorts, Medanta- many major hospital groups have so benefitted by entering into signed agreements.

In addition to the land, such hospitals were also given import-duty and tax exemptions in return for similar free care agreements which also were not honoured. This again was brought to light by another court appointed panel in the 1990s.

There is a similar situation across all states. There are a large number of so-called charity hospitals in Maharashtra which got land and other benefits in return for free services. Such contracts began to get more sophisticated and varied in the last decade.

One such contract, much hailed by the then Planning Commission was the case of the Super-specialty hospital in Raichur, Karnataka. Here the hospital and equipment was transferred to a corporate agency winning the bid for operations management. An enthusiastic description of this model written in 2007 goes like this:

"The Rajiv Gandhi super-specialty hospital in Raichur Karnataka, was built at a cost of Rs 600 million. This economically backward region of the state has no modern health facilities so people are forced to travel long distances to seek specialist medical care. As government was unable either to deploy or retain specialist doctors, the hospital was lying unused. Apollo Hospitals Ltd, a corporate hospital chain, was seeking to establish its own hospitals in the region, but it was not sure about building a super specialty hospital. The respective dilemmas of the Government of Karnataka and Apollo Hospitals Ltd were highly conducive for establishing this partnership for mutual benefit. Through this partnership, the Government is able to provide free services to the poor, and Apollo Hospitals Ltd is able to establish its business operations without having to invest in constructing physical infrastructure. The corporate hospital is able to pay well for its staff so it could retain the desired manpower. "The rates they could charge were to be 30% less than in their Hyderabad hospital.

By 2009 this PPP was in trouble and in 2011 when time came for renewal that did not happen. There were three or four major

reasons for this. First it had failed to fulfill its obligations to provide free care to BPL- though there were a number of insurance schemes for the poor in operation. Secondly there was an over 50% under-utilization of capacity. Thirdly there were revenue losses partly because of inadequate capacity utilization and failure to attract insured poor patients or paying non-poor. There were also reports that the services available within were limited- and referrals to the larger corporate branch in nearby Hyderabad was frequent.

Yet another famous example is Fortis Heart Care Hospital established for providing advanced cardiac care and another similar corporate hospital established for providing gastro-enterology care in Raipur in the first years of the newly formed state of Chhattisgarh. Here again the costs of building and equipment were paid, the corporate agency was allowed to charge at unspecified market rates. Fortis was to keep 15% of beds to provide free care to poor patients, but even for them it was allowed to charge unspecified prices of drugs and consumables. Government employees were to be given 15% discount on unspecified list price of charges. They were also to provide training to local personnel to take over these cardiology services over the year. In practice, only a very limited range of procedures was established, and much of the cases who needed advanced treatment had to be referred to Delhi. There was no evidence that any benefits were extended to those who could not pay. This example too is clearly motivated by local elite who need an advanced care model near home- but not only do these models fail to deliver on care for the BPL which is used to justify the government funding- they even fail to deliver on the promise of care to the elite. The owners want more, the elite want more and both are unhappy. The poor never learnt that they had an entitlement in this facility- and therefore they do not notice its

coming or its going. The tertiary government hospitals meanwhile have developed capacity to provide many of the critical cardiac care services. Last year, the Fortis Heart Care PPP officially came to an end. The gastro-enterology PPP ended so soon after it started, that there is no memory left of it at all.

One interesting variant was an effort by International Finance Corporation which is an important player in such efforts. It supports private sector growth in many critical areas through subsidized loans to large corporate hospitals. These can be best understood only as part of its efforts to develop hospital chains – or in other words consolidation within the hospital and health care provider space. One example of this is a $50 million IFC financing package to Apollo Hospitals for creating Apollo Reach, a new low-cost hospital chain, that is billed as treating both low and high income patients; with higher fees paid by wealthier patients cross-subsidising lower fees by the poor. This is initially to set up 15 tertiary-level healthcare facilities to provide oncology, radiology, neurosurgery, and other state-of-the-art medical services in underserved areas and then expand its network to provide specialized health services in smaller cities and semi-rural areas. The usual narrative accompanies it- it will bring specialists to local communities, and will cost 30% less than in large urban hospitals and above all it is a viable business model.

A similar PPP model was mooted for urban Bhubaneswar with IFC financing it, and the municipal corporation partnering it. The tenders were floated- when at some point it was stalled.

The most recent of this is from Chhattisgarh:

Where the health department as again invited bids by private sector to build and manage six 100-bed hospitals to provide

secondary care. The hospitals will be built according to the "Build Own Operate and Transfer", or BOOT, model. The bidder must have a minimum net worth of Rs 20 crore and an annual turnover of Rs 50 crore to be eligible. The state government would lease land for 30 years at Re 1 and provide a one-time grant to help set up an infrastructure of upto Rs 4 crore per hospital. The private agencies will have to run them for the next three decades. Though justified on the grounds of providing for under-serviced communities these are to be located in urban centres of Raipur, Durg and Bilaspur, which already have a large number of public and private hospitals of the state. The hospitals are free to charge unspecified market rates. Their only commitment is to make free care available for 20% of out-patients and 40% of inpatients and the in-patient part too is to be reimbursed by government financed insurance schemes at the package rates. This proposal is at the tender finalisation stage.

Outsourcing for tertiary care - the theory-practice interface

It is not clear what economic or management theory supports these schemes. Clearly these go well beyond the sophistications of contracting and incentive environments. Indeed there is little in healthcare literature on health reform that can explain this.

Such PPPs can only be understood as an effort to be seen to be using public expenditure to help private healthcare industry to grow further and within that to push for consolidation around larger players. Clearly what is happening after each round of failure is that instead of giving up or slowing down, further concessions are advanced. And if it does not work- it does not seem to matter. Even the pretense of wanting health outcomes is wearing thin in the most recent PPPs of this category.

However, there are some specific tertiary care services which are not available adequately in public hospitals. There may be ground to empanel private hospitals on fee for service basis for 3-5 years. And with some effort, government tertiary care hospitals can also start providing these services.

PPP Category – 4: PPPs for Outsourcing of Diagnostics

The current thrust for PPPs in the national level policies and practice by states is concentrated on two main areas: a) Diagnostics b) Dialysis. Central government has been pushing PPPs and funding them through NHM. Though in case of diagnostics, the NHM guidelines allow strengthening of in-house laboratory services in government hospitals for "High-volume Low-cost" tests, the emphasis in practice is on PPPs to outsource diagnostics. The following discussion is focused on 'diagnostics' outsourcing. We are discussing it separate from ancillary and support services because of its much closer association with medical care.

Diagnostic services could further be categorized into two (a) imaging services and (b) all the other laboratory tests- whether of pathology, microbiology, hematology, biochemistry or genetic studies.

In imaging services the Tamilnadu Medical Services Corporation (TNMSC) has been managing very well for over two decades. Here the logic is the same- an institutional arrangement that allows institutional capacity to develop. But there is one important difference. The TNMSC is also a public institution, albeit under a different governance arrangement. The main objective of TNMSC was for procurement, where it is a clear winner. Early fears that this was a form of corporatization that will lead the way to privatization have not materialized.

Private agencies have been tried for outsourcing procurement and supply chain management- but have never succeeded. On imaging, on the other hand there are many more sustained efforts at outsourcing imaging services to private agencies- and the results are more mixed. One critical issue here is the capacity required to procure and maintain the equipment without serious downtime.

Outsourcing of all other diagnostics to a single private agency across the state has become a new and widespread trend since 2015.

Case Studies: Andhra and Maharashtra Diagnostics PPP

The Andhra scheme is called the NTR Vaidya Pariksha scheme. Through competitive bidding a single service provider was selected to provide designated laboratory tests at 8 District hospitals, 35 Area Hospitals, 192 CHCs and 1125 PHCs. The in-house laboratories continue to provide 10 to 12 basic and mostly rapid kit tests at all levels of facilities. The PPP scheme provides 7 tests at PHCs, 21 tests at CHCs, and around 40 tests in bigger hospitals.

An assessment report indicates that the total number of patients in OPD increased by about 16% and IPD by about 29% in 2015-16. Per capita out-of-pocket expenditure on diagnostics also reduced. When the private labs were not able to adhere to the turn-around time stipulations, government agreed to make them less stringent. But, cost escalation was a major problem and many restrictions had to be brought in. Fee for service models are known for increase in utilization, also because a lot of un-necessary tests or procedures get prescribed.

For providing services under this scheme, the service provider set up 104 laboratories outside the Government health facilities.

The samples are taken in the health facilities by phlebotomists of the service provider and reports are put up in web as well as dispatched. The laboratories are of three types termed mother laboratories (L1), advanced tests (L2) and routine tests (L3).

Maharashtra also has an identical model but the service provider is HLL – a public sector company. The advantage is that there has been an improvement in diagnostic availability- and it is free. However on the government tests, many of which are more basic user fees are being imposed. Also there is little supervision or dedicated technical help available for the government tests. The PPP has brought in a technical expertise that could expand the range of diagnostics and arrange to deliver it within a time limit. It is able to introduce and more important maintain more sophisticated equipment at its laboratories. The business model does work to maximize volumes.

However there are problems also. Many of the tests done, at both ends – the highest priced, lowest volume tests and the simplest tests being done in the PHC are both being over-consumed, and this is related to the business model. A public sector unit which has no pressures to break even may be less inclined to game the system thus.

Further for practical reasons there are many laboratories at the L2 level which are not functional- and a number of pathology and microbiology samples get sent to the central laboratory. These tests do not have clinical details making interpretation difficult, and the systems do not allow for dialogue between clinician and pathologist or micro-biologists. Sample transport systems are inadequate. The PPP partner is clearly unable to get pathologists and micro-biologists even at a regional level within states- and cutting corners to send it all to the state undermines the quality and timeliness of reports.

Many other states have outsourced diagnostics but with less success and scale. Chhattisgarh tried outsourcing of diagnostics for district hospitals, CHCs and PHCs in 2013-14, but the attempt failed because no agency bid for the remote districts. The state has again issued a tender to outsource diagnostics for district hospitals and CHCs in 2018. One of the problems is that a lot of the tests existing government labs are providing are also in the list to be outsourced. Like Andhra Pradesh, Chhattisgarh also is unable to do a reasonable identification of "high-cost low-volume" tests, which are not happening in government labs due to gaps in management-capacity. The persistent gaps in government capacity are related to maintenance of equipments and supply of reagents. The other danger in Chhattisgarh is of user fees like Maharashtra.

Lessons from the experience:

It is still within the first three-year period, and too early to comment. Yet two problems are visible, even as of now. Firstly the main input these PPPs bring is by contracting in a management capacity. But the problem that comes with this process of competitive bidding, rates and reimbursement, is that even where there is a public sector company playing the role, the instinct is to game the system so as to maximize returns. There is a need to ring fence what tests are ordered – from what remuneration is earned- but within this model it cannot be done. The second is a huge decline in the quality of the employment and de-skilling of the work force. Laboratory assistants are hired, but they work as phlebotomists. The testing skills are centralized in the laboratories but even here they are paid much less than what a government lab tech earns.

The Andhra Pradesh government has since come into an understanding with IFC **to** engage private sector partners in

improving diagnostic services at four state medical college hospitals. In addition, under this agreement, the IFC (International Finance Corporation which is the arm of the World Bank dealing directly with private sector) will develop a comprehensive policy framework for future public-private partnerships in health. It specifies that these shall be PPPs that are "attractive to private partners and can be replicated in other state medical facilities."

Clearly there is some excitement that these PPPs could be a new model for "private sector led growth", which is the IFC's mission statement. On the other hand there are so many problems of contracting, and after contracting gaming of the payment terms and questions of quality and costs- that sustaining these are going to be difficult for the government. If this leads to the development of TNMSC type institutional arrangements within government that can provide leadership and develop capacity to deliver free diagnostic services in the public sector, it could be the most desirable result. Rajasthan has also demonstrated significant improvements in providing diagnostics using the state medical service corporation for setting-up and maintaining diagnostics.

There is no doubt that this approach has shaken up the low set equilibrium and comfort zone of public providers and shown how much more needs to be done and can be done to improve public services. The key is in the organization of services- not in its ownership. When ownership is incentive and contract driven, there are some initial advantages – but the more difficult the terrain, the more the disadvantages. Potentially one could develop HLL or TNMSC or some other public sector concern, to develop diagnostics within states in a Built- Operate – Transfer approach, where the contract clearly includes how the transfer would be achieved in three to five years.

PPP Category -5: PPPs for Ancillary/Support services for healthcare

There is a recent surge in the outsourcing of ancillary services of the public hospital. Outsourcing for support services are almost a universal norm. This includes security services, sanitation services, gardening services, laundry services, diet services and even increasingly personnel transport. One driver for this change is successive pay commission reports that have almost ruled out any creation of Class IV jobs in the public sector. That is not being examined here- though even on this it is doubtful whether services are better and whether efficiency is really inequity in disguise- with workers being paid a pittance and working conditions worsening.

Use of outsourcing for bringing in nurses or other health HR in difficult areas is also fraught with many problems. One additional issue is its use to bypass the caste reservations.

The first and most successful of PPPs for ancillary services is undoubtedly the out-sourcing of the ambulance services in the dial 108 format. This has been followed by the Dial 102 services, which is a similar patient transport system.

The justification for outsourcing these services are best made in terms of expanding the organizational capacity of the public health system. Whether these PPPs are first steps towards privatization of healthcare or whether they are a useful way of strengthening access to free care delivered through quality public health services is an important question. Clearly access to ambulance services has dramatically increased and in many states, though there are still large inefficiencies in remote areas. The average *median* time for a patient to be picked up by an

ambulance is less than 30 minutes from the time the call has been made. Earlier, ambulance services used to be with each facility and not networked nor linked to a call center. Public hospitals were, more often than not, diverting the vehicles to other functions. Now by creating an autonomous network of ambulances, a functioning modern call center with GPS tracking of all calls and ambulance responses, and a trained dedicated emergency medical staff, the scene has got transformed. There are over 20,000 ambulances plying. In most states, at least till a few years back no nexus with private hospitals and the whole services was cashless- and quite affordable to the government. There were only two creditable providers and one of them had the bulk of the state contracts.

Success in this can be attributed to the ability to develop specialized institutions where all the necessary skills could be housed and the requisite capacity could be built up. It is worth noting the Dial 108 model started as an attempt at business model, and then partly by serendipity, and partly by good technical innovation moved more and more into a not for profit public service model. Managing a modern ambulance services is a highly specialized area, and a number of administrators who are passing through the department or clinicians can find it difficult to build up the experiential and theoretical knowledge that such a service needs.

However managing contracts can be very difficult too. In some states there are problems with the tenders, and very poor performance. There is a monopoly developing and with that a return to profit maximization efforts may resume. There are labor issues, and the current labor policies are far from adequate to address these.

Peoples Health Movement Demands:

a) There is enough experience to state that in the delivery of primary level care and secondary hospital care, PPPs would be unable to deliver. One important reason for insisting on discontinuation of the push for PPPs in the delivery of primary health care and secondary level care is so that the government is not distracted from its primary task of developing the minimum infrastructure and deploying the minimum HR and providing the minimum equipment and consumables needed for good public provision of services.

b) One can provide some space to NGOs or individuals to provide services in challenging areas; these are strictly to be seen as exceptions and not as the rule. A cap that not more than 2 % of facilities should be so outsourced may be enforced. Commercial organizations should be excluded from the process and selection should not be by lowest quote- since the rates would be fixed, but only by merit. Genuine charitable hospitals or organization should be identified based on their track record in the area. These PPPs may provide the same salary structure and input costs as the government does, with overheads being provided explicitly- and all other unused money to be returned.

c) In the provision of diagnostics services- PPPs have played a useful role in demonstrating what can be done- but the contradictions are many and growing. So these are best replaced by a dedicated institutional arrangement of government at the state level to better organize and delivery diagnostic services- rather than leave it to just a

joint director and his clerical team. These institutional arrangement must be able to attract and nurture the skilled personnel and capacities that modern diagnostics requires.

d) With respect to outsourcing of support services- laundry, diet, security, sanitation, gardening etc- the terms of contracting should specify adherence of the contractor to all labour laws and best practices in labour management and the rates of outsourcing should be able to address this.

e) All PPPs with corporate hospitals where land and funds are transferred to them in return for free services must be abandoned. Past efforts at this must be reviewed, and where the commitments have not been kept, government must demand compensation. There is a case for legal action to prevent further PPPs of this format. There is a need to mobilise both public and private providers against these PPPs.

f) External aid agencies must be restricted from work at promoting the corporate private sector in healthcare, and the development of monopolies.

For engagement with the large private sector, the JSA recommends the development of training programmes, orientation programmes and technical support as appropriate – most of which would be directed to the thousands of small providers who provide affordable care. This could combine with regulatory measures and involvement in government programmes that would give an advantage to affordable and ethical care providers. The JSA cautions that current policies on both regulation and insurance and PPPs is doing the opposite-

pushing out the ethical, not for profit or less profit hungry small provider, who provides affordable care in favour of the corporate sector in health care. Nations with extensive purchasing from private sector like the Japanese have legal restrictions against any profit making in the healthcare area, and other developed nations too have very tight regulatory regimes. And to the extent that the Indian government wants to use purchasing as an approach, it must learn these lessons too from these nations.

The peoples health movements understand that there can be contradictions between its policy recommendations against PPPs and its stated action at the level of implementation. But it also understands that civil society at the district level would have to contend with schemes and programmes as it finds them and it needs to charter an action plan where there is immediate assistance to the poor in seeking health care from available facilities, even as it builds up awareness of the larger structural changes that is needed.

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