Twenty Years of Public Private Partnerships - Time for a re-think !

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Dr. T.Sundararaman[1], Dr. Samir Garg[2],

Public Private Partnerships (PPPs) in the health sector are often presented as a new and innovative strategy that public health systems need to adopt to improve their efficiency, quality and coverage. But the truth is that PPPs have been around for at least 20 years in the Indian health sector. There is a wealth of experience on PPPs and we need to review this experience to learn what works and what does not, and to what extent and in what contexts.

The discussion on PPPs has renewed importance at a time when Universal Health Coverage (UHC) has become the main framework within which goals, directions and processes of health systems are discussed (Xu et al. 2015). Officially international organizations insist that UHC does not imply any one road-map and nations are free to choose their own road map (WHO 2019; World Bank Group 2019; KPMG International 2016). But in practice, UHC is often identified with strategies that shift the role of government from being a provider or 'maker' of services to becoming a buyer or 'purchaser' of services (Mehtsun 2017, JLN 2016, United Nations 2016, Health Systems Global 2018). UHC aims to ensure universal access to healthcare and financial risk protection in a short period and in order to do so efficiently, it recommends buying healthcare services from the private sector. UHC visualizes the main role of governments not in providing the services, but in funding and buying the services from various kinds of providers and in being a steward of a mixed provider system (WHO 2010, Gwatkin 2005, Lagomasino et al. 2009).

There are many strategies through which governments can purchase services. One of these is insurance - where empanelled private hospitals are reimbursed pre-decided amounts for treatment of those patients who have insurance coverage (GoI 2017). The other route is outsourcing of services to private providers through PPPs. Public Private Partnerships (PPP) is a term commonly used to describe a collaborative relationship between public and private actors for the achievement of common goals (Singh and Prakash 2010). The term carries connotations of reciprocal responsibility, mutual commitment, equality, joint decision-making and sharing of risks and investments (Venkat Raman and Bjorkman 2007; WEF 2005). Technically an engagement with a private agency can be called a partnership only if the private agency shares in the investment, rewards and risks (Venkat Raman and Bjorkman 2007). But this is seldom the case. In practice the usual form that a PPP takes is of 'Contracting', where the government contracts a private agency to provide an agreed upon package of services,

[1] Earlier Executive Director, NHSRC, New Delhi and Dean, School of Health Systems Studies, Tata Institute of Social Sciences

[2] Chief Program Coordinator, State Health Resource Centre, Chhattisgarh.

and the government pays for it in part or full (Venkat Raman and Bjorkman 2007). These packages of services may range from just some part of the health care provided, like ambulance services or diagnostics, or it may be for a large set of clinical services.

The Rationale of Promoting Public Private Partnerships:

Overcoming Market Failure:

There are many reasons given for the government choosing to contract a private agency to provide healthcare services, instead of organizing these services through government owned and operated facilities. Most of these reasons are based on a framework of understanding that consider public services as necessarily dysfunctional and inefficient and of poor quality, because market forces are not allowed to act, and government has a monopoly or because poor consumers cannot go elsewhere due to financial constraints (Gwatkin 2005). In this understanding, the private sector is considered to greater efficiency since it is subject to competition and consumers make explicit choices. However neo-classical economics, the dominant economic theory for over a century, also concedes that markets fail to act for healthcare services (Preker and Harding 2000).

In a seminal paper published in 1963, Kenneth Arrow, the Nobel Laureate in Economics, brilliantly described how markets fail in the health sector, because of the uncertainty in outcomes, information asymmetry, and the relative powerlessness of the sick consumer to make a choice at the moment of need, and the nature of professional practice (Arrow 1963). One conclusion from this was that health services are best delivered as public services - and this is what most welfarist European nations were doing (Maarse 2006). But another conclusion is for a government agency, instead of the individual patient, to negotiate the rates and purchase the care from private providers and through its contractual terms ensure that patients get appropriate care (Preker et al. 2007; WHO 2000). This is how it seeks to mitigate the market failure by constructing a 'quasi-market' (Le Grand 2011).

There are many explanations of how explicit contracts make for better performance. The contract would explicitly spell out the outputs that the agency should deliver in a measurable way, and payment would be based on this. This also provides the opportunity for government to give rewards and incentives to encourage good performance and penalties and disincentives for poor performance or failure to observe any of the contractual terms. Since the government determines the scope of the contract, aspects like quality of care can be made part of the conditions or terms, measured using appropriate indicators and incentivized (Vining and Globerman 1999; Preker et al. 2007).

In the language of Principal-Agent theoretical framework, the contract makes explicit the outcomes that the principal (government) wants and then the terms of payment is so organized that the interests of the agency (provider) 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 (Preker et al. 2007).

In this principal-agent framework, public systems are theorized as dysfunctional because public providers and managers of a public facility get their salary and other inputs, irrespective of outcomes. Also, there may even be poor clarity about what are the desired outcomes. The public system does not offer incentives to innovate, whereas a private partner would always innovate to reduce costs to achieve the specified objectives (Preker and Harding 2000).

Further in this understanding, government can reduce costs and incentivize efficiency by procuring the services of the agency through a transparent procurement process, involving floating tenders for which different agencies bid. Here the belief is that if the private agency to provide the services is selected by competitive bidding, then we can get an agency with a better track record, at the lowest possible rate for the same outputs. Their managements would make the workforce work harder, hire cheaper, and innovate i.e. find new ways of doing the same job for less funds (Donahue 1989).

Thus market failure is overcome through institutional arrangements that shift competition and choice from the level of individual consumers to institutions (Le Grand 2011).

Organizational Capacity:

A completely different rationale 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 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 rationale has also been described in National Health Policy of India (2017) as "strategic purchasing" or PPPs for 'critical gap closing' (GoI 2017). Here the main thrust of government intervention is through public health services - but it supplements what government can directly provide by purchasing care from select private providers. It has been argued that such supplementation is vital. When close to 80% of doctors, and an even higher proportion of specialists are in the private sector, and when close to *70% of patient* care is from the private sector, government policy cannot ignore its presence and its impact on people's lives. While regulation is necessary, there is a need to construct ways of engaging with private providers, and PPPs could be one important way (Shroff et al. 2018). 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.

In the last two decades since PPPs became an important part of health policy in India both of the above rationales have been used for establishing a large number of PPPs. There is a scope therefore to examine the experience with PPPs over these years to

review how far these objectives are achieved and what difference it has made to the coverage, quality and efficiency of healthcare. Unfortunately there are few evaluations available and there is little information on effectiveness in terms of health outcomes, or in terms of efficiency, or on longer-term sustainability. PPPs in India have not received adequate attention in empirical research (Karnataka Knowledge Commission 2010). A part of PPP literature in India claims its advantages without empirically studying it (Singh and Prakash 2010). There is even less information on the impact of PPPs on the public sector, or the sector as a whole. There is also no information available on the many PPPs that were attempted, sometimes sustained for a few years and then collapsed (Garg 2019).

PPPs also offer immense scope for operational research to improve how services are costed, how performance indicators are crafted, how payment mechanisms are designed, and how contract management is organized and how the needs of equity are addressed. A small body of research has emerged in this area, but most of these are in the nature of documentation of specific PPPs, often commissioned by their funding agencies.

In this review we present 3 case studies, each representing a sub-category of the organization of healthcare services and discuss how these PPPs evolved and to what extent they met multiple expectations of a PPP. We then overview the experience with PPPs in that sub-category, of which the case study was an example and reflect on what could be the lessons for further PPPs in this domain.

PPPs for outsourcing Primary Healthcare:

Case Study- 1: The Rajasthan PPPs for Outsourcing Primary Health Centers:

In Rajasthan in year 2015, initially 30 and under them 99 Health Sub-Centres 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 2015). WISH Foundation was to help in selection of providers and managing contracts and making payments to them for running PHCs. The 99 Health Sub-centres have been distributed amongst 20 NGOs and private agencies, many of who belong to local areas.

The contracts were for managing the PHCs, where the entire infrastructure was handed over to a private agency (Dhar 2015; Makkar 2015). The private agency could hire the human resources required for the organization of services. Drug logistics remained with the government. User fees were as a rule not allowed but could be charged for services outside the selective package of Reproductive & Child Health (RCH) services that were specified in the contract. The RCH services specified were the same as available in government-run PHCs – largely ante-natal care, normal delivery and post-natal care, immunization and treatment of childhood diarrhea and pneumonia.

There was considerable positive reports of this effort in the first year, and there were plans to expand such contracts to 300 PHCs. But soon, both due to internal doubts about the advantages gained by contracting, and because of external pressures these were given up. Two years after the launch of this project, it is not clear what advantages it has conferred. There was some concern that these could collapse, but they survived and perform reasonably, but that is about the best that one is able to say for them. No gains are recorded in quality, efficiency or innovation. Since these PHCs and sub-centers were not chosen based on any criteria of poor functioning or remoteness, and there were no base line measures, it was difficult to ascertain whether there were any advantages realized by such outsourcing.

The contract itself was well written, with considerable technical support and there was a capable resource team to guide the private agencies. However these PHCs and Sub-centers faced the same problems as faced by the government PHCs - difficulty in finding and retaining Human Resources (HR), issues of logistics for medicines and diagnostics and poor referral support. More importantly, if the lack of credibility and performance of the government PHCs and sub-centers relates, not to management, but to design then outsourcing the same design can hardly be expected to solve the problem. Since the mandate of the outsourced PHCs and sub-centers was the same highly selective set of services, it is little surprise that outsourcing made little difference to outcomes.

Overview of PPPs in outsourcing Primary Care:

Before the nineties, only the occasional PHC would be outsourced. Some states took help of industries and philanthropy for improving the amenities, appearance and functioning of a few PHCs – but that is as far as it went. Then in the 1990s under the World Bank's Health Systems Development Programme, this idea gained traction. In the late nineties under the sector investment programme, run with European Commission's support, there was a systematic effort made to outsource urban PHCs to NGOs and private agencies. This went to scale across many states - notably Andhra Pradesh, Assam and Orissa. Since most urban areas had little or no primary care provision by government, this could have been a useful supplement. However little of this has survived after the external funds for this ceased to flow.

Under the National Rural Health Mission (NRHM), there was encouragement to outsource PHCs in remote areas, and even a formulation that about 5% of PHCs could be outsourced. A number of PHCs were so outsourced, largely to NGOs, but only a few of these survived and these were mostly in remote areas with a specific NGO- more of niche than a general alternative. At least part of the reason for this was the failure to establish any successful examples of such outsourcing as a general alternative. For example, in the early years of the NRHM, Bihar explored this route as one of the main routes to reform. But when at last two rounds of outsourcing PHCs in the last decade collapsed in less than two years, the effort had to 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 30 in Rajasthan(along with 99 sub-centers), 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. Thus the few PPPs that involve outsourcing of primary health centers and sub-centers are all examples where agencies have been identified purposively to supplement the capacity of the government to reach such areas.

A recent study of PPPs in remote tribal areas reported mixed results. While the study reports some increase in utilization of maternal care services, the studied PPPs had several problems. The mobile medical units had poor continuity. Handing over PHCs to non-profit organizations gave mixed results with a few well performing PHCs and many poorly functional ones (Kandamuthan and Madfireddi, 2016).

A study of PPPs in Gujarat suggests that PPPs emerged because government was unable to meet growing demand single handedly as it was short of infrastructure and trained manpower. However, the implementation on the ground did not meet the stated objectives. While the responsibilities were well defined, implementation suffered due to insufficient monitoring and accountability mechanisms. The incompleteness of contracts was inevitable and it posed risks of opportunism by partners and vested interests. The study questions the effectiveness of dynamic contracting and its up-scaling without robust evaluations (Barua, 2015).

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, often through competitive bidding, 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 in 4 they are non-functional. 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. Here again we find a niche situation where it is easier for the government to identify a motivated NGO to entrust it to- rather than a general solution where agencies are identified by competitive bidding and lowest quotes.

There have also been a large number of efforts to build a business model which will recoup at least the running costs through user fees and use technology to lower the costs of service delivery and standardization of care. One of the lead examples of this tried on scale was the SKY clinics of Bihar and Uttar Pradesh. The SKY clinics were a social franchisee network organized by World Health Partners (WHP), an international NGO and funded by Bill and Melinda Gates Foundation (World Health Partners 2013, Chaudhary 2013, Angus 2016). This program had recruited, unqualified health care providers to set up clinics providing medical care in rural areas of Bihar. The recruits are provided training, a brand image, and a link 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 it

clearly did not sustain. The WHP team was to ruefully accept that without public financing and government 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 business model approach that was tried is the Merrygold chain of health care facilities in Uttar Pradesh (Centre for Health Market Innovations 2013). 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.

In summary:

After 20 years of continued efforts, there is as yet no model of PPPs for primary level care that seems replicable. Even with the best of such 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.

One conclusion, the obvious one to make, from these experiences is that contracting private agencies makes little difference to service delivery or health outcomes. Our experience is no different from other developing countries where contracted private providers faced similar constraints of attracting HR and supplying drugs as faced by public-sector (Rao et al. 2018). Contracts have little in the way of incentives and even less room for innovation. Even when selection of the agency is through competitive bidding, there is little gain in performance or efficiency and governments are hard pressed to find any commercial players who are willing to engage at rates, which are less than what governments spend on their facilities. One caution is that such PPPs often reduce the remuneration and have worse terms of employment for its staff, and therefore they face an even greater turn-over than government does.

But there is another strand of thinking especially among leading multilateral and bilateral aid agencies and in neoliberal policy circles. To those within this ideological framework, PPPs have been tried on too small a scale and if a large area were outsourced or a large network was contracted to provide both primary and secondary care, that could do better. The Bill and Melinda Gates Foundation (BMGF) has therefore in partnership with Uttar Pradesh government floated a tender to outsource a number of blocks in Uttar Pradesh to corporate agencies and bids were received from a few consortia. That was over three years ago, and it has not proceeded further since then. In another effort USAID has given a bank guarantee to a corporate agency 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, which can then be taken to scale. There are many other private corporate players also entering this primary healthcare market, and some of them are hopeful of persuading government to

partner with them and route public health expenditure in primary healthcare through them. But clearly if one goes by the evidence there is no case for doing so.

PPPs for secondary and tertiary care:

Case Study 2- 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 (Bajpai 2014). 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 in the state had USAID or World Bank Support. Consciously designed to apply the theories of contracting, incentive environments and principal-agent alignment, the selection was by tendering, with bidding based both on experience of provider but also on the financial bid. There were rewards for performance and penalties for non-performance. Not one but a cluster of CHCs was outsourced, some in difficult areas and in some in non-difficult near urban areas, so that the private agency had a situation comparable to the government and a better chance of success. The contract duration was for five years. Clearly the highest quality of technical thinking had supported the preparation of the tender document. 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 PPP outsourced 12 CHCs, to two agencies who won the tender - one for 4 and another for 8 CHCs. 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, because they had more public health functions to perform whereas the focus of the contract was on clinical services- both ambulatory and in-patient. National health programmes that the CHCs were to perform also remained with the government. The private providers were to be paid a flat rate for each CHC based on their bid and then there were performance based incentives - using four indicators that included number of institutional deliveries and diagnostics done. Another interesting feature of the model was that user fees were allowed for many services, at the same rates as in other government facilities, but this would be collected by a government worker, and not handed over to private agency.

The PPP was officially launched in May 2013 and one year later this was being praised as the model for the future and other states were being welcomed to come and see the success story. But soon complaints were trickling in, and these related to - providers inflating the output figures so as to earn more incentive, and their failure to deploy the agreed number of Specialist doctors. 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.

Again, as in the case of PHC outsourcing, the best that could be said about the outsourced CHCs was that they were able to provide 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 Specialist doctors 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 argued that other CHCs also had such gaps. But as local officials pointed out, the case for outsourcing had been that such sophisticated contracting would remedy these gaps.

Clearly the problem of sub-functional CHCs had not been their ownership, or the lack of clarity on outputs or incentive environments but structural constaints to attracting human resources and better organization of services. And the private agency was less able to address these problems than the government. In addition new problems appeared in the form of lack of coordination with the PHCs below and the district hospitals above, for receiving or sending 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.

Overview of PPPs for Secondary and Tertiary Care:

There have been many past efforts to outsource Community Health Centres and District Hospitals (secondary level hospital care). Important past examples of this are the outsourcing of two district hospitals in Karnataka, and similar efforts in Gujarat and Andhra Pradesh. A study of handing over a tertiary government hospital to a private for-profit actor found poor utilization, lack of measurable benefits to the poor, weakening of accountability and absence of independent evaluations (Karpagam S, 2013). However, there is overall a situation of poor documentation of past efforts of such PPPs. We know that many of them did not sustain, but there is little documentation or analysis of this.

An interesting relatively more successful variant of this theme has been outsourcing a set of services within the secondary hospital and not the whole hospital. One example of this is the PPP between the Deepak Foundation, a Corporate Social Responsibility organization and the Government of Gujarat (GoG) in 2006 for operating the Mother and Child Care Centre within 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 Gujarat has not been able to scale it up.

Recently the NITI Ayog has renewed attempts to find possibilities for outsourcing select services like Dialysis or NCD care within district hospitals but it remains to be seen whether there are any takers, whether it can go to scale and whether these efforts sustain. As with primary health centres, the reasons why governments are unable to manage these district and sub-district hospitals relate to ability to secure adequate number of suitable human resources, the lack of investment in infrastructure, the limited number of services made available and an overall restriction in availability of funds. If the PPPs were signed only where the private agency could bring in additional supplemental public capacity there could be a sustained programme. This for example happens in some partnerships, like the Child Heart Protection Scheme in Chhattisgarh, when patients needing surgery for congenital heart disease are referred by the public hospital to a private hospital which can provide this service and which is willing to deploy its marginal unutilized capacity for this purpose and reimbursed at rates that recover their running costs. Over the years, it has increased the share of non-profit hospitals in the scheme (Garg 2019). Such partnerships have sustained for years- and can be multiplied. But since they are not part of the ideology of substituting public services by private, on grounds of inherent superiority of the latter, these never get projected or scaled up.

There is another type of public support for the private sector which often gets projected as a PPP. The prototype of this was the PPP with Apollo Indraprashtha Hospital, New Delhi, where the government leased 15 acres of prime land in urban Delhi on a token payment of one rupee a year, and provided a capital grant of Rs 16 crore to set up a hospital that would provide super-speciality care on a no profit, no loss basis. Projected as a joint venture with the Delhi government, 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. This was not philanthropy, but a legal obligation to provide certain health services to people in return for a substantial financial subsidy to the company. Since then many major corporate hospitals, Fortis, Escorts, Medanta- many major hospital groups have so benefitted by entering into signed agreements. In many states including Maharashtra a large number of hospitals have got such benefits. None of these hospitals have lived upto the obligations of the agreement on the basis of which they got the land and the grants and the tax concessions and the customs duty

exemption for importing equipment (Sama 2011). Yet despite Parliament and the courts taking this up and passing strictures against, this these practices continue.

The most recent of this is from Chhattisgarh in 2017. In this instance, the health department invited bids by private sector hospitals 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 uptoRs 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 was 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 (Nandi and Joshi 2018). The tender failed because no private hospital was willing to bid. Clearly in a changing mood when there is an increasing possibility that contractual obligations would be insisted upon, the interest for such partnership wanes.

Such PPPs are neither an act of coping with market failure or building up public capacity. These can only be understood as efforts to use public expenditure to help private healthcare industry to grow faster.

PPPs for Ancillary Services:

Case Study -3: Outsourcing of Diagnostics in Andhra and Maharashtra

The Andhra PPP scheme for outsourcing diagnostics 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" deployed by the service provider and reports are put up in web as well as dispatched as hard copies. 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 Hind Labs, an arm of Hindustan Latex Limited – 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 also problems with such PPPs. Because of the business model both the highest priced immunological tests and the simplest tests being done in the PHCs were over-consumed. A public sector unit, which has no pressures to break even, may be less inclined to game the system thus. There is a need to ring fence what tests are ordered – from what remuneration is earned, but it cannot be done within this model.

Further for practical reasons there are many laboratories at the intermediate level are not functional and get sent to the state level central laboratory. Tests are seldom accompanied by adequate 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 all samples to a single state laboratory undermines the quality and timeliness of reports.

There is also a resulting inattention to the functioning of the laboratories in the hospital, which is a serious problem, since they continue to be the only source of advanced diagnostics of the intermediate type needed most in a referral center, where results are required almost immediately.

Yet another problem 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 laboratory technician earns.

Many other states have outsourced diagnostics but with even less success. Chhattisgarh tried outsourcing of diagnostics for district hospitals, CHCs and PHCs repeatedly but in the attempts fail because no agency bid for those remote districts where public laboratories are less functional (Nandi 2018).

Despite all these problems this approach has shaken up the low set equilibrium and comfort zone of public providers with respect to diagnostics and shown how with innovative measures at organization of services, a much larger volume of services can be

provided at much lower costs. The key is however in the innovative organization of services- not in its private ownership. When ownership is through a contract with a private agency, there are some initial advantages – but the more complex the services, the more the disadvantages and difficulties in sustaining.

As the program matures state government may find it expedient to develop semi autonomous public institutions that will serve as the additional capacity to learn from these models and re-organize the services on more innovative and efficient lines. Because these are public it would be easier to finance them on the basis of reimbursement of "whatever it costs", rather than performance based incentives. One could however consider private agencies for change management- to develop diagnostic services within states in a Build-Operate-Transfer approach, where the agency is required to operationalize the system, build internal capacity to manage it and transfer it to public management in three to five years in return for an adequate consultancy fee.

Overview of PPPs for ancillary services:

The area where PPPs have had relatively more success in the health sector is for ancillary services. One of the most successful of these is the outsourcing of the Dial 108 Ambulance services. The justification for outsourcing ancillary 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.

The success of PPPs for ambulance services can be attributed to the ability to develop specialized institutions where all the necessary skills for a modern ambulance services could be housed and the requisite capacity could be built up and retained. Managing a modern ambulance services is a highly specialized area, and neither the general administrator or the clinician-administrators can have the experiential and theoretical knowledge that such a service needs. The PPP contract then brings in the organizational capacity to perform this service

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.

After ambulances it is the outsourcing of diagnostics, which has had better success, though after a few years it is difficult to sustain, and states return to government ownership. Dialysis services are also going through this process. In Imaging services the Tamilnadu Medical Services Corporation (TNMSC) has been managing very well for over two decades. Here a publicly owned institutional arrangement that allows capacity to develop is used as the organizing agency. Fears that outsourcing of ancillary services is only an interim arrangement to pave the way for full privatization have so far been unjustified.

In contrast to outsourcing the clinical ancillary services, outsourcing for non-clinical 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 reason for this change is successive pay commission reports that have almost ruled out any creation of Class IV jobs in the public sector. There is very little reliable study available on whether such outsourced services are better and whether efficiency is really inequity in disguise- with workers being paid a pittance and working conditions worsening.

In conclusion:

There is little evidence to support any approach to PPPs that aims to address market failures in healthcare through contracts and strategic purchasing. There is even less evidence to support a contention that purchased services are more efficient or have higher quality and can therefore be preferred over and substitute public providers. This applies to all services - primary, secondary, tertiary or ancillary.

There is a disconnect pointed out about PPP literature in India (Singh and Prakash, 2010). While the normative literature extols its virtues, the empirical literature reports poor design and implementation and raises questions about the concept itself. Studies point out several gaps in PPP contracts and recommend partnership with for-profit sector only as a last resort for critical gaps in public provisioning (Venkat Raman and Bjorkman 2007). PPPs that are built on the rationale of providing additional capacity for the delivery of public services tend to do better. Here PPPs supplement and do not substitute for public services.

Even as additional capacity, there is as yet no successful model for PPPs in primary healthcare. Though there can be some advantages of select partners in special contexts, a replicable model that can be taken to scale on a PPP mode is unlikely. An empirical study covering several PPPs in India reported that the multiplicity of actors, overlapping roles and fragmentation of authority in PPP had negative consequences for the comprehensiveness and effectiveness of health care and its governance (Baru and Nundy, 2008). A set of recent case studies on a variety of PPPs including dialysis,

diagnostics, rural mobile medical units and HR outsourcing point out a variety of gaps and risks of opportunistic behavior (PHRN and JSAa,b,c, 2017).

In PPPs for secondary and tertiary care, outsourcing the public facility to a private agency seldom works. At best they are able to sustain the contract, but better efficiency and quality has not been demonstrated. However PPPs for select services in select regions where the government is unable to deliver a specific services in sufficient volume or not at all, but a private agency is available and willing to utilize its marginal capacity for providing these services works well. Here the PPP is supplementing public provisioning, and not substituting it.

Provision of land and subsidized inputs to tertiary hospitals in return for free or subsidized services are neither compensating market failure nor expanding public capacity. In practice they are only the use of public expenditure and power for private profits, and should not even be considered for PPP.

In the provision of ancillary clinical services like ambulances and diagnostics services- PPPs can play a useful role in innovation and demonstrating what can be done to support change management. But for government managing these contracts are difficult and for private agencies it is difficult to sustain performance at such low margins So these are best replaced by a dedicated institutional arrangement of government at the state level to better organize and deliver the requisite ancillary services. This institutional arrangement must be able to attract and nurture the skilled personnel and capacities that modern clinical services require.

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

One important question that is often asked is that if partnerships do not work as expected, how best the governments can engage with the large private sector that we have. Ignoring it is not an option. Despite the growth of the corporate hospitals, the private health care scenario is still dominated by small providers, many of whom provide relatively more affordable care. Most such providers would welcome the development of training and orientation programmes for constant renewal and upgradation of skills and technical support as appropriate.

The above form of engagement could combine with regulatory measures and involvement in government programmes that would give an advantage to affordable and ethical care providers. The effort should be to encourage transparency and limit the development of conflicts of interests that incentives that promote inappropriate care-like kickbacks for referrals. 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 and PPPs as an approach, it must learn these lessons too from these nations.

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