

Public-Private Partnerships in Healthcare Evidence from India

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Current evidence points to the mixed performance of public-private partnerships in India and globally. A detailed study of the formulation and performance of specific PPPs in the healthcare sector in Bihar, Chhattisgarh and Delhi reveals that PPPs faced challenges similar to the government health system. Though they filled a gap in some cases, their long-term implications and sustainability need more serious assessment.

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In India, the central and state governments have had several arrangements with the private sector for the provision of healthcare for almost two decades, and in recent times the NITI Aayog too has emphasised the need for these (Rajasulochana and Maurya 2020). The National Health Policy, 2017 acknowledges the presence of the large private sector and suggests ways of engaging with it to achieve universal health coverage and a stewardship/regulatory role of the government in the mixed system of public-private providers (GoI 2017: 21). Even globally, the engagement of government with non-state partners has been a critical element of health system reforms in lower- and middle-income countries (Rao et al 2018).

However, concerns have been raised both in India and globally on the implications of public-private partnerships (PPPs) for healthcare access and equity, including issues of transparency and accountability, high costs and user fees, transfer of public funds to private entities, fragmentation of services and weakened health worker rights (Tizard and Walker 2018; Gideon and Unterhalter 2017; Kotecha 2017; Hall 2015). The ethical implications of PPPs have also been questioned (Prasad and Sengupta 2019). Evidence from different states of India points to mixed performance of PPPs. Studies have shown that while the PPPs led to increase in services in some cases, in most there were problems. Reports highlight issues, such as irregularities in functioning, corruption, problems in quality of services, affordability and access, existing in-house services becoming dysfunctional, lack of accountability and systems of monitoring and

grievance redressal, and the private agencies facing similar challenges as the government (Khetrapal et al 2019; Baru and Nundy 2008; Karpagam et al 2013; Roy 2017; Roy and Gupta 2011; Venkat Raman and Björkman 2009).

There are several descriptions and definitions of PPPs. D Montagu and A Harding (2012: 15) refer to PPPs as, “a more or less permanent cooperation between public and private actors, through which the joint products or services are developed and in which the risks, costs and profits are shared.” A Venkat Raman and J W Björkman (2009) categorise all forms of interaction between the private sector and the government as PPPs. Some researchers maintain that despite several risks, feasible and desirable PPPs do exist and can be deployed in an innovative way, provided there are government regulations which are strictly abided by (da Costa e Silva et al 2017). They classify PPPs in health as “possible,” “possible with caveats,” and “impossible” (da Costa e Silva et al 2017).

In this formative study, cases of outsourcing by the government of clinical services and human resources (HR) recruitment have been studied in the states of Bihar and Chhattisgarh and the union territory of Delhi, with the objective of analysing their formulation and implementation, assessing their performance and impact, and understanding the perceptions of the health staff and the community with respect to the initiative. This research hopes to contribute to the discussions and debates around PPPs and enable evidence-based planning and policies in India and globally on PPPs.

Methods

Study design: This was a qualitative study, using the multiple case study method. Four case studies were undertaken to explore PPPs in healthcare in two Indian states (Bihar and Chhattisgarh) and one union territory (Delhi). This was an exploratory study with an iterative methodology, revised as per need, availability and access to data.

Selection of case studies: For the study, a case (PPP) was defined as one which is currently operating or was started but had to be shut down subsequently. Efforts were made to identify cases that “will provide a full and sophisticated understanding of all aspects of the phenomenon” (Rice and Ezzy 1999: 42). Four such PPP initiatives were identified. The services selected for outsourcing were those that represented initiatives that were being promoted in the government’s policies. The PPPs that were selected for the study included: (i) outsourcing of radiology (x-ray and ultrasound) services in Bihar; (ii) outsourcing of HR recruitment in Chhattisgarh; (iii) outsourcing of rural mobile medical units (MMUs) in Chhattisgarh; and (iv) outsourcing of haemodialysis services in Delhi.

Data collection: Data collection was undertaken in 2015–16 through key informant interviews, group interviews and desk review in all three locations. Key informants such as nodal officers, managers from government and private institutions, health staff, civil society members, and beneficiaries were interviewed (Table 1).

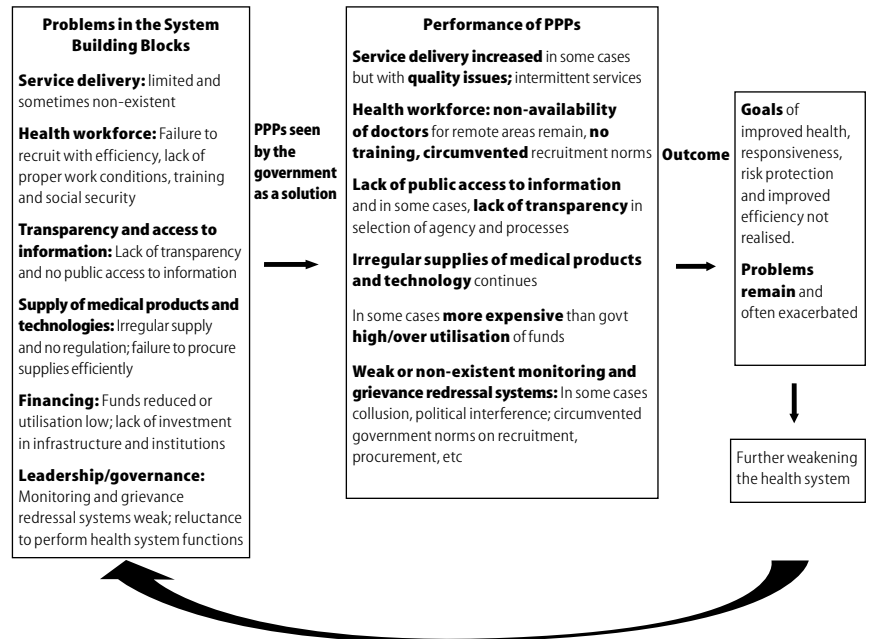
Checklists for individual and group interviews were prepared based on the objectives and design of the PPPs, quality of care, financial protection, community participation, impact on the public health system and so on. Secondary data available in public domain or collected from stakeholders and available literature were reviewed. This included existing studies, media reports, programmatic data, meeting minutes, evaluation reports of the scheme, grey literature, and so on. The sources of data in four cases varied depending on the availability and access to data. For instance, in Bihar, due to the reluctance of officials to consent to interviews, secondary sources in the public domain had to be used. Hence,

Table 1: Number of Interviews and Group Interviews in Four Case Studies

Type of Interview	Rural MMU (Chhattisgarh)	HR Outsourcing (Chhattisgarh)	Outsourcing of Haemodialysis Services (Delhi)	Outsourcing of Radiology Services
Interview of government officials (state/district/block)	5	7	1	–
Interview with hospital staff/ex staff	2	5	5	3
Interviews with patients/community health workers	1	–	2	33
Group interviews with hospital staff	1	3	–	–
Group interview with community/community health worker	5	2	1	1
Interview with private player	–	–	1	–

Source: Data collected during fieldwork.

Figure 1: Emerging Framework on the Impact of PPPs on the Public Health System



Source: Data collected during fieldwork.

modifications in data collection had to be made as per availability of data in each case study.

Analysis: Being a multi-case study design, the analysis was twofold (Yin 2009). The cases were analysed and written individually and subsequently, they were analysed together on emerging themes, in order to draw cross-case conclusions. Detailed notes of the interviews and review of literature were analysed on the basis of parameters such as the stated objectives and how far they have been fulfilled. The four case studies have been published individually (PHRN et al 2017a, 2017b, 2017c, 2017d). This paper presents the combined findings and analysis.

Ethical considerations: Ethical clearance was taken from the Institutional Ethics Committee of the Public Health Resource Society. An informed consent form was prepared, translated into the local language and read out to the participants.

Thereafter, verbal consent was taken. The names of the respondents and, in some cases, designations have been masked to protect confidentiality. No risks were perceived to the participants of the study.

Limitations: There were challenges in accessing data and information from the government and very little data regarding the PPPs was available in the public domain. In all three states, formal requests to the government were made to share financial and programmatic data, and this yielded varied results in different states. Analysis of finances was not possible in all case studies. Moreover, some government officials were reluctant to talk and others spoke only under anonymity.

Conceptual framework: Studies on PPPs in India have mostly focused on assessing the models of contractual relationship and partnership between the private party and the government, developed typologies or described the necessary conditions and parameters (Venkat Raman and Björkman 2009; Baru and Nundy 2008). Some others have evaluated their performance (Kandamuthan and Madhireddi 2016; Karpagam et al 2013; Roy and Gupta 2011; Roy 2017). The findings of the current study enable a conceptual framework for the genesis of PPPs and their impact on the

public health system, which could be useful for future analyses (Figure 1, p 30).

Results: The combined findings from the four PPP case studies describe the salient features, origin, roll-out, performance, monitoring systems and current status of the PPPs. We discuss various aspects and issues under service delivery, workforce, transparency and access to information, supply of medical products and technologies, financing, and monitoring and grievance redressal with respect to the four PPPs.

Service Delivery

This section provides information on the background and context of the origins of the PPPs and examines their efficacy and

performance in terms of service delivery. This was studied through a review of secondary information, views of various stakeholders and observations. The salient features of PPPs are described in Table 2.

Issues in Bihar and Chhattisgarh: In Bihar, the outsourcing of radiology (x-ray and ultrasound) services was undertaken through the state health society, Bihar, across 38 districts starting 2006–07. At that time, there were gaps in the provision of diagnostic services in government health facilities (PHRN et al 2017c). A newly elected government in the state was expected to show performance and the National Rural Health Mission (NRHM) provided the budget

and policy direction towards PPPs (PHRN et al 2017c). However, there is limited evidence of any situational analysis or research on previous PPPs having been undertaken prior to launching the PPP (PHRN et al 2017c). In the sample district, East Champaran, out of 28 government health facilities, 19 had radiology services running in PPP mode when the study was conducted (2015–16). The state-level data shows that the number of beneficiaries of radiology services till December 2011 was found to be around 27.5 lakh since the inception of partnership in 2009, with a target of reaching 40 lakh in 2012–13 (PHRN et al 2017c).

During the study, it was observed that more women than men were availing radiology facilities, especially during

Table 2: Salient Features of the Four PPPs

	Outsourcing of Radiology (X-ray and Ultrasound) Services	Outsourcing Recruitment	Outsourcing of Rural MMUs	Outsourcing of Haemodialysis Services
State/UT	Bihar	Chhattisgarh	Chhattisgarh	Delhi
Year of Initiation	2006–07	2014	2011	2012
Geographical spread/number of units	Selected primary health centres (PHC), community health centres and district hospitals (DH) across 38 districts.	Twelve districts of Bastar and Sarguja divisions. The outsourcing led to recruitment of 784 staff nurses and 13 medical officers.	Thirty MMUs rolled out in a phased manner in 14 districts.	As of March 2016, dialysis PPP is operational only in the three hospitals in Delhi, out of the six hospitals where it was originally planned.
Salient features of the PPP	<ul style="list-style-type: none"> ➤ Objective of the PPP was to provide cost-effective and timely services as per the community's needs. ➤ The private agency could appoint and subcontract the radiology services to a third party. 	<ul style="list-style-type: none"> ➤ Companies/agencies invited for recruitment of health staff in tribal districts. ➤ Staff could be recruited from within or outside the state. ➤ Male staff nurses could be recruited. ➤ Reservation norms not applicable. ➤ Differential payments designed by state depending on the remoteness of posting location. 	<ul style="list-style-type: none"> ➤ Curative, reproductive and child health, contraceptive and diagnostic services to be delivered in remote villages. ➤ Five staff per MMU, including doctor, auxiliary nursing midwife and lab technician. ➤ At least 20 village health camps to be held monthly. ➤ Vehicle, equipment and consumables to be arranged by the company. ➤ Medicines, vaccines, contraceptives and information, education and communication materials to be provided by the health department. ➤ State Health Resource Centre (SHRC) Chhattisgarh engaged as the third party to undertake monitoring. 	<ul style="list-style-type: none"> ➤ Consortium to install new haemodialysis equipment, operate, maintain and manage the centres for seven years, after which they had to hand facilities back to the government. ➤ Sufficient human resource, requisite utilities like power, water, measures to ensure safety of patients, employees, staff, equipment and the facility to be arranged by private agency.
Payment mechanisms	<ul style="list-style-type: none"> ➤ Government would pay the cost for patients being referred by the government facility. ➤ The subcontracting third party would submit the bills to the PHC/subdivisional hospital/health facility, which then would be approved by the approving authority. ➤ The contracting/second party will be paid some commission on the payments made. 	<ul style="list-style-type: none"> ➤ Government to pay to the contracting company which would then pay wages to the health staff. ➤ Service charges will be given to the agency by the Government of Chhattisgarh at the rate of 8% for normal areas and 12% for hard to reach areas as notified by the Government of Chhattisgarh. 	<ul style="list-style-type: none"> ➤ MMU payments fixed with annual adjustment as per escalation rates. ➤ System of bonus and penalties as per performance. 	<ul style="list-style-type: none"> ➤ User charges ➤ Two kinds of patients: "paying patients" and those sponsored by Delhi government

Source: PHRN et al (2017a, 2017b, 2017c and 2017d).

pregnancy, and this was corroborated by health managers (PHRN et al 2017c). Women respondents seemed satisfied with the services as they were free and being provided inside the hospitals. However, discussions with the accredited social health activists (ASHAs—community health workers) revealed that x-ray and ultrasound reports were often delayed and many patients had to travel long distances to collect the reports (PHRN et al 2017c). The hospital administration opined that free radiology services were good for any health institution, they helped in increasing the number of patients, and that this PPP was filling the existing gap. However, they expressed concerns regarding the quality of services, inadequately trained staff and poor safety measures.

The Comptroller and Auditor General of India report (2014–15) of Bihar found that pathology services were available in 54% of the referral hospitals (RHs) and 31% of the primary health centres (PHCs), while sonography facility was available in 14% of RHs and 9% of PHCs (PHRN et al 2017c). Observations made during visits to the facilities reveal that none of the x-ray and ultrasound service centres adhered to the norms mentioned in the agreement. The issue of overuse of radiology services was also observed in the sampled health facilities. The Sixth Common Review Mission to Bihar was critical of the diagnostics (including radiology) PPP initiative and raised concerns related to qualification of staff, personal safety, non-adherence to Atomic Energy Regulatory Board norms, kidney and liver function tests being paid services for all patients, and a long turnaround time (NRHM 2012a).

In Chhattisgarh, the NRHM issued the request for proposals for outsourcing of rural MMUs to provide primary health services in tribal dominated, remote and conflict affected districts in August 2011 (PHRN et al 2017b). Prior to this, the state government was operating MMUs in tribal districts. Through a selection process, the company “Jain Video on Wheels” was selected and a memorandum of understanding (MOU) was signed in June 2012 (PHRN et al 2017b). Around the same period, this agency was named in a high-profile

“scam” over the purchase of MMUs in NRHM Uttar Pradesh (PHRN et al 2017b).

The 30 rural MMUs in Chhattisgarh were distributed across 14 districts and stationed at base locations. The district health office planned the monthly schedule for MMUs, mostly according to the weekly markets. This meant that most of these camp locations were less remote villages, with some road infrastructure and often with a PHC nearby. The experience regarding frequency and regularity of MMUs was mixed for community members, with the MMUs being more regular and timely at the market locations than in the villages. Third-party monitoring by the state health resource centre (SHRC) revealed that the MMUs were often not regular, few were not operational due to lack of doctors, and the situation was worse in the left-wing extremist-affected and more remote areas (PHRN et al 2017b). Third-party monitoring reports state that primary treatment for diseases, such as tuberculosis and leprosy and treatment for minor surgical cases was not being provided (PHRN et al 2017b). Community members emphasised that no antenatal care services were being provided and that the MMU staff would treat minor illnesses, while for any other illness, people would have to visit the nearest government health centre (PHRN et al 2017b).

Haemodialysis centres in Delhi: In 2012, the Delhi government decided to develop haemodialysis centres within Delhi in PPP mode in two clusters, each cluster comprising of three government hospitals. A health department official opines there was a consensus to undertake PPPs for “advanced” services like diagnostics, computed tomography imaging and dialysis and that there were several PPPs in the pipeline (PHRN et al 2017a). Possible reasons for this decision, which emerged from officers’ interviews, were that the patient load was too heavy for the hospital to provide dialysis services in its current state and that the government had not invested in dialysis machines (PHRN et al 2017a). The government awarded the project to two consortia for two clusters of hospitals in July 2013, after a competitive two-stage bidding process (PHRN et al 2017a).

However, only one consortium agreed to participate. The dialysis centres started in two tertiary hospitals—Lok Nayak Hospital (LNH) and Rajiv Gandhi Super Specialty Hospital (RGSSH)—in mid-2014. As of March 2016, dialysis PPP was in operation only in three hospitals in Delhi, instead of the six planned. The dialysis centre at RGSSH started functioning in May 2014 where dialysis service is provided in four shifts round the clock, with the capacity to provide services to 30 patients in each shift. The dialysis centre at LNH was running as a “business model” in which the private partner provided dialysis at a subsidised rate of ₹1,073 (PHRN et al 2017a). Sponsored patients have to go through a three-step procedure (pre-authorisation, authorisation and submission of papers to dialysis coordinator) to avail free dialysis treatment at these centres. There was usually a waiting list and the number of paying patients was negligible (less than 10%).

The chief executive officer of the company believed that it has been advantageous to partner with the government as “it had opened up a new patient segment for the company,” of patients who would not have otherwise availed dialysis due to high market prices (PHRN et al 2017a). The medical superintendent of RGSSH was satisfied with the services being provided by the company. Grievances articulated by the patients included lack of skilled technicians, having to undergo creation of the fistula for performing dialysis at a separate centre, problems in getting medicines free of cost from the public hospital and out-of-pocket expenses incurred on travel and medicines (around ₹3,200 per month) (PHRN et al 2017a).

Health Workforce

In the case of HR outsourcing in Chhattisgarh, views on performance of the “outsourced” staff (filling the posts which were otherwise lying vacant) varied among the health administrators. Moreover, the community or *mitanins* (ASHAs) were not aware of the outsourcing or any improvement in services in the period (PHRN et al 2017d). The Chhattisgarh government decided to outsource the recruitment and management of health staff (doctors, nurses, and pharmacists) to

private agencies in order to address the shortage of staff in rural, remote and conflict-affected areas (PHRN et al 2017d). The reasons given for the shortfall were that qualified candidates were reluctant to go into these areas and that the government was unable to fill the posts reserved for Scheduled Caste and Scheduled Tribe categories (PHRN et al 2017d).

However, previous evidence suggests that poor implementation of the existing scheme for providing additional incentives for health staff in remote and difficult areas (Lisam et al 2015) and contractualisation of staff might have resulted in lower recruitments (NRHM 2012b). Moreover, no empirical analysis had been done of the actual vacancies (reservation category-wise) or of the current or potential availability and interest of nurses or doctors in the market (PHRN et al 2017d). The state government's usual policy has been to recruit local staff domiciled in the district, recruit female staff nurses and follow reservation rules. However, the outsourcing allowed for recruitment from outside the state and of male staff nurses and also for flouting of reservation norms (PHRN et al 2017d).

Advertisements were given in newspapers in December 2014 for outsourcing HR recruitment, and by January 2015, six companies were empanelled, of which two dropped out (PHRN et al 2017d). After empanelment, the department provided necessary information regarding vacancies in the selected districts to the companies for recruitment. The outsourcing led to the recruitment of 784 staff nurses and 13 medical officers (PHRN et al 2017d). Most of the existing health staff (block medical officers and regular staff nurses) said that this step was advantageous mainly because it led to filling the posts lying vacant for many years.

However, most of them also said that local people should be preferred and recruited. The remuneration offered to the staff nurses recruited via outsourcing was significantly higher than that offered to the contractual staff nurses appointed within the National Health Mission (NHM), hence making it more attractive. Nevertheless, staff nurses in these PPPs spoke of delays in receiving their salaries through the contracting agency (PHRN et al 2017d).

The regular staff nurses felt that their workload had decreased after the recruitments, and the male nurses would do more of the outreach work.

An official who was involved in training of health staff expressed concerns regarding the quality of the staff recruited from other states (personal interview 2016). Issues regarding health workforce were also seen in other PPPs. In the MMU PPP, one of the main problems faced by the agency was the high attrition rate of the doctors and irregular salaries. This hampered MMU performance. In the Bihar initiative, the Sixth Common Review Mission (in 2012) as well as the respondents from hospital administration raised concerns about the qualifications of the health staff (NRHM 2012a, 2012b). Concerns about the lack of skilled technicians were also raised by respondents regarding the haemodialysis PPP.

Transparency, Supply and Financing

Access to information: There was very little information regarding the PPPs in the public domain and it was challenging to get any data on them from the government. In the case studies, there were indications of non-transparent selection (HR), political interference (radiology), selection of an agency with dubious antecedents (MMU) and lack of information on the reason for selecting a service for PPP (haemodialysis) (PHRN et al 2017a, 2017b, 2017c, 2017d). Financial information could not be accessed by the researchers in Bihar and Delhi due to reluctance of the administration to share the data. In the haemodialysis study, information regarding the composition and functioning of monitoring committee was not made available to researchers at both hospitals (PHRN et al 2017a). In the case of HR outsourcing, the Chhattisgarh finance department, upon releasing funds, recommended that such outsourcing should be done through an open tender rather than simply through an advertisement, as was done in this case.

Supply of medical products and technologies: In the MMU initiative, even though the state had been budgeting for MMUs in its NRHM Programme Implementation Plan from 2006 onwards, they could

not be made operational due to procurement issues. Even after outsourcing, necessary equipment, such as semi-autoanalyser, infant weighing machine and blood pressure machine, and consumables such as reagents and stains were not available, resulting in limited diagnostic services being provided (PHRN et al 2017b). In the case of dialysis outsourcing, we saw that of the target of setting up 120 machines across six hospitals, less than half were functioning at the time when the study was conducted. At the dialysis centre at LNH, which was started in March 2013 (before the PPP was initiated by the government), only 10 machines were operated at a time in four shifts and two were kept as spare (PHRN et al 2017a). In Bihar, the overall non-availability of drugs and pathology services in the facilities was highlighted as a big challenge by the respondents (PHRN et al 2017c).

Financing and fund flows: Finances are a critical part of any project. In Bihar and Delhi, no financial data could be obtained. However, one hospital administrator in Bihar expressed concern that in the few months preceding the study, the utilisation of radiology services had exceeded budgetary allocation in their facility (PHRN et al 2017c). For Chhattisgarh's HR outsourcing, permission was not taken from the finance ministry before starting the initiative, and hence, the service initially ran short of funds (PHRN et al 2017d). It was also expected that NHM funds would pay for the initiative but that did not materialise at first. This hurdle led to delays in the initial payment of salaries to the nurses. Subsequently, the finance department granted approval in May 2015. Funds amounting to ₹18.10 crore were finally provided to the health department, of which ₹17.66 crore were spent for the duration of the PPP. The MMUs in Chhattisgarh were funded under the NRHM. During the period of outsourcing, the government spent more than ₹5.9 crore for the MMUs from September 2012 to May 2014 (PHRN et al 2017b).

Monitoring and Grievance Redressal

In all cases, except for the rural MMU, there was lack of regular monitoring of

the PPPs. In Bihar, the study revealed a gap in the monitoring of the radiology PPP. As per the 2006 contract agreement, the district health society (DHS) and the rogi kalyan samitis (RKS) were to monitor and supervise the units. Interviews with health officials revealed that the DHS and the RKS have not been playing an effective monitoring role, mainly due to lack of requisite information about the PPP and technical skills, work burden, and collusion (PHRN et al 2017c). In the HR outsourcing in Chhattisgarh, the department was not concerned with “how, from where, or through what process the company gets these employees” as per the state nodal officer (PHRN et al 2017d). Critiquing this, one official said that there were no quality checks by the government of the HR recruitment and as a result, a very variable quality of nurses was finally recruited (PHRN et al 2017d).

Monitoring of the rural MMUs at the state level was undertaken by nodal officers from the company and the health department, along with SHRC Chhattisgarh, which was designated as the third-party agency (PHRN et al 2017b). The private agency had to submit regular performance reports to SHRC Chhattisgarh, which also made monitoring field visits. District-level monitoring was to be done through the district health office, with no formal mechanisms for feedback from the block, leading to a laxity in monitoring and, subsequently, performance (personal interview 2016) (PHRN et al 2017b). At the community level, the camp was verified either by a member of the local elected bodies or the secretary of the village health sanitation and nutrition committee who is the *mitanin*. The company failed to operationalise the centralised toll free number that was mentioned in the MOU (PHRN et al 2017b).

The MOU for dialysis PPP in Delhi lists provisions for grievance redressal that include patient feedback forms, a complaint policy, and a grievance redressal cell (PHRN et al 2017a). Though officials reported the formation of a monitoring committee for quality assurance and grievance redressal cells at both hospitals, information regarding their composition and functioning was not made available to the researchers (PHRN et al 2017a). In

December 2015, nearly 75 patients from RGSSH had submitted a petition to the health minister pointing out various problems that they face, seeking relief. However, no action had been taken as yet on the grievances (PHRN et al 2017a).

Discussion

The four case studies demonstrate certain commonalities and pathways set within the conceptual framework and contribute to an emerging theory on the grounds for PPPs and their impact on the public health system (Figure 1). The study finds that in all four PPPs, the rationale for outsourcing was the non-availability of these services or HR (in the case of Chhattisgarh), but the decision to undertake a PPP was prompted by certain specific factors in each case. The failings of the government in providing and managing health services were sought to be overcome through PPP measures that largely did not work. PPPs also led to the violation of rights of the health workforce and circumvention of various types of norms (related to salaries, reservations, social security, recruitment, procurement, etc) and to poor quality services. Meanwhile, since investments were made in parallel to the health system rather than within it, and time was lost in an inadequate process that had to often be recalled or terminated. Hence, it could be hypothesised that they weakened the government healthcare system further.

Weaknesses in public health systems:

The building blocks of the health system are based on its essential functions (WHO 2007). The case studies illustrate that there were weaknesses in one or more of these health system building blocks and the PPPs per se were introduced, ostensibly, to address service gaps in diagnostics, haemodialysis and primary healthcare, as well as shortage of human resources. The rationale for initiating PPPs often arises from low budgetary allocation and increasing gaps and inadequacies in services in the public sector, along with the belief that efficiency will be increased by purchasing services from private providers and that it will bring in private investment (Roy 2017). However, the case studies demonstrate that the

specific weakness in the health system may, to an extent, have been a consequence of not merely under-resourcing of the health system, but the failure of the government to undertake management functions, like recruitment, training, monitoring and governance.

Even though certain rationales were provided for initiating the PPPs, the study shows that adequate situational analysis was not undertaken to understand the reasons for the gaps and whether those reasons could be countered by the PPP being considered. In fact, the initiation of the PPPs seemed to be dictated by policy rather than evidence. For instance, in the case of Bihar radiology services and Chhattisgarh rural MMUs, the NHM seems to have played a role in promoting the PPPs. It provided policy direction and increased budget allocation, in addition to pressurising the state to spend the allocated funds. In other instances too, providing a rationale for the PPPs through the use of data and evidence has been missing (Karpagam et al 2013).

Quality issues, non-adherence to the contract and substitution:

During the study, concerns were raised regarding the quality and regularity of services being provided by the private agencies in all four cases. For instance, there were lapses in regularity and quality of services being provided by the MMUs, especially in the more remote and underserved areas. In Bihar, it was found that the x-ray and ultrasound service centres did not adhere to the agreement and there were lapses with respect to timing, safety, human resources and quality of services. Other studies too have found problems related to regularity and quality of services in the functioning of PPPs.

An evaluation in Odisha similarly found that though some of the PPPs led to an increase in services in tribal areas, there were irregularities in their functioning and operations (Kandamuthan and Madhiredi 2016). B Roy's (2017) review of hospital-related PPPs found issues in the quality of services being provided in most of the PPPs. Studies have also found people being excluded due to user fees imposed in PPPs or due to the inability to show the below poverty line card to avail

services (Roy and Gupta 2011; Karpagam et al 2013). R V Baru and M Nundy (2008) suggest that such partnerships need to be evaluated beyond monetary terms, looking at quality of care through dimensions like “responsiveness, interactive quality, trust and accountability.”

Though the PPPs in the case studies were introduced in response to the gaps in the health system, instead of complementing existing services, they seemed to be substituting them. However, at the time of the study, in most cases, the PPP finally either had to close down or is currently functioning at a suboptimal level. Meanwhile, as a result of this “substitution,” the same services that were being provided by the government facilities themselves were reduced, as we see in the case of diagnostics in Bihar. Other studies and reports have similarly found that once services are outsourced, these same services that were being provided in-house become underutilised and dysfunctional (Roy and Gupta 2011; NRHM 2012a).

Circumvention of government norms and practices: One of the motivations for introducing PPPs seems to have been the opportunity to circumvent government norms and practices so that the specific health system gaps could be addressed without adherence to regular government processes. This is quite clear in the case of the MMUs and the HR outsourcing. For instance, the human resources outsourcing was a way to circumvent constitutional safeguards and labour rules related to caste reservations, gender and domicile. The negative impact of PPPs on labour rights, their social security and working conditions has been documented globally (Hall 2015).

Lack of transparency and public access to information: One common characteristic amongst the PPPs studied was that very limited and sometimes absolutely no information was available in the public domain about the projects. Though being financed through public funds, there was no public disclosure of essential financial, programmatic and performance data. Except in Chhattisgarh, financial information and programme data was not made available for study even after

making requests to the appropriate authority. Baru and Nundy (2008) have expressed concerns about the possibilities of corruption in the selection of the private partner in such partnerships.

Absent or insufficient systems for monitoring and grievance redressal: Other than for MMUs, there did not seem to be any monitoring systems in place to monitor the PPPs. The community did not have any role in monitoring the services. Even in the MMU PPP, there were issues of possible conflict of interest as SHRC Chhattisgarh, which was the appointed third-party agency for monitoring, was also the agency that had facilitated the PPP initiation. There appear to be no systems for redressal of patient grievances in any of the PPPs. The lack of a monitoring system, poor accountability and the absence of a grievance redressal system have similarly emerged as common features in most studies of PPPs (Venkat Raman and Björkman 2009; Karpagam 2013; Roy 2017).

Challenges similar to the government health system: The study finds that half of the PPPs had to be closed down or terminated due to non-performance of the private agency, disinterest of private agencies and problems that resulted due to circumventing government norms and procedures. Challenges faced by the private agency were similar to those faced by the government health system. The agency running the MMU was unable to get health workers to work in remote rural areas and the attrition rate was very high. The issues related to governance still existed. The PPPs filled certain specific gaps, with most being temporary and selective. For instance, in Bihar, though patients could avail x-ray and ultrasound services free of cost, they raised concerns about the non-availability of drugs and pathology services in the hospitals.

The HR outsourcing led to mainly nurses being recruited, and while a large number of nurses did join the health workforce, a shortage of medical officers and specialists still remained. As discussed previously, many of these gaps themselves existed by design and, in fact, had to eventually be covered by the public health system itself once the PPP failed. Studies both

in India (Kandamuthan and Madhiredi 2016) and elsewhere (Rao et al 2018) have found private agencies facing similar challenges as the public sector, such as recruiting and retaining health workers, especially in rural and underserved areas.

Conclusions

The PPPs filled a gap in the health system functioning and did appear to work in the short term, albeit partially and selectively. However, their contribution to the larger health system strengthening remains doubtful. Such interventions seem to reinforce the piecemeal, vertical approach in which interventions function in isolation, without necessarily strengthening the health system or providing the comprehensive service that patients needed. The study casts doubts upon their long-term implications and sustainability and prompts a more serious assessment. Only a comprehensive public-health approach can truly analyse the applicability of PPPs in a situation where people are deprived of services in the public health system, and forced to welcome any small *prima facie* improvement. Further research is needed on the experience of PPPs in various states in India and on the differing experience with for-profit and not-for-profit private sectors. The emerging theory needs to be further tested and developed.

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