Chapter 7
Role of Public Private Partnerships in Ensuring Universal Healthcare for India

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In the early 1990s Health Sector Reforms (HSR) undertaken as part of structural adjustment programmes proposed a range of changes in governance, provisioning, financing and resource generation. In India, these reforms contributed to shifts in structural, organisational and managerial aspects of the public sector healthcare system which has undergone complex organisational rearrangements (Bennett and Muraleedharan, 2000; Baru and Nandy, 2008). Public Private Partnerships (PPPs) are very much a part of these rearrangements. When, over a decade, the reforms actually increased catastrophic expenditures in the developing countries, the concept of Universal Health Coverage (UHC) and ways of achieving it was offered to rescue the HSR. India's National Health Policy (NHP) 2017 proposes to provide "universal access to good quality healthcare services without anyone having to face financial hardship as a consequence" (GoI, 2017: 1). Despite this new approach, the public health system continues to weaken, state investment in public sector health is stagnating, and the unregulated private sector in health has come to play a vital role in the provisioning of care. In this scenario, even to achieve UHC with efficiency and effectiveness seems an enormous task. Nevertheless, to attain it, PPP is seen as a viable health policy option both nationally as well as internationally. International bilateral and multilateral bodies, financial institutions and consulting companies have particular interest in it.

Introduction

Built on the foundations of New Public Management, PPPs have made inroads into the public health facilities at various levels, establishing a contractual relationship

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between the public and private sectors; transforming the provisioning and financing pattern of institutions and initiating cultural shifts in the public health system.

PPPs are driven by the rationale of cost containment with increasing monetary efficiency in the delivery of services, and with a heavy dependence on the private sector for quality of care. A wide range of PPPs have evolved over the past two decades, expanded, got refined and gained permanence.

Prior to the 1990s the state directly procured and provided the majority of the healthcare and its supportive services. In the mid-1990s the nature of procuring and provisioning of non-clinical and clinical services changed, paving the way for contractual services. PPPs gradually became a public policy objective in India, blurring the boundaries between the two sectors and impacting people using the public health system. Emerging evidence from studies of types, implementation and functioning of PPPs is beginning to reveal their functioning, efficiency, political and economic significance and ability or otherwise to reach out to the marginalised, as well as their value for public money invested. This chapter explicates the process of embedding PPPs within the public policy in two phases and reviews the studies of PPPs in India's healthcare services over a period of two decades— 1995–2015. The first and second sections chart out their nature and scale of proliferation, and identify the policy milestones that promote PPPs. These policies are well thought out mechanisms for institutionalising PPPs and grounding them structurally and legislatively; they are not simple coping strategies. The third section of the chapter examines the evidence of their utility in terms of coverage, cost, quality, efficiency and the risks they introduce for the state. A discussion at the end looks at their role in achieving UHC.

Types of PPP and Structural Issues: 1995–2015

Like concessions in land acquisition, subsidies in imports to the private sector, and state led insurance systems, PPPs are also one of the institutional mechanisms to promote commercialisation of health services. During 1995–2015, the traditional public sector procurement and provisioning of services has seen alterations through PPPs that emerged in different forms, such as service contracts, management contracts, lease contracts, concessions and build-operate-transfer contracts. Across these forms of PPPs, a distinction needs to be made between those that provide services (non-clinical and clinical) within healthcare facilities or National Health Programmes[1]; those which operate and manage health facilities and services; and those where the private sector builds health infrastructure, manages and provides services. Table 7.1 lays out the types of PPP models in healthcare.

The evolution of these PPP models is based on the range of available Private Providers (PP). Each type, depending upon its complexity, has varying degrees of responsibilities for the public and private sectors. These models have 'created opportunities' for different types of PPs within the healthcare landscapes "which were once the preserve of public sector organisations" (Buse & Harmer, 2004: 50). Gradually,

Table 7.1 Function based models of PPP in India's health sector

Types of functions	Public and private responsibility	Examples
Outsourcing of supportive non-clinical services	Public Sector: Provides the space, pays for the contracted services Private Sector Provides the service, appoints the staff	Diet, security, cleanliness, solid waste management in healthcare facilities; Ambulance Service (108 Ambulance Service)
Outsourcing of Supportive clinical services	Public Sector: Provides the space, pays for the contracted services Private Sector: Provides the service, appoints the staff	Pathology and Radiology, Diagnostics within National Health Programmes (like sputum collection centres and also to act as microscopy and treatment centres within Revised National Tuberculosis Control Programme (RNTCP)
Outsourcing of clinical services	Public Sector: Provides the space, pays for the contracted services Private Sector: Provides the service, appoints the staff	Dialysis, Maternity Care Services (Institutional Birthing); Cataract surgeries under National Blindness Control Programme, Private Providers in RNTCP_DOTS
Purchasing of medical services	Public Sector: Calls for Tender and Empanels the Private Operators, Pays for the Contract Private Sector: Provides the Service	Central Government Health Services, ESIS, RSBY, Yeshasvini, Rajiv Arogyasri Scheme, Kalaignar; Voucher Schemes
Social franchisee	In which the developer of a successfully tested social concept (franchiser) enables others (franchisees) to replicate the model using the tested system and brand name to achieve a social benefit	Social marketing of condoms under Family Planning Programme
Operate and manage	Public Sector: Owns the healthcare facility, pays for the contracted services, regulates and monitors Private Sector: Manages the healthcare facility, provides the non-clinical and clinical services, appoints the staff	Primary healthcare facilities by NGOs (rural and urban), super speciality hospitals
Building, designing, operating and facility management (BOT/BOOT/ DBFOT)*	Public Sector: Provides land, finances Private sector: Designs, builds, finances, operates and transfers the healthcare facility	Diagnostic Centres, Hospitals (projects in pipeline)

*BOT (Build Operate and Transfer)/BOOT (Build, Own, Operate, and Transfer): BOT/BOOT is a PPP model to develop a public infrastructure project with private funding. DBFOT (Design, Build, Finance, Operate, and Transfer): These projects involve designing and building the infrastructure, operating them for a specific time period and transferring the ownership of the project to the government after a specific time frame, which runs normally between 10 and 30 years.

they are reconfiguring the national healthcare scenario through policy discourse and fast changing structures of public sector healthcare, and enabling the private sector "to exercise power and influence" (Ibid.: 50).

Our review shows that a wide range of PPs (for profit/not for profit; local/national/multinational corporates), are entering into partnership with the state for scaling up healthcare provisioning without the state expanding public services. It also reveals that local private nursing homes/hospitals participated in the PPP-based institutional delivery programmes, even when the scheme was not attractive. Under the Mamta Scheme in Delhi, around 45% of PPs became part of the scheme since it enabled them to develop collaboration with the state government and around one-third saw it as a means to expand business and acquire a certain credibility in the local market, even though it did not provide any financial incentive, and the release of funds was often delayed (Bhat et al., 2007; Nandan et al., 2010). Ancillary services like diet, security, sanitation also bring in non-health PPs. This creates a multiplication of authorities and loss of control of health facility staff.

Corporate companies too (national and multinational) are beginning to participate in the PPPs. For example, in the case of Rajiv Gandhi Super Speciality Hospital in Raichur district of Karnataka, Apollo Health Enterprise Limited from Hyderabad had an agreement with the Karnataka Health Department to operate and manage the Raichur government hospital and provide services. The state evaluation of this experiment was critical of its functioning (Karpagam et al., 2013). In Maharashtra and Punjab multinational corporate entities have joined hands with the respective state governments for operation and maintenance of radiological diagnostic services[2]. This trend raises concerns, as private partners often tend not to comply with the agreed terms and conditions and thus weaken administrative authority (Qadeer & Reddy, 2010).

This opening up of public institutions to markets through a plurality of private partners creates a diverse set of interest groups and restructures the relations of power and authority between the public and private sectors. PPPs, particularly in the field of supportive clinical services (i.e. hi-tech diagnostics), and curative care (dialysis) shows that public sector healthcare is now beginning to be linked to the medical-industrial complex and these two areas are good examples of high end markets. Given this it is doubtful if PPPs can safeguard the public sector's interests. This restructuring also leads to significant shifts in the financing of complex PPP models that have evolved over time and are discussed in later sections.

Policies Enabling PPP

Tracking polices in the health sector reveals that there are definite policies that enable PPPs to gain space and permanence in the health sector. These policies change the relationships and domains of influence of the state and the private sector, and favour the private sector by empowering it. They do so by encouraging involvement of different types of PPPs that have evolved with or without the support of international

organisations, and, by setting up institutions and supportive legislative frameworks for enhancing PPPs. The evolution of these policies can be divided into two phases.

First Phase (1995–2005)

The Eighth Five Year Plan (1992–97) recommended targeting health for underprivileged within the strategy of 'Health for All' (HFA) and privatising services in the public sector through user charges (Government of India (GoI), 1994). It advocated the need to regulate the private sector, not out of necessity, but because the government wanted to promote the private sector (Ibid.). The Ninth Five Year Plan (1997–2002) reinforced the need for public sector healthcare institutions to generate revenue by charging supportive and diagnostic services and increasing 'the involvement of voluntary, private organisations and self-help groups in the provision of healthcare and ensure inter-sectoral coordination in implementation of health programmes and health-related activities' (GoI, n.d.). Thus, the 1990s marked a shift towards a new public and private mix whereby the public sector was sent on the path of being privatised from inside and outside. Initially the PPPs emerged through the outsourcing of first level referral services from the Primary Health Centres (PHCs) and of non-clinical and clinical support services in hospitals, national health programmes, and private management and operation of health facilities. This transition towards PPP could be traced in the government policies from the early 1990s, with the implementation of the State Health System Development Project II in the States of Karnataka, West Bengal, and Punjab in 1995 (World Bank (WB), 1996). Subsequently, the second National Health Policy, 2002 emphatically supported the private sector by recognising its increasing presence at all levels of care and how it needs to address the economic restructuring that is ongoing in the country through statutory regulation, and monitoring of minimum standards (GoI, 2002). The Tenth Five Year Plan emphasised the need to develop standard treatment protocols and to improve area-specific public- private-voluntary collaborations for the marginalised sections of the population (GoI, 2002a). At the same time, it cautioned about the success of NGO involvement at the primary healthcare level mainly due "to the commitment of individuals and credibility of NGOs, which is difficult to replicate" (Ibid.: 87).

The National Macro Economic Commission too, marked PPPs as one of the innovative ways to increase access to and delivery of comprehensive healthcare services caused by shortages of specialists, high end technology and ancillary services within the public system (GoI, 2005). Across all these recommendations policy makers adopted PPP as a solution to manage the problems within the public health sector but without adequately examining PPP's effectiveness. Within the health department, Regional Resource Centres were created and one of their activities was to provide technical support for the state level PPPs. West Bengal was the first state to draft a PPP policy[3] in the health sector, in 2004. It stated that,

> The Government of West Bengal will proactively engage with the Private Sector in Public Private Partnerships in Tertiary and Secondary Level of Healthcare, … and proper safety net for the poor, such engagements at Primary Level will be carefully decided and shall generally attempt at providing alternative modes of healthcare delivery in underserved, remote and difficult to reach areas (Government of West Bengal (GoWB), 2006: 4).

Second Phase (2006–2015)

The second phase is characterised by the expansion of PPPs through private investment and state financing for addressing infrastructure gaps (construction of public health facilities) in the health sector. The Planning Commission in its reappraisal report on PPP in healthcare recommended promoting PPPs in areas like infrastructure, health manpower, Information-Education-Communication (IEC), capacity building and managerial services besides service delivery and ways to make them cost-effective (GoI, 2006). The Report proposed partnerships with branded clinics (primary care units of corporate hospitals) and involvement of the corporate sector under Corporate Social Responsibility (CSR), through the Confederation of Indian Industry (CII) and Federation of Indian Chambers of Commerce and Industry (FICCI) and other industrial associations, for advocacy and funding NGOs (Ibid). It neither specifies the role of branded clinics for the unreached populations nor the use of CSR funds for strengthening public infrastructure.

Over the same period, the health committee of CII, in collaboration with International Finance Corporation and World Bank Institute worked to lay out areas for PPP interventions and their promotion. It prepared a white paper which primarily viewed PPPs as one of the most promising integrated initiatives in developing capital4 and infrastructure, wherein the private sector consortium designs, builds, finances, and provides the services (CII-HOSMAC, n.d.).

Creation of PPP Cells

For enabling and institutionalising PPPs across sectors, centre and state level policies, institutional mechanisms and legislations have been introduced. In 2006, a PPP cell was established under the Union Ministry of Finance. Creation of PPP cells within the public sector facilitated the framing of policies, technical assistance, capacity building and in the proliferation of PPPs across sectors. This was a turning point as these cells accelerated the process of setting up PPPs through managing tenders, drawing up MoUs, liaising between departments, etc. under the overall guidance of the state. Several PPP cells have already been set up in West Bengal, Haryana, Punjab, Andhra Pradesh, Karnataka, Assam, Rajasthan, Madhya Pradesh, Tamil Nadu, Gujarat, Orissa and Uttarakhand, within different departments including health. These cells would enable streamlining of PPP projects and deepen its penetration.

Infrastructure-Based PPP Projects

To use private finance in public service infrastructure, the government created financial intermediaries like the Infrastructure Finance Development Company (IFDC) (1997) and India Infrastructure Finance Company Limited (2006). In infrastructure projects the private sector raises the money on behalf of the government and in return the private sector is awarded with the contract to design, construct, maintain and operate during the concession period. The hospital bears the responsibility to pay back the debt along with the interest including the cost escalation if it takes place. This experience from UK shows that it creates an affordability gap. As a measure to keep such projects attractive for the private sector, the Indian government in 2006, issued guidelines for Viability Gap Funding (VGF). The gap in VGF is the difference between the revenue needed to make a project commercially viable and the revenue generated through user fees. Under this scheme the government funds maximum of 20% of the total project cost. However, the financing state department or the ministry can give assistance restricted to another 20% of the project cost.[5]

The Eleventh Plan proposed to grant 'private players' infrastructure status so that the private sector could participate in provisioning of public services through PPPs with access to various government incentives, subsidies and tax benefits. Thus, it legitimised private players' access to certain concessions like, "land at concessional rates, increasing floor area ratio and ground coverage, tax holiday, and loan at concessional rates" (GoI, 2008: 82). The draft National Health Bill, 2009 set the stage for PPPs by ensuring affordable 'coverage' of services to people. The state's role was restricted to providing this economic access to the very poor. For the rest, its role remains ambiguous. The Bill then is a legislative draft that, like the Five-Year Plans, avoids ensuring tax- based state provisioning of healthcare (GoI, 2009) and encourages private providers.

In PPP models like Build-Operate-Transfer/Design-Build-Operate—Transfer (BOT/DBFOT), long-term partnerships are envisaged with both sectors financing the project. These projects are sustained either through the user charges collected by the private partner or through the annual payment by the government over a period of time. Earlier in 2005, when the Cabinet Committee on Economic Affairs approved the VGF Scheme to support PPPs in infrastructure and identified health as one of the eligible sectors for financial assistance, there were no annuity provisions. The draft National PP Policy, 2011 then, addressing the need for PPPs across sectors, proposed internal restructuring and developing infrastructure through annuity-based PPP projects in sectors like health that are 'not amenable for sizeable cost recovery through user charges' (GoI, 2011). Annuity funding is another mechanism by which the government provides 40% of the project cost as loan during the construction period with a provision for deferred budgetary payment, i.e. the public sector pays when the asset is delivered, or pays in instalments during the different stages of construction (See Endnote 5). Over the multiple annual plan periods the government pays the charges (cost of the physical assets, operation and maintenance) of the

sanctioned annuity projects. Such annuity projects have an impact on the future availability of resources for the new programmes and this, "may tend to increase the total cost to the exchequer" (GoI, 2010: 6). The Planning Commission (PC) expressed caution about this. Economists like Basu also cautioned against their detrimental impact on the public sector due to a long-term burden on future budgets (Economic Times, 2010).

Such health facility projects in India are at their initial stages. They generate three important concerns at this point. Firstly, infrastructure based PPPs complicate the contractual structure of organisation. Secondly, the government goes all the way to make such initiatives lucrative for the private sector and in the process, spends much higher overall amounts including the concessions granted to them. This also reflects misplaced and heavy reliance on the private sector. Finally, how much commercial benefit the private sector accrues through these long- term arrangements and concessions is barely disclosed, in the name of business confidentiality. The commercialisation of healthcare provisioning is thus guided by the need of the private sector and private capital. It is important here to learn from the UK where, despite subsidies and efforts to meet the affordability gap, annuity based Private Finance Initiative (PFI) hospitals remained underfunded and more expensive than the traditional procurement alternatives for hospital infrastructures. Consequently, many National Health Service (NHS) trusts working with long-term PFI initiatives faced financial problems (Hellowell & Pollock, 2009).

The Twelfth Five Year Plan, in the name of public spending in backward and remote areas, paucity of capital and sustaining growth, pushed further the need for private investment in infrastructure (GoI, 2013). Despite these risks, the NHP 2017 again underlines the need for purchasing services of private healthcare through contracting out and empanelling hospitals (GoI, 2017). These policies and processes push the private sector ahead but do not necessarily address the complexities and difficulties created for the public sector and the patients. PPPs claim to smoothen and reorient the structural and governance problems of public sector healthcare, but in whose interest, is left unsaid.

Evidence on Access, Quality and Processes of Implementation

PPPs are projected as designed to overcome the weaknesses of public sector health services (inefficiency, lack of coverage and access and poor quality) and work in coordination to improve them. They need to be evaluated for (i) access to their services; (ii) quality; and (iii) the processes at work, like complexity of PPs engaging in PPPs, their selection process, monitoring and regulation, and risks embedded for the public partner in the contracts. These processes are interrelated but discussed separately for convenience.

Access to PPP Services: PPP services could be for ambulatory or in- patient care and diagnostic facilities. Access to these facilities needs to be understood in physical, social and economic terms. Physical presence of providers, though necessary, is not always sufficient given caste and monetary constraints of those seeking care. The studies reviewed either do not explore all services or all the dimensions of access.

*Geographical and Social Accessibility***:** As there is chronic shortage of functional health facilities, PPPs do bring immediate respite to the people in remote areas. Our review of literature shows that, for free services at the point of delivery through the PPP model, the specific target population groups are: pregnant women, new born children, or all irrespective of age and sex if they are from BPL families. Several studies report inability to provide free service to those with certified BPL certificates (Roy, 2007 and 2015). Often non-issuance of health insurance cards created difficulties for the patients to access free care at the point of service delivery (Jega, 2007; Karpagam et al., 2016; Nandi et al., 2016). Secondly, location and accreditation of PPs for PPP schemes was pertinent, especially in rural areas and urban slums and in remote areas. The researchers report that PPs near urban slums or in rural areas are not well trained or are mostly unqualified (Deshpande et al., 2004). Accreditation of private hospitals or nursing homes based on Janani Swasthya Yojana norms was not very encouraging in Bihar, Madhya Pradesh (MP), Orissa, Rajasthan and Uttar Pradesh. In MP, accredited hospitals were located in urban areas; and only two hospitals could be accredited in three districts out of five in Bihar (United Nations Population Fund (UNFPA) 2009). A review of PPPs for maternal health services across states shows that they did not increase physical access to services for rural women. Experiences of voucher schemes in Agra and Kanpur showed that very few PPs could be accredited, and were once again found to be concentrated in urban areas (Ravindran, 2011). Similarly, in the PPP-based maternity care services (MAMTA scheme, Delhi; Chiranjeevi Scheme, Gujarat and Janani Sahayogi Scheme, MP), the empanelled PPs were located in the economically better off districts and in the urban centres (Acharya & Mcnamee, 2009; Nandan et al., 2010 and 2008). In a study of Chiranjeevi Yojana (CY) in Surat, marginalised people found it difficult to access empanelled PPs located in developed areas (Acharya & Mcnamee, 2009). During the fifth year of its operation, in 40% of the talukas no empanelledPPs became part of this scheme. Secondly, even though the delivery per PP had increased, the number of empanelled PPs had declined. In 2008, under the extended CY, it failed to expand PP services in the 40 under- served talukas except in two districts (Government of Gujarat (GoG) 2010). Not only this, anaesthetists were available only on call since most of them lived in urban areas. They wanted money to attend such cases soon after the delivery and expressed their reluctance in attending to BPL cases (Jega, 2007). Janani Suraksha Yojana (JSY) experience in Madhya Pradesh shows that due to non-fulfilment of selection criteria, only 10% of rural PPs were empanelled and the majority of PPs included were in urban areas (Nandan et al., 2008). Lack of rural PPs limited people's access and coverage (Devaraj, 2006). Distant location of the PPs increased the cost of access for the poor in Amravati District of Maharashtra (Rathi et al., 2012). The state-level PPPs in insurance schemes are not concerned

with needs, suffering or urgency for the patients as often their selection is based on their suitability for full intervention package rather than needs (Vasan et al., 2015).

In the Revised National Tuberculosis Control Programme (RNTCP) scaling up and sustaining of the PPP model has remained a challenge (Pradhan et al., 2011). The review showed that the case detection rates had increased with greater referrals to the public sector and the case notifications varied within a range of 2–26% (Dewan et al., 2006). However, in a PPP TB-DOTS project in Delhi, the majority of the patients referred by the PPs were from the middle class (Unger et al. 2010). Added issues reported were problems of neglecting standardised treatment, follow-ups and holding back information on the availability of free treatment from public institutions (Ibid.). Ramaiah and Gawde (2014) point to the fact that in urban areas where public sector healthcare is diminishing, the involvement of PPs in the detection of TB cases and referral plays, "a short-term measure to improve effectiveness of the TB Control Programme" (Ramaiah & Gawde, 2014: 370). Doctors in Bengal echoed similar ideas in the context of PPP-based diagnostic units, i.e. "the PPP units are only seen as a midway arrangement. Issues of equity and exclusion continue to persist" (Roy, 2015: 195).

The experience of contracting with NGOs for managing primary healthcare services and provisioning in tribal areas of Meghalaya showed an increase in OPD attendance. The problem however was of functioning in distant areas without the state support of regular funds, drugs and periodic monitoring (Mairembam et al., 2012).

Thus, even though it was assumed that PPP-based services will improve access and coverage, the accessibility of good qualified PPs to the poor and remote areas remains a problem.

Financial Accessibility: PPs partner with the public sector only when this is commercially viable. The user charge is linked to financial sustainability of the PPs. The PPPs charge the Above Poverty Level (APL) patients directly and the government pays for the BPL patients. Their user charges and exemption rules vary across the states and impact the poor differentially. For example, PPP diagnostic units in West Bengal government hospitals provided 10% of BPL patients' free diagnostic services per month (Roy, 2015), whereas in PPP diagnostic units of Bihar, both, APL and BPL patients were entitled to free care (Kumar, 2013). In the urban slum health project of Andhra Pradesh and Assam, managing NGOs were allowed to levy user charges in order to raise 20% of their recurring expenditure for their sustainability while keeping in mind positive discrimination. However, to make this project sustainable, continuation of the government grant- in-aid to NGOs remained critical (Raman & Bjorkman, 2006). In recent times the pre-feasibility report for the PPP-based MRI in Karnataka recommended revising the user charges every two years (Information and Crediting Rating Agency in India (ICRA), 2013). In the public sector tertiary and secondary hospitals of many states, Computer Tomography (CT) Scan and Magnetic Resonance Imaging (MRI) and other diagnostic facilities, provided under the PPP scheme, are either priced at par with the Central Government Health Services (CGHS) rate or priced lower than the market rates in consultation with the government.

Table 7.2 CT scan at the PPP unit in tertiary hospital (TH), Kolkata (2004 and 2011)

CT scan at the PPP	(A)	Percentage of waiver cases given to patients**				(B)	(C)	Total No. of patients doing
Unit in TH Years		100%	75%	50%	25%			CT scan A+B+C
2004[a]	11062 (86.85%)	n.a	n.a	n.a	n.a	1211 (9.50%)	464	12737
2011[b]	16254 (81.45%)	82	36	1982	1257	3357 (16.82%)	343	19954

Source: [a]Roy 2007; [b]Medical College Kolkata 2012. A: *Total No. of Government Patients doing CT Scan*

B: Total No. of patients doing CT Scan receiving Waiver C: Total no. of Private patients[#] doing CT Scan

*Cases where patient paid government rate; **Patients who received exemptions; # Patients who paid at market rates

All BPL patients availing CT scan services in the Tertiary Hospital in Kolkata did not get 100% exemption (Table 7.2). Though the share of free cases had increased over the past six years, maximum patients received only 50% concession on the actual price and very few got 100% exemption for the CT scan. Empanelled PPs for diagnostic services in rural hospitals revealed that patients requested for further concessions on the subsidised price and also requested PPs to accept the payment in instalments (Roy & Gupta, 2011). Empanelled PPs of the rural hospital of Islampur, Murshidabad accepted this practice in order to sustain the contract (Ibid.). In a PPP-based diagnostic service in Bihar, only 19 diagnostic tests could be provided free of cost to the patients referred by government healthcare institutions; the rest were charged the market rate (Kumar, 2013). Most of the patients were not aware of the cap and consequently they ended up paying. Complaints regarding extra charge by the technicians were common (Ibid.).

In addition to variations even the out-of-pocket expenditures remained high in PPPs. Under the Mamta Scheme in Delhi for antenatal checkups, three-fourths of the women had to incur the cost for Ultra Sonography (INR 750), other tests and medicines (INR 1028) and, in case of more than one postnatal check-up, the empanelled providers levied further charges (Nandan et al., 2010). Similarly, under the JSY in Madhya Pradesh, around 45% of the PPs levied user charges. These charges were higher in the districts of Indore, Jabalpur and Chhindwada (Nandan et al., 2008). Among the 100 beneficiaries only 3 reported to have availed free-of-cost maternity care services and only one tenth of them received pre-decided cash assistance for maternity care services. Out of the 32 PPs only 6 provided free OPD service to the expecting BPL women. Under the Chiranjeevi Scheme in Gujarat, empanelled PPs did not reimburse transportation charges to the beneficiaries even when it was a part of the policy (GoG, 2010). Similar Out-of-Pocket Expenditures (OOPE) were also reported in cases of deliveries through Caesarean sections in JSY PPP scheme

(Chaturvedi & Randive, 2011). Women said that the subsidy of INR 1,500 was inadequate to meet the costs of institutional births. They had to take private loans at a very high rate of interest or mortgage property (Ibid.).

Thus, it is observed that even when a PPP service aims to provide free service to the BPL patients, the problem of either indirect or partial out-of-pocket expenditure persists. Secondly, the policy of capping the number of patients who can access free services (clinical or investigative), or the limits to the number of free tests, restricts the access to free medical care and adds to the burden of cost. This stands in opposition to the principle of universal access to healthcare.

Quality of Care

The government favours the PPP over the public system under the assumption that it brings in efficiency and quality of care. The experience of Reproductive and Child Health (RCH) services through the Mother- NGO scheme revealed that the NGOs often did not have full-time personnel for the health activities and the new workload was added on to existing personnel (Bhat et al., 2007). Similarly, in Meghalaya in NGO managed PHCs, despite the availability of staff there was a lack of skilled providers (Mairembam et al., 2012). PPPs try to bring about efficiency by cutting on budget allocations on staff. Even though the ancillary contracts in hospitals specify payment of minimum wages, in practice contractual staff is under-waged with poor working conditions (Roy, 2010). The high-end diagnostic PPP units in district hospitals of West Bengal had minimum staff with poor wages and full-time radiologists were not appointed (Roy, 2015). In Bihar, the private provider could not be empanelled under JSY due to poor infrastructure facilities and the lure of unregulated Caesarean operations in the market (UNFPA, 2009). In PPP-based institutional delivery schemes, empanelled private nursing homes were not equipped to deal with emergency obstetric cases owing to lack of a blood bank facility and anaesthetists (Mohanan et al., 2014; GoI, 2008 and 2014). Likewise, JSY for Emergency Obstetric Care (EmOC) in Maharashtra among the 34 private facilities studied, showed that 10 did not have operation theatres (Randive et al., 2012). These evidences show that PPPs are plagued with problems of human resources and infrastructure that impacts the quality of care. Meal services, laundry and cleanliness play a critical role in rendering good quality of care for in-patients and out-patients both in hospitals and primary healthcare settings. There are studies to show that contracting out brings down the quality in several instances (Bhatia & Mills, 1997; Roy, 2010). The fourth and eighth National Rural Health Mission (NRHM) Common Review Meeting Report (CRM) found grossly inadequate resources for outsourced services like diet, sanitation and security and the need to improve the poor levels of these services in the government hospitals of different states excluding Kerala (GoI, 2010a, 2014). Selected PPs tended to establish collection centres6 for collecting blood/urine samples rather than diagnostic centres in rural public hospitals under the district hospital of Murshidabad (Roy & Gupta, 2011) and Bihar (Kumar, 2013; GoI, 2014). These arrangements

influence the quality of tests carried out in terms of 'prolonged turn-around time and reporting time' (GoI, 2012).

The evidence reviewed shows that the involvement of PPs does not necessarily improve quality of services and care. PPPs from different states still reported lack of adequately skilled personnel, poor working conditions, along with poor maintenance.

Processes of PPP Implementation

The MoUs vary with the type of provider, complexity of services contracted out and their numbers. Also, there is a range of common operational issues that we take up in this section.

Selection of PPs and Implementation: There are a few studies that focus on the selection process of PPs. Local level process of selecting PPs for some of the PPP-based healthcare services show that it is not always based on competitive tendering (Roy, 2007). At the district level for JSY in Maharashtra, the relations of medical superintendents with the private specialists determined the awarding of contracts to PPs (Randive et al., 2012). Similarly, political connections played a role in the selection of PPs in UP while contracting NGOs for the management of primary health facilities (Heard et al., 2011). Thus, a level of arbitrariness enters the selection process and influences the efficiency of PPPs.

In the working of service-based PPPs, the roles of the partners are often not well defined. Lack of trust, blaming each other and clash of interests, delayed payment is perennial across different PPP experiences (Devaraj, 2006; Kumar, 2013). Thus, in Ahmednagar district of Maharashtra, neither the district level government health officials nor the private doctors wanted to own the scheme for EmOC in JSY through PPPs. Records of MOUs could not be traced (Chaturvedi & Randive, 2011). Implementation of this programme varied across blocks and was mostly limited to Caesarean sections. There was no referral protocol and patients could go to any of the available PPs (Ibid.). Likewise, in PPP-based diagnostic services in West Bengal, information on exemption rules were not displayed by public institutions nor did the PPs provide this information to the poor patients. To meet their revenue targets, they targeted patients and even contacted the nearby private practitioners (Roy, 2015). The study of the Global Health Initiative on HIV in India showed that when Treatment Counselling Centres (TCC) were revived in 2009 the state medical officers viewed it as a duplication of Antiretroviral Therapy (ART) centres and cumbersome for poor patients. TCC staff too had problems with state provisioning and, in order to meet their patient targets, they began poaching (Kapilshrami & McPake, 2012). Internal conflicts between the civil society and government operated services can negatively impact patient counselling, follow-up and continuity of care as in the case of Global Health Initiative on HIV in India (Ibid.). Partnerships thus demonstrate internal tensions with hierarchical arrangements.

Monitoring and Regulation: There is a constant conflict between what is endeavoured through the PPPs (public health goals) and the actual output. PPPs range from

simple to complex contracts. Even in simple contracts like in PPP diagnostic units at the secondary level hospitals in West Bengal patient utilisation records were not well maintained (Roy, 2015). Similarly, the experience of PPP in TB control in Ujjain showed that urban doctors viewed record keeping and tracking default cases as 'unrewarding' (De Costa et al., 2008). The complex contracts make the operationalisation and management very critical. From the government's point of view, the nature of engagement goes beyond just implementing and administering the PPPs. Evidence shows limited preparedness in implementing and handling PPP operations by the government (Bagal, 2008; Heard et al., 2011; Kumar, 2013; Sarma, 2006). Government officials face multiple managerial challenges (of quality control and monitoring) in dealing with a wide range of PPs operating at different levels with diverse efficiency and quality. For example, in the Mother NGO scheme there were NGOs not only at different levels of efficiency and quality but with differing nature of agreements. This required differential monitoring and evaluation at each level and made the process complex (Bhat 2007). Periodic monitoring and evaluation of the empaneled PPs during the annual renewal of contracts are important as there is laxity in this process as well (Roy, 2007).

Also, the analysis of terms and conditions of contracts show that performance and outcome indicators for different kinds of PPP are not always built-in. In the Uttar Pradesh Health Systems Development Project's call for tender specifications, the staff and infrastructure requirements that a selected NGO should provide were not clearly defined (Heard et al., 2011). Regular in-house monitoring of the ongoing PPP and outsourced services were found to be weak in the public sector hospitals as they did not have adequate personnel (Roy, 2007 and 2015; Kumar, 2013; Randive et al., 2012). These PPP-related structures overstretch government's stewardship abilities.

Risks: The underlying assumption of PPP policy is inefficiency of the public sector and efficiency of PPPs. Procedurally, PPP contracts are expected to draw up possible risks at different stages of a contract's life cycle. Risks often emerge when the PP declines to undertake the agreed role by shifting the responsibility to the public sector or when the starting of services is delayed. Round 4 of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) fund grant for HIV and AIDS is an example where, despite the partnership with the corporate sector, it declined to shoulder the establishment cost and forced the state to renegotiate for funding of drugs and laboratory reagents (Kapilshrami & McPake, 2012). Similarly, there were delays in meeting targets like when the corporate sector did not establish the promised number of ART centres and was not inclined to provide care to the patients in an advanced stage (Ibid.). Thus, the experience of the contractual relationship shows that it operates within a certain level of uncertainty, i.e. not always predictable, and its operation is at risk.

One risk commonly faced by the public sector is a lawsuit between the partners. This particularly interferes with the call for new tenders after the completion of the contract period. As long as the matter remains sub-judice, the old contract continues and the long drawn process impedes the administrative functioning and

quality of service (Roy, 2007). The scope of risk is high in complex multiple operational contracts. Such an inherent risk questions the very logic of efficiency through the private sector in PPPs.

Several states have opted for the BOT/DBFOT model of hospital projects such as Punjab, Maharashtra and Meghalaya, expecting that through these models' large-scale infrastructure projects will be delivered on time and prevent cost overruns. Presently in Meghalaya the state government, through external agency International Finance Corporation (IFC) financing, is setting up Shillong Medical College and Hospital with Kali Prasad Chowdhury Medical College and Hospital (KPMCH) based on a '99 year concession' wherein the private sector builds and operates the institution (International Finance Corporation (IFC, 2013). The state government provided land (23.8 acres) for the project, a 40% capital subsidy for the construction phase, and an operational subsidy for the first 12 years of operations (Ibid). Added to this the private sector protects itself from risk by fixing a higher price at the competitive bidding stage and thus the government loans are used to 'sustain and subsidise' PPPs. Construction of this tertiary hospital is unlikely to meet the 2017 deadline. In such delays, the state, besides bearing a large proportion of the financial risk, may also end up paying more as the costs of construction go up. Finally, the government cannot pull itself out of these partnerships because of the complicated procurement system.

This evidence indicates that the public sector faces higher risks from the PPP MoUs, defeating the purpose of PPP policy to save immediate capital expenses for the government and transfer risk from the public to the private sector, and thereby secure better managed and lower cost of services (Froud, 2003). Such a policy remains a myth and needs to be challenged, as Froud rightly does.

Discussion and Conclusion

The emergence of PPPs in healthcare has allowed a foothold to the private sector within the public sector healthcare system. Focused policy shifts in its favour give it greater power over the public sector healthcare services leading to their gradual commercialisation. Evidence shows that PPP has by itself done little to remove inefficiencies and improve quality of the public institutions. It has in fact forced them 'to change their own practices' in its mirror image. As of now, the PPP process is characterised by poor management, monitoring and regulatory mechanisms. Yet, this development alone is not a factor in the decline of public institutions.

Other than resource crunch, there are historical factors rooted in the socio-political structure of public sector health service infrastructure in India that also contributed. Permitting the doctors in the government hospitals to do private practice was one of them that led to creeping corruption. Lack of regulatory legislation and monitoring mechanisms for minimum standards added to the decline of government hospitals over time. Public sector hospitals also bore the impact of caste and class based familial associatons between doctors of public hospitals and private clinics and hospitals

owned by their relatives. Caste class hierarchy was also retained within health care workforce in the hospitals. The policies of downsizing and casualization with HSRs primarily influenced the middle and lower strata of workforce ranging from nurses to sanitary workers who came mostly from the lower social classes. These together resulted in inequities, malpractices that impacted the quality of care and work ethics.

The so-called 'Reforms' in the mid-nineties were implemented without recognising the systemic and organizational issues in the public sector. The narrow perspective of HSR leading to resource crunch, imposition of new public management model and, penetration by private capital changed the very nature of public hospitals. The means to 'Reforms' in the public sector hospitals was through permitting market-like behavior and competition among multiple providers. This altered the very ethos, and values within the working of institutions and altered the perspective of doctors (Baru, 2005). There was little policy discussion about how public sector hospitals in low-middle income countries like India can be oriented to meet the health care and the financial needs of the infrastructure and become sustainable in the long term. Strengthening of public sector hospitals found little space in these debates. Consistently, it has been implied that public sector secondary and tertiary level hospitals being weak, provisioning at this level can be left to the private sector with the state providing primary health care in developing countries. This weakened the public hospital system.

The first phase of PPPs showed that the public sector institutions in all three levels of care were facing greater pressure to govern and manage the 'new models of provisioning' which unleashed changes within the social, financial and power relations of the public sector healthcare system. It introduced monetary values and reduced service- based values of providers and changed the class background of users (Baru, 2005). While institutionalising these practices, PPPs have replaced the old direct system of provisioning by a unified structure, with a much more complex, layered, and yet fragmented organisational structure. This demands perhaps greater administrative attention than the previous public health system. In the second phase complications increased in long-term infrastructure PPP projects operated through a large number of contracts and sub- contracts. This asked for huge administrative and managerial investment. Therefore, a weak public healthcare system with declining expenditure was put under additional pressure to ensure that the private sector remained accountable.

We have seen that PPPs, across different levels of healthcare, focus on curative care and those components of it where there is the possibility of maximising profits. Being selective in approach and with their need to meet the affordability gap in long-term healthcare infrastructure projects, PPPs reinforce medical dominance and fragmentation of patient care. This drastically impacts continuum of care as well as its quality. Furthermore, this ongoing expansionary project of PPP focuses on well-endowed regions, neglecting remote areas and marginalised populations.

With budget constraints in low-middle income countries like India, the evolution of PPP from meeting incremental service gaps to healthcare infrastructural gaps necessitates a look at the importance of capital investment. This determines the access, cost, quality and planning of healthcare. Already, along with changes through

PPPs, reforms in financing healthcare are in progress. This is reflected in the NHP 2017 that recommends a shift from "input oriented to an output based strategic purchasing" (GoI, 2017: 7). This is best suited for acute care and focuses on funding healthcare institutions based on volume of activity, such as the number of surgeries done. Evidence from Canada shows that the output/activity based funding could not reduce administrative costs in hospitals; there was mixed evidence of efficiency gains; and led to treating "high-volume, low-risk patients over higher- needs, less predictable patients" (Cohen et al., 2012: 7). Thus, with the growing fragmentation in the production of services, the healthcare planning process recedes further into the institutional framework. This makes it easy for it to be gradually taken over by the market through financial performance, incentives and rationing of care in the name of efficiency.

Despite the popularity of the PPPs at the policy level, its advantage has been questioned in recent time in different states. Civil society organisations like Jan Swasthya Abhiyan (JSA), Karnataka Jana Arogya Challuvalli have resisted PPPs in healthcare and taken the issue to the public. In Chattisgarh, the PPP initiative for diagnostic services in 379 health facilities was cancelled in 2013, followed by the cancellation of the mobile medical units where doctors and technical staff complained of non-payment of salaries and non-availability of essential medicines (Bagchi, 2013). JSA also questioned the need to replace the existing diagnostic services in these health facilities with PPP arrangements. Recently, in Karnataka the health department closed down the Arogya Bandhu Scheme under which the private sector was empanelled to manage and operate 52 primary health centres, and brought it back under its direct administration and management (Yasmeen, 2016). This happened due to non-compliance of the terms and conditions by the private sector. As of now the resistance movement has been able to shut down initiatives like the Rajiv Gandhi Super Speciality Hospital, Raichur contracted out to Apollo Healthcare Limited.

At this juncture, it is important to recognise that the challenge of genuine reform of the public sector health services and its universalisation continues and requires a critical look at the shrinking space of public sector hospitals in the name of inefficiency. Shifting the role of the state from providers to purchasers of services needs to be examined. The state level initiatives (Tamil Nadu, Rajasthan, Kerala, Orissa), like provisioning of free medicine that can work if strengthened, maintaining high standards of efficiency, quality and accountability in the public systems (Tamil Nadu Medical Services Corporation Ltd. and Rajasthan Medical Services Corporation). Studies show increase in footfall in the public healthcare institutions with increased availability of essential medicines. This has come through the efficient procurement, stocking and delivery of medicines (WHO, 2014). Direct public provisioning of services does matter to the people. Critical evaluation of ongoing service-based PPPs and infrastructure-based PPPs question their claims of creating an evidence base of efficiency, value for money, and quality. The resistance by people's movements and the evidence from studies of PPPs challenge the assumptions about their efficiency and utility and show that PPPs are an unreliable means to achieve UHC.

Notes

1. Many of the PPPs which proliferated within national health programmes have been initiated through the development of global programmes like Global Alliances for Vaccines and Immunisation (GAVI), and GFATM. Global programmes have therefore encouraged partnerships at the programme implementation level between the government and NGOs, individual private providers (PP), and the corporate sector. All these increased the range of partners and, therefore, complexities of managing PPPs.
2. http://ehealth.eletsonline.com/2013/06/ensocare-and-wipro-ge- healthcare-enter-into-a-public–private-partnership-with-government- of- maharashtra-to-upgrade-district-hospitals/accessed on January 26, 2016.
3. The draft Policy for PPP in the Health Sector in West Bengal was finalised in 2006.
4. Capital means a pool of funds whereby the government builds, acquires or upgrades the physical assets such as property, buildings, technology or equipment (Klein et al., 2013).
5. www.pppinindia.com accessed on January 25, 2016.
6. Collection centres are units where only the blood/urine or other samples are collected. They are taken elsewhere for examination.

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