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CHAPTER

PUBLIC PRIVATE PARTNERSHIPS
for Outsourcing Management of Primary Healthcare Facilities

Uttarakhand | *Karthik Sharma; T. Sundararaman*

Introduction

Uttarakhand, the 27th Indian state founded by division from Uttar Pradesh is 86% mountainous with a population of approx.10.8 million people and 189 per Sq.km density, less than the national average density at 382. Uttarakhand is predominantly a rural state, with population of less than 500 people in 81% (12,699) rural settlements. The small size of the population settlements and their scattered distribution in the state pose a considerable barrier for service delivery.

In May 2013, a Public Private Partnership (PPP) for outsourcing of primary and secondary Healthcare facilities was initiated through a Memorandum of understanding (MOU) between the Directorate of Medical Health & Family Welfare (D.O. Ministry of H&FW, Government of Uttarakhand) and two private sector parties. This initiative was part of other such efforts for the outsourcing of public health facilities and services. (see accompanying box) This outsourcing practice has been ongoing in Uttarakhand for the last 20 years with results varying from limited to no success- making it important to study the PPP model because it is one of the most recent and innovative of such initiatives- which have not been studied despite being around for sometime now. Outsourcing of primary health centres, urban health centres and even of district hospitals has also taken place many times across many states- but few have sustained- and it is important to understand this better.

Rationale for PPPs

Outsourcing has been justified by a perception of a dysfunctional public Healthcare delivery system. The reasons for this are attributed to the fact that there is little accountability and motivation in the salaried government employee. Therefore the theory is that outsourcing will make deliverables much clearer and therefore accountable. Further selection by competitive bidding can get motivated ownerships whose personal financial interests will be aligned with the government objectives. It is for this reasons the Uttarakhand PPP model for outsourcing of primary and secondary healthcare facilities has crucial lessons for current and future PPP models for service delivery in India. The fact that 80 % of the population have utilized the private sector for ambulatory Healthcare is seen as a supporting fact. Therefore, it is reasoned, partnerships and synergies

between the public and private healthcare sector are becoming essential.

The Evolution over time of the PPP model

The PPP cell in the Government of Uttarakhand was formed with technical assistance from the Department of Economic Affairs (DEA), Government of India and Asian Development Bank (ADB) for promotion of PPP in the State. There have been many PPPs in the past and some are ongoing. This PPP for outsourcing of Community Health Centre's (CHC) was initiated by the PPP cell after discussions with key stakeholders – both of the general administration and the technical directorates.

The MoU to outsource 12 selected CHC's was signed on 14th May 2013 in Dehradun, Uttarakhand between the Directorate of Medical Health & Family Welfare, Government of Uttarakhand and the two private agencies Rajbhra Medicare Pvt. Ltd., New Delhi and Sheel Nursing Home Pvt. Ltd., Bareilly (UP). The two private agencies were incorporated under a PPP design which was called the "Operation and Maintenance (O&M) form" of PPP. One immediate reason stated for the outsourcing of the CHCs being to help closing in the human resource gap in the rural facilities, where the public sector units were unable to consistently provide medical staff. Especially for specialists required for emergency obstetric care and in maternal and child health.

The two private parties Rajbhra Medicare Pvt. ltd., New Delhi and Sheel Nursing Home Pvt. Ltd., Bareilly (UP) which won the selection process were outsourced 4 CHCs and 8 CHC's respectively. These 12 CHC's are spread over 13 districts of the 2 divisions -Kumaon and Garhwal.

Rajhbra Medicare an ISO company, works in providing preventive, diagnostic and curative healthcare services through mobile medical units & rural hospitals for inaccessibleregions. The company registered at Delhi states over 10 years of experience of operating mobile clinics in rural settings with previous experiences in states such as Gujarat, Rajasthan and Bihar. It also operates mobile clinics in Uttarakhand.

Sheel Nursing Home statesan experience of 35 years in the field of medicine and healthcare. The company was set up in 1979 as a Sheel maternity nursing home in Bareilly. Over the years it has established itself as Gangasheel University for higher education in the field of medicine in 2015.

According to the officer in charge of PPP cell, these 12 CHC's were selected based on their geographical location. Andon an assessment where it was found that these particular CHC's were not running on

Table 1 : List of CHC's outsourced to private players by district

S. No.	Private Player	Location (Distances)
1	Rajbhra Medicare	**Sahiya** (61. 8 km from Dehradun) **Raipur** (9 km from Dehradun), **Naugaon** (125 km from Dehra Dun and 30 km from Uttarkashi, Dist.) **Thatyur** (68 km from Dehradun and 20 km from Tehri)
2	Sheel Nursing Home	**Chaukutia** (295 km from Dehradun and 90 km from Almora) **Lohaghat** (445 km from Dehradun and 14 km from Champawat, Dist.) **Bajpur** (230 km from Dehradun and 106 km from US Nagar, Dist.) **Kapkot** (345 km from Dehradun and 24 km from Bageshwar Dist.) **Munsiyari** (450 km from Dehradun and 128 km from Pithoragarh Dist.) **Gairsain** (260 km from Dehradun and 37 km from Chamoli Dist.) **Garampani** (290 km from Dehradun and 14 km from Nainital Dist.) **Jhakoli** (218 km from Dehradun and 38 km from Rudraprayag).

full capacity and had problems with maintaining consistent medical staff.

The PPP was officially launched in May 2013. And in December 2014 there were complaints made mainly related to over-charging. As there was an element of payment according to outputs- and the charge was that the outputs were inflated. There were also complaints that the staff as promised were not there- and later complaints from the public as well. By about August 2015, an understanding between the state and the private player was not reached and the payments were stopped.

In December 2015, the contracts were formally terminated, at which instance the contracted went to court and by August 2016 got a stay order.

Table 2: Time line of events in PPP health service model

Date	Activity	Repercussions
May 2013	MoU signed between Govt. of Uttarakhand and Private players	Work began at CHC's as per MoU.
December 2014	Complaints from local population and instances of over diagnosis noticed.	Payment Fluctuations to private sector.
August 2015	Over Diagnosis and absence of medical specialists found in all CHC's.	Payment fully stopped.
December 2015	Contract Terminated	Private players file case on Govt.of Uttarakhand in High Court.
February 2016	Court case proceedings.	Part payment released
May 2016	Payment Stopped	Court case pursued at Supreme Court
August 2016	Stay order by Supreme Court	PPP work resumes.

In the stay order the Supreme Court had asked the government to allow the private sector more time to deliver to the promises in the MOU. On 24th November 2016, the court agreed for the contract with Rajbhra to be officially terminated with the government given one years time for releasing approximately past 6 months dues. The contract with Sheel is not formally terminated and currently in limbo with neither payments being made nor services being delivered.

The Contracting Design

The MOU was signed for a period of five years with a clause for renewal for further five years based on a performance review by an expert committee. As per the MOU, the expert committee was to be chaired by a representative of rank of additional secretary or above form the Dept. of Health, Uttarakhand with members comprising of domain experts from the government, PHC, CHC, doctors and hospitals. The expert committee also included two patients and two super specialist doctors.

An initial 6 months termed as the 'Implementation period' was provided for setting up, appointment of staff and procurement of consumables, equipment and medicines. The equipment and medicines were to be provided by the government health department.

The main features of the MOU are summarized in Table 3 below:

Table 3: Overview of MOU

Particulars	Description
Project Owner	Department of Medical Health & Family welfare
PPP Model	Operations & Maintenance service
Concession Period	10 years
Number of CHC's	12
Financial Grant	a). Capita Grant for equipment's above ₹ 15.00 lakhs on one-time basis b). For any subsequent purchase of more than Rs.5 lakhs, 100% grant subject to approval by DOMH & FW. c). Operating Grant : Fixed plus Variable on Revenue sharing between PPP partner and govt.
Identified services	a). Diagnostics: X ray, Ultrasound, ECG & Pathology b). Maternity cases c). Minor Injuries d). In patient services e). Surgical services f). Orthopaedic surgeries
Monitoring Arrangement	Expert Committee

The Selection Process: The government PPP cell with development partner support carried out extensive preparation in designing the tender document

and a competitive bidding process was followed for finding eligible parties for implementing the project. There was a formal evaluation process by which these two private agencies were selected. Some respondents working in the Secretariat allege that the actual tendering process was more on paper and the private players were preselected by higher authorities based on previous interactions, and the bidding process being more of a legal formality. But such allegations too are routine. (A light-hearted comment that goes around in those who bid for such tenders is that if you are not taken into confidence while the tender document is being drafted, you are probably not a serious contender for the bid).

Table 4 : L1 prices of Tenders

Tenders	Package 1 (crores)	Successful bids	Package 2	Successful bids
Rajhbra Medicare	53.67	L2	-	-
Bombay Hospital	55.34	L3	36.39	L2
Sheel Nursing Home	45.73	L1	27.15	L1
Citizen Foundation	-		163,160	L3

Table 5: Technical bid points of Tender's

Tenders	Bids	Technical points
Rajhbra Medicare	Package 1 & 3	90
Bombay Hospital	Package 1 &2	85
Sheel Nursing Home	Package 1& 2	80
Citizen Foundation	Package 2	80

Several officers and the medical officer responsible for administration in the CHC were of the view that a selection based on L1 i.e. the lowest price offered by a particular tender is inherently faulty since there is undercutting in the proposal cost to win the bid. The salary required to retain specialists and medical officers in rural and remote areas was in particular under-estimated. The private agency selected however maintain that the quote was realistic and the L1 price never being the problem while the reason being fluctuations and erratic payment release by the public sector.

Another senior officials in the PPP division stated that the MOU had inherent weaknesses. Though definitions and interpretations were well defined and laid out, the MoU lacked real authority for monitoring quality of health services being provided at the facilities. The MOU emphasised primarily only administrative procedures which were not adequate or relevant for assessing the performance- especially in the event of a dispute.

A sum of ₹ 30 Lakhs was reserved as a security to be released immediately on contract termination. Other than this there are no clear penalties for lapse in service delivery.

Work Outputs expected under the MOU: The CHC's mostly have 30 indoor beds with one operation theatre, labour room, X-ray facility and labour facility. There are separate wards for males and females for inpatient Department (IPD) care. The outsourced CHCs varied in built up size- and the fixed component of grant amounts changes with this as the financial bid has to be quoted on this basis. This is a curious feature.

Under the MOU some tasks remain with the government and some of the task are outsourced to the private agency. The private agencies were to have no role in the national and state health programmes except for DOTS in TB control and testing and treating for Malaria and HIV. The other responsibilities that remained with the government were medico legal cases ,ambulance services and collection of user charges.

The private agencies were responsible for providing all outpatient services free of cost and for providing Ante-natal care.

Outpatient services to be included were: general medicine, general surgery, paediatrics, obstetrics, gynaecology and contraceptive services and dental (optional).

Inpatient services were to include emergency services, delivery services including emergency obstetric care, surgeries including orthopaedic surgeries, cataracts.

The MOU also specified drug dispensing services and a range of diagnostics both in radiology & pathology.

The timings were specified as 8 am to 4 pm for out-patient, 8 am to 8 pm for diagnostics and 24x7 for Emergency. Records were also to be maintained.

In the PPP MOU the private agencies are responsible for division of facilities into an entrance zone, ambulatory zone, diagnostic zone, inpatient nursing unit, operation theatre/labour room, service zone and administration zone. Rooms were already available for Minor operation theatre, injection and dressing rooms as well as an observation room.

Table 6: Responsibilities of the private sector in PPP

S. No.	Responsibilities of Private Sector
1	All Clinical services
2	Up gradation of the facility and management as per the prescribed IPHS standards.
3	Add specialized services/beds for procedures over and above existing scope as prescribed by the DOMH & FW from time to time
4	Recruit, retain and manage human resources.
5	IT- based management information systems.
6	Maintenance of all movable and immovable assets of the hospital.
7	Abide by the existing government health laws/rules and policies.
8	Undertake all statutory responsibilities except medico legal cases.
9	Timings of the OPD (8 am to 4 pm) and Diagnostics (8 am to 8 pm). Emergency 24x7
10	Clinical Services: OPD, IPD, emergency, drug dispensing, diagnostics (radiology & pathology) ,maternity cases, surgeries, orthopaedic surgeries, transplants, cataracts .
11	Catering & dietary and Linen & Laundry
12	Hospital Waste Management, Pest Control and Sterilisation Services.
13	Online Clinical Record, Security and Patient discharge process.

Human Resources under the MOU: The private agencies are responsible for recruitment, training and remunerations of all personal staff, employees and staff for operations & management of the CHC. The trained medical personnel's which include doctors, nurses, paramedics, emergency medical technicians have to be certified and qualified according to protocol and credentials be notified to the public sector. The list of staff to be hired is given in the table below. For hiring medical staff the minimum criteria mentioned is at least 5 years of work experience along the respective qualification degree for specialists, general surgeons ,nurses and other medical staff.

The Public sector also had to retain a certain complement of staff to perform its functions. This was a complement of 5 staff members – a medical officer, a Pharmacist, a Driver, a Ward Boy and a Sweeper. The Medical Officer (MO) at the CHC is responsible for matters related to public health and legal issues such as medico-legal cases and national health programmes simultaneously going on in the CHC. They are responsible for also monitoring the performance of the concessionaires and providing support.

Table 7 : Staff expected from private sector as per MOU

S. No.	Clinical Staff	Number
1	General Physician	2
2	Physician	1
3	Obstetrician& Gynaecologist	2
4	Paediatrician	1
5	Radiologist	1
6	Orthopaedic	1
7	ENT Surgeon	1
8	Anaesthetist	2
9	Eye Surgeon	1
10	Dental Surgeon	1
11	General duty medical officer	6
12	Staff Nurse	15
13	Maternity Assistant (ANM)	8
14	Total	41

Financing Under the MOU: The operating grant provided by the public sector in the PPP was done in two formats - the fixed and the variable form. The variable grant is based on performance on a monthly basis . The unit rates had been fixed in the MOU and is provided in the table 8 below. Fixed operating grants also in table 8 are provided every month irrespective of outputs to cover recurring costs such as housekeeping, laundry, waste management, hospital administration, manpower, outpatient department expenses and emergency. All payments are transferred from the government treasury to the private agencies bank account.

The variable operating grant is provided for the following :

a). No. of actual diagnostic procedures performed in a month – X ray, Ultra Sound, ECG and Pathology.

b). Number of actual maternity cases delivered in a month.

c). Number of minor accident/injury cases treated.

As a form of incentive for good performance for renewal of contract a 10% increase on fixed and operating costs after a period of five year was to be provided.

Fixed grant : The fixed grant is provided per annum based on per square (sq) metre of built area. This is divided by 12 and paid every month. This rate rises sharply over the 5 years. The rate per square meters changes for each CHC (see table 8 below) so that the amount received per month per CHC in the first year works out almost always to about ₹ 20 lakh per month or ₹ 2. 4 crores per year. This is without including the variable cost. The rationale for a using such a formula- cost based on built up area, but at different unit rates – has not been clearly laid not.

The public sector provided the equipment and infrastructure costs in all the CHC's as per the IPHS norms. These equipment's would not include any non-medical appliances. For equipment requirement for over 2 Lakhs a notice period of at least 6 months was required. This period was for review of the utility and requirement of the equipment before procurement. The private agencies were responsible for reimbursing service charges to the public sector during this period such as property tax, water tax and sewerage charges for the project site.

These outsourced CHC's also 'on behalf of the government' collected nominal user charges by the patients which were then duly submitted to the DOMH& FW. As the private agencies were not authorised to collect these user charges as part of their PPP MOU, it was the Chikitsa Prabhandan Samiti of the CHCs that were responsible for collection charges of diagnostics, maternity cases, and minor accidents among others. This Samiti also maintain proper records of number and type of diagnostics, bed occupancies, consumables and medicines given to patients on payment. The output reports of the private agencies are tallied at the end of the month with the the user charges collected.

Case Study of Thatyur CHC

Tatyur CHC is in Tehri district, some 68 km from Dehradun on the main road to Tehri town. It takes about two and half hours to reach from Dehradun.

Table 8: Government Grant payable to the concessionaires

S. No.	Description	Procedures	Year 1	Year 2	Year 3	Year 4	Year 5
A	**Variable Grant**						
1	Diagnostic Govt. support (₹ per procedure)	X-ray	90	90	100	120	120
		Ultrasound	180	180	230	250	270
		ECG	80	80	80	150	150
		Pathology test	50	50	50	70	70
2	Maternity Cases (₹ per procedure)		1600	1800	1800	2200	2200
3	Accident Cases (₹ per procedure)		300	300	300	500	500
4	Fixed Grant (Districts) Govt. Support ₹ 'per sqmt' of built up area per annum	Almora 1280 sqmt	19 140	19140	20617	22976	24776
		Champawat 1643 sqmt	14912	14912	16062	17900	19657
		US Nagar 8228 sqmt	2977	2977	3315	3513	3768
		Pabou (Pauri) 2893 sqmt	9222	9637	10467	11089	12126
		Thalisan (Pauri) 2893 sqmt	8220	8635	9018	9786	10968
		Haridwar 6061 sqmt	4022	4270	4651	5034	5400
		Hindolakhal (Tehri) 418	59521	60956	63612	70598	75909

On interviewing the government MO his perception was that service delivery was the sole responsibility of the private agencies and that there was no facilitation needed from the government. He also observed that Interns from medical colleges were being posted at the CHC which was far less than the qualifications specified. The private agencies were responsible for posting in total 42 ancillary staff at each facility- but in practice even at its peak only a part of this had been made available.

On interviewing the Manager of the private agency stationed and leading the CHC team at Thatyur, the total strength of human resource was found to be 22. The only medical staff available was a dentist and 2 General Duty Medical Officer (GDMO)'s against 19 doctors and specialists who were needed as per the MOU. There was 1 (General Nursing and Midwifery) GNM Staff and 1(Auxiliary Nursing and Midwifery) ANM staff though the total requirement was of 23 staff members. The GDMO was paid at average from 60–70 000 p.m. Due to the on-going legal case, fluctuations in wage payments were inevitable. The manager stated that they had managed to get a General surgeon, a gynaecologist, a paediatrician, a physicians and a radiologists – but they left the CHC for employment elsewhere. The numbers of staff in place was 22 only because the number of allied staff such as ward boys, peons, dressers, pharmacists, lab technician were as per the MOU even though they were unpaid for the past 6 months. The reason for the allied staffs continued reporting for work was due to the fact that the allied staff were hired from the local village and continued in the hope of receiving their outstanding dues.

On further probing the manager agreed that human resources were an issue and at the peak their CHC had 11 medical staff. This peak was for a period of 6 months from January to June 2015. In other CHCs the medical staff ranged from 6 to 8. In Tehri the CMO's view of the staffing was that at peak the medical staff was found to be at 8 that too only for a period of 4-5 months. This included an Orthopaedic surgeon, Gynaecologist, Paediatrician, Ophthalmologist, Physician, Anaesthetic and a dental surgeon. The ophthalmologist it is learnt travelled on a rotating basis through 4 CHC's under Rajbera private agency.

No CHC established C-sections except for Raipur CHC- which was distance wise only 9 km away from Dehradun - and there was no clarity why this CHC was particularly selected. As to why other CHC's were not undertaking surgeries, it was informed that due to lack of proper infrastructure and availability of blood. The availability of anaesthetist and gynaecologist specialists at the same time was also a major challenge.

An official at the directorate of health informed that during routine inspection it was found that the private agencies were not only having insufficient medical staff but the medical staff at the CHC's were found to be either above 60 and almost retiring or fresh graduates from medical school, and this was true even in the CHC visited.

It was also learnt that there were trust issues between the public staff posted at the CHC and the private agency doctors. There was also a feeling of hierarchy and interpersonal issues. A Chief Medical Officer (CMO) on interview commented that the main reason for the PPP failing was that the managers lacked leadership qualities and were not well equipped and unaware of the (Key performance Indicators) KPI's.

Outcomes and referral system: A CHC in Uttarakhand at an average has an catchment area of 45000 people with two PHC's and sub centres referring their patients to the CHC. Curiously the private agency did not have any responsibilities with regard to functioning of the PHC's and sub centres. They were responsible to provide clinical services only and that too for patients coming either from referral or reporting directly to the CHC. There was no active mechanism of handling referrals from lower facilities or with other CHC's in the PPP and no feedback either. However for few cases in which referrals were essential as in the case of Caesarean sections or blood requirements ,these were referred mostly to Dehradun using the government 108 ambulance service.

At an average there were about 30 to 50 cases per day reporting at the CHC, with less than 14 in-patients per month. No surgeries and caesarean sections were ever undertaken in any of the CHCs and the only one exception being Raipur a semi

urban CHC. There were 6 cases of delivery in a month but surprisingly at an average 3 blood tests per OPD patient- which is interesting since this being one of the measured outputs for the variable payment is more amenable to over-reporting.

In Table below we present the total number who availed of different services. This is calculated as a monthly average from the sum of 30 months. (Knowing that there must have been a slow pick up in early months the figures of 36 months are attributed to 30 months). We show the figures not only for the CHC studied but also for the best performance CHC.

Table 1 : Avg. Case load per month over a period of 3 years in Tathyur CHC & Raipur CHC

Services	Tathyur CHC (Cases Per Month)	Raipur CHC (Cases Per Month)
OPD	1054	4820
X Ray	259	547
Path Test	3126	10765
ECG	33	287
Admissions	46	184
Accidents	15	97
Operation	0	24
Maternity cases	8	39
Dental	15	49
USG	2	627

These numbers are very modest numbers for any CHC. But what is interesting is a much higher consumption of USG and of laboratory tests than is usually seen. Both of these are part of the variable financing formula and therefore earns higher remuneration.

Access to Medicines and Diagnostics: Under the MOU the public sector was responsible for providing all diagnostic equipment and ensuring an effective supply chain of medicines at the CHC. The private agency were responsible for maintaining the inventory for a period of at least 15 days to avoid stock outs according to the essential drug list (EDL). Prescribing and procurement of only generic medicines at the CHC was also agreed upon. The payments for generic medicines was done by the Public Sector on a quarterly basis at an actual amount for a maximum of Rs.3 Lakh per annum per CHC.

The patients paid a minimum user fee for diagnostics made available as per the schedule. The medicines were free of cost. These charges were collected by the Public Sector. No user fee collections were to be made by the private agency for their services.

Information system in use: The private agencies were required to install a hospital management software's for Key Performance Indicators (KPI), patient wise data report, for creating invoices, for creating daily and monthly reports. As they were responsible to maintain and preserve professional records of diagnosis, treatment and care given for all patients receiving treatment. Such a medical record was seen to be maintained by the private agency which documented health of patients and treatment prescribed. These records were to be sent to the PPP cell in the directorate as monthly digitalised reports and the reimbursement for variable costs were computed based on these outcomes reported.

The private agencies were also responsible for maintaining a complaint register and submit to the directorate. The request to see the register was however denied stating that it was confidential. The monitoring reports sent to the directorate showed attendance for the OPD, emergency, in-patient, maternity, diagnostics, minor surgeries, procedures and patient death rates.

The private sector was responsible for installing a GPS enabled biometric attendance as well as IP based addresses for live streaming on State area wide network (SWAN) nodes, but no information on this was available.

Problems in Performance – the breakdown process

As part of the MOU the public sector maintains a medical audit by the district medical and health officer to ensure that only necessary diagnostic procedures are recommended by OPD - since variable payments were dependent on diagnostic procedures. This payment was initially made only on the basis of what was reported- till an officer investigating a hospital found, mismatches in the number of patients and the investigations being reported. There were also complaints by local public in regards

to poor supplements and services. The complaints reported that the private agencies were responsible for providing high quality dietary supplements to their patients, while this requirement was reported to be not fulfilled. On uncovering these status quo, the auditing officer refused to sign the report to be sent to the CMO, who had to sign approval for the Director General (DG) to release funds.

As a counter measure when the KPI's were examined, it was found that none of them had any emphasis on healthcare service delivery. They related mainly to minor administrative processes- and that too were poorly defined. The fixed amounts based on such KPIs amounted to approximately 2.4 crores per annum i.e. about 20 Lakhs a month. However measures for performance appraisal were weakly defined in the KPI with minor penalty for failures.

This pattern uncovered first in one CHC, was slowly uncovered in all outsourced CHC's. It was then that the government stopped all payments to the private agencies until an examination could be undertaken.

Table 10 : Key Performance Indicators and penalties for low scores

	Explanation
KPI 1	Attendance of Clinical Staff
KPI 2	Attendance of Paramedical & other support staff.
KPI 3	Proper Inventory Management to avoid stock outs.
KPI 4	Asset management and servicing & maintenance of equipment

Average KPI Score (AKS)	Percentage of total reimbursement to be paid to private agency for that quarter
0–5 %	100%
6–10 %	95%
11–15%	85%
16–20 %	75%
>20%	60%(with show cause and explanation)

The main bone of contention was the increased number of false prescriptions and diagnosis. Directorate official interviewed, stated that on surprise inspections at the CHC's they found that though on paper many tests had been done and reimbursement asked for, on contrast the stock position reflected far lesser consumption of consumables. There were other instances found where a number of tests had been conducted for series of days on the same patients. There was also a large number of accident cases being reported.

It is alleged by the directorate that when such excessive reporting of outputs were kept a check on and payment release curbed, the private agencies started letting go of medical staff so as to maintain their profit margins. A number of CHC therefore started having insufficient medical staff, many housing doctors with Ayurveda (traditional) qualifications filling up for allopathic medical doctors. According to the directorate, these were the main reasons for the PPP break down.

While according to the private agencies it was the continued delay in payment release due to 'refusal in kick backs' that led to delay in salary payment and uncertainties leading to exit of many doctors. The MD of the private agency explained that the over reporting had been a software glitch- and the agency had immediately stopped and fixed the problem, even returning excessive money charged. However there were few takers for this justification.

The community response to the PPP model was also found to have mixed opinions. In district Champawat the private agencies were ordered by the local leaders to leave their area. Some of this however could be politically driven due to change in the local government. There was also a case in Tathyur where the CHC had to be shut down for almost 2 weeks. Due to alleged negligence leading to the death of a women during delivery, causing turbulence from the local population. In Raipur a CHC close to Dehradun the response from the public was found to be less than positive. This lack of community response was also a major reason why the government withdrew from this approach of Public Private Partnership (PPP) for outsourcing of primary and secondary Healthcare facilities.

Learnings from PPP case study

There are many PPPs which have gone through the same cycle- first they give rise to high expectations

and are projected as an innovation. In about 18 months after launch the first problems show themselves and there is some discontent and contestation. In about three years they have shut down. Then there is a gap of a couple of years- and then the cycle repeats.

The "Programme Theory" or the ''theory of change" behind a PPP is that it brings about more accountability, it brings in higher levels of motivation and it has better human resource policies and hence it solves some of the problems that ailed the public system. However, as this case study show, the change of ownership and an elaborate contract did little to resolve the problems of healthcare delivery. Some issues like continuity of care actually got worse.

It is tempting to attribute the collapse to inter-personal issues or politics leading to failure to make payments on time. But the fact is that even local leaders who went out of the way to get the PPP to their constituency got disenchanted with the failure to deliver. Without popular support, the political will melted away. There was no way that these commercial agencies could have made adequate returns on this. Some agencies get into such contracts hoping to attract cases for their hospitals elsewhere- but there was no such possibility here. Failures of such PPPs are often based on contract design- which in this framework of analysis further improvements in contracting are expected to solve. It could have been sustainable for a philanthropist who brought in funds or even for a not for profit who was seeking to reach the poor and willing to sacrifice for it. But the very basis of a PPP is to bring in the commercial player- and with them there is no reason for it to work.

A change of ownership will not improve the functioning of the CHCs if the problem was not about the nature of ownership but due to the design of the system. There are serious defects in the package of services, in continuity of care, in human resources availability, and in the exclusionary practises of user fees – to name a few- which the contract did nothing to address. The very nature of the contract prevents that spirit of innovation required to overcome these constraints- even if the management had recognized these constraints in the first place. Which they obviously did not- seeing that they bid for it.

Box-1

Table 1 : PPP projects active in Uttarakhand Health Sector at present

S. No.	Project Name	PPP Model	Private Partner	Project cost	Benefits (Project Initiation date)
1	Mobile Hospital Units in all districts	Operation and Management (O&M)	1). Dr. Jain Video on wheels Ltd 2). Rajbhra Medicare	23 Crores	Efficient utilization of existing resources and access to remote areas. (01/05/2008)
2	MRI at DOON Hospital	O&M	Mahajan Diagnostics, New Delhi	7 Crores	34% of revenue sharing in second half of project. (01/04/2008)
3	Nephrology, Dialysis Unit at Coronation Hospital, Dehradun	Build Operate and Transfer (BOT)	Apollo Hospitals, Chennai	5 Crore	For decongestion of Doon Hospital for availability resources. (01/05/2009)
4	Cardiac care unit at Coronation Hospital, Dehradun	BOT	Fortis Hospital	17 Crore	For decongestion of Doon Hospital for availability resources. (01/04/2009)
5	Nephrology, Dialysis Unit at Coronation Hospital, Haldwani	BOT	M/s Rahi Care	5 Crore	For providing services. (01/05/2009)
6	108 Emergency Response services	O&M	M/s GVK EMRI	11 Crores	Better emergency response (01/05/2008)

S. No.	Project Name	PPP Model	Private Partner	Project cost	Benefits (Project Initiation date)
7	PPP at CHC (Gairsain, Munisiyari, Kapkot, Garampani, Jhakoli)	O&M	Sheel Nursing Home	45 Crores	Better delivery of health services (14/05/2013)
8	PPP at CHC (Chaukutiya, Lohaghat, Bazpur)	O&M	Sheel Nursing Home	27 Crores	Better delivery of health services (14/05/2013)
9	PPP at CHC (Sahiya, Raipur, Naugaun, Thatyur)	O&M	RajbhraMedicare Pvt Ltd	29 Crores	Improving Healthcare (14/05/2013)

Note: A previous batch of PPP models such as voucher schemes in Haridwar, Udham Singh and Nainital began in 2005. There was dissatisfaction with their results and after JSY was introduced they became redundant. They were given up in 2011-12.