Impact of Public Private Partnerships on Healthcare Delivery in India

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Abstract

This paper seeks to evaluate the efficacy of Public Private Partnerships in making quality healthcare accessible at all levels in India. The reasons why governments across the world are embracing PPPs to deliver healthcare have been examined. The policy framework that has been developed in India for enabling PPPs has been described by tracing important developments. The paper then looks at three selected healthcare projects implemented in the PPP mode: (i) Chiranjeevi Yojana (ii) Mukhyamantri e-Eye Kendram, and (iii) Rashtriya Swasthya Bima Yojana. Taken together, these schemes represent different types of PPP projects from different parts of the country. Based on their evaluation, certain problem areas have been identified which emphasise the need for monitoring and expanding the scope of PPPs to reduce the medical expenses of the poor. Policy recommendations based on this analysis have been offered.

Introduction: Why PPPs in healthcare?

A long-held notion about social infrastructure was founded on a (false) dichotomy between the public and private sectors. The public sector, it was argued, existed for making basic services such as education and healthcare affordable to the common people. The private sector existed for those who could afford to pay more and did not depend on the state's welfarism. This traditional understanding has proven to be ill-informed in the face of the stark limitations of the public sector.

The reality in case of healthcare, evidence suggests, presents a contrasting picture. The poor are greatly dependent on the private sector to meet their healthcare requirements while public healthcare remains concentrated in urban areas[1]. The poor are, in fact, inclined more towards the use of private healthcare service providers for reasons of accessibility and quality. However, in this process, they often have to resort to taking loans at high interest rates to settle hospital bills (AfDB-WITS 2017, 38).

The private sector has grown to cater to the needs of the bulk of the Indian population. It has built a presence that the public healthcare system cannot conceivably match or compete with. Therefore, governments have been compelled to accept private healthcare as an integral of national healthcare systems (Mitchell 2008, 5). The policy stance that arose out of this acceptance is one that favours

[1] According to the Health NSS (75th Round 2017-18), for 62% of ailments, people in rural areas go to private hospitals or private doctors/clinics. Moreover, while the number of government hospitals is greater in rural areas, the number of beds is far greater in urban areas than in villages, as can be seen from the data of the Ministry of Health and Family Welfare

cooperation with private healthcare providers, to facilitate the reach of healthcare delivery as well improve the quality of healthcare available to people.

The drive to integrate private players into public healthcare programmes has also been reinforced by the commitments undertaken by developing countries receiving aid from international financial institutions to expand the scope of the private sector. Speaking of global institutions, the World Health Organisation has as one of its founding principles, 'universal health coverage' i.e., universal access to healthcare[2]. This principle has also been incorporated as one of the Sustainable Development Goals. Public-private cooperation is seen as vital for the attainment of this objective.

The most significant expression of this changed policy in healthcare has taken the form of Public Private Partnerships (PPPs). The Department of Economic Affairs (Ministry of Finance, Government of India) has provided a comprehensive definition of PPPs:

> A PPP means an arrangement between Government or statutory entity or Government owned entity on one side and a private sector entity on the other, for the provision of public assets and/or related services for public benefit, through investments being made by and/or management undertaken by the private sector entity for a specified period of time, where there is a substantial risk sharing with the private sector and the private sector receives performance linked payments that conform (or are benchmarked) to specified, pre-determined and measurable performance standards (DEA 2016, 6).

As can be seen from this definition, PPPs allow the government to make use of private capital and private managerial expertise to offer better public services. What is important to note here is the emphasis placed on performance measurement. In other words, PPPs must be able to deliver quality services/assets to be sustainable. However, PPPs in healthcare have been embraced by the government without adequate assessment of how effective they are in reality (Roy 2021, 123). The core assumption underlying PPP projects is that competition driven efficiency helps the private sector provide better services at less cost to the public exchequer. It is also expected that private participation would result in greater innovation in designing and distributing essential services as well as in bringing in advanced technologies.

This paper will examine the working of selected PPP projects/schemes in India to see how effective they have been in expanding access to, and the quality of, healthcare for ordinary citizens.

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[2] See https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc)

Review of Literature

PPPs have been extensively studied in the context of healthcare, both globally and in India. Detailed studies also exist for specific PPP projects analysed in this paper viz. Chiranjeevi Yojana, Mukhyamantri e-Eye Kendram, and Rashtriya Swasthya Bima Yojana.

'An Overview of Public Private Partnerships in Health' by Marc Mitchell (2008) gives a useful introduction to PPPs in healthcare by enumerating the principles for successful partnerships, the reasons and motivations behind PPPs, the models/forms in which they can work and the key concerns that surround their usage in improving healthcare delivery, namely equity, quality and costs.

Venkat Raman and Bjorkman (2009) in their book 'Public-Private Partnerships in Health Care in India: Lessons for developing countries' describe how PPPs can be used for delivering quality healthcare to poor and underserved populations in developing economies. Several case studies have been analysed by the authors in various states of India and analyse certain critical issues surrounding these projects such as performance measurement, scalability and sustainability.

In their paper, Rajasulochana and Maurya (2020) discuss the problems associated with the design of healthcare sector PPP projects in India and suggest areas for reform. The authors also point out the importance of aligning the interests of the private and public sectors failing which, they argue, PPPs may end up being a burden on the public exchequer.

Bijoya Roy (2021) takes a broad look at the role of PPPs in healthcare in India by tracing the evolution of the institutional PPP framework from the 1990s, when they came into vogue, upto 2015. She argues that PPPs were a product of the trend towards New Public Management brought about by neoliberal policies and have not been sufficiently studied before being implemented on a large scale. The main areas of concern highlighted are accessibility, quality and operational aspects of PPPs.

The National Health Systems Resource Centre (Nundy et al 2021) has brought out a research report containing analyses of various models of PPPs that have been implemented in India under the National Health Mission, namely PPPs in Primary healthcare, mobile medical units (MMUs), contracting out emergency medical services and diagnostic services. The authors suggest strengthening the governance capabilities of the public sector to effectively administer and assess PPPs.

This paper seeks to contribute to the existing research literature by examining the efficacy of PPPs in attaining the objectives for which they are fundamentally intended: (a) expanding access to quality healthcare at all levels and (b) reducing the poor from the financial burden of healthcare.

Methodology

This paper has relied entirely on secondary data for the analysis of various PPP projects in the Indian healthcare sector. For Chiranjeevi Yojana, data pertaining to Maternal Mortality Ratio was sourced from the Sample Registration System of the Census of India. For the Mukhyamantri e-Eye Kendram scheme, the statistics were obtained from an online dashboard available in the public domain which is updated by the State Government of Andhra Pradesh. For the Rashtriya Swasthya Bima Yojana, data was obtained from the press releases available on the website of the Press Information Bureau. In addition to these sources, data from studies conducted by researchers was also used for understanding the reach of the schemes and disparities in their implementation. Most of the studies used here have been sourced from the online database PubMed Central, government portals and UN websites. All the data so obtained has been tabulated and graphically represented. Inferences have been drawn therefrom to highlight trends, growth and disparities.

Models/Designs of PPPs in Healthcare

There are several ways in which PPPs can work in the healthcare sector. The following types have been identified by Bijoya Roy (2021, 121):

1. Outsourcing non-clinical services: Contracted private sector provides services like catering, sanitation, ambulance services etc. for government hospitals which pay for these services.
2. Outsourcing clinical support services: These include diagnostic services such as sonography, pathology, radiology etc. which are performed by contracted private providers.
3. Purchasing of medical services: In these arrangements, the public sector calls for tenders, empanels private providers and pays them for providing free medical services to beneficiary patients. This works like a state-sponsored medical insurance scheme where the premium is borne by the government.
4. Operate and manage: The government owns the healthcare facility but the private sector manages its functioning, appoints staff and provides all clinical and non-clinical services, subject to the supervision of the government.
5. Design-Build-Operate-Transfer: The government provides land to the private sector which then carries out the designing, financing and building of the health facility. After operating it for an agreed period, the facility is transferred to the public sector.

In all these cases, a contract has to be drawn up between the government and the private entity concerned, demarcating the roles and obligations of each party. In most instances, these contracts are in the form of a Memorandum of Understanding (MoU), typically drafted by the government. Before signing contracts, the government authority/hospital is required to invite tenders from potential private providers and this process must be kept competitive.

Institutionalising PPPs in the Indian healthcare sector

The idea of promoting PPPs in healthcare goes back at least till the Eighth Five Year Plan which highlighted the need for privatising public health services for the attainment of the goal of 'Health For All'. The Ninth and Tenth plans continued this emphasis on increasing private sector participation to provide healthcare access to marginalised sections of the population. The National Health Policy 2002, as well as the latest National Health Policy of 2017, have both argued in favour of a proactive role of the private sector in healthcare delivery. The 2017 document envisages collaboration with the private sector in the areas of capacity building and skill development programmes, awareness generation, training local communities to strengthen mental health services and disaster management (National Health Policy 2017, 19-20).

However, it is noteworthy that GoI has not yet released any definitive policy document on PPPs. A draft National Policy on Public Private Partnership was released back in 2011 but has not yet been formally adopted although the Department of Economic Affairs has brought out detailed manuals and guides for PPP planners and administrators, and green-books[3] for PPP projects in various domains including healthcare. In 2004, West Bengal became the first state to release a PPP policy specifically for the healthcare sector.

Besides these policy documents, the government has also been setting up institutions to facilitate and regulate the PPP ecosystem in the country. In 2006, a PPP cell was established under the Ministry of Finance. Several states have also followed suit and set up their own PPP cells. These have helped to accelerate "the process of setting up PPPs through managing tenders, drawing up MoUs, liaising between departments, etc. under the overall guidance of the state" (Roy 2021, 124). The Infrastructure Finance Development Corporation, established in 1997, also serves to finance PPP infrastructure projects. However, its share in funding PPPs is not as prominent as commercial banks which provide the bulk of debt financing (PwC 2007, 20).

Corporate involvement in the health sector has also been bolstered by the thrust on Corporate Social Responsibility in the Companies Act, 2013. In keeping with CSR, associations like the Confederation of Indian Industries (CII) and the Federation of Indian Chamber of Commerce and Industries (FICCI) have given financial or technical support to healthcare programmes of the government (AfDB-WITS 2017, 42).

[3] Green-books are guides for helping frame the terms of PPP agreements. The DEA has designed them in the form of ready templates that can be appropriately modified by the parties concerned. Templates are available for various kinds of PPPs like diagnostics, medical colleges, primary health centres etc. See https://www.pppinindia.gov.in/guidance-material-and-reference-documents

Having reviewed the broad institutional measures that have been taken by the government over the past three decades, let us now consider three PPP schemes in healthcare from across India.

Chiranjeevi Yojana (Gujarat)

Need and Concept

Chiranjeevi Yojana (CY) is a maternal healthcare scheme formulated and is being implemented by the State Government of Gujarat since 2007[4]. In 2005, Gujarat's maternal mortality rate (MMR)[5] was at 54, worse than that of Maharashtra, Uttarakhand and West Bengal. This was in spite of Gujarat's high performance on industrial development indicators (Acharya and McNamee 2009, 14). Women from poor households were not able to afford institutional deliveries (in hospitals, maternity homes etc.), leading to a high rate of maternal deaths as well as infant mortality.

It was found that while private gynaecologists were in good numbers present across the state, there was a severe shortage of gynaecologists in public healthcare centres. Therefore, the government decided to take private practitioners on board in a PPP scheme to expand access to institutional deliveries. Under Chiranjeevi Yojana (CY), women from Below Poverty Line (BPL) families can avail of services from private maternity homes for free. In addition, they also receive payments to cover the cost of transport and the expenses of the person who accompanies the pregnant woman.

The private gynaecologists and hospitals who enrol in the scheme (referred to as Empanelled Private Providers or EEPs) are compensated by the government based on a fixed package rate. This rate has been determined by a group of experts including state government officers and representatives of the e Federation of Obstetric and Gynecological Society of India (FOGSI) by taking into account all possible cases - normal and complicated (such as caesarean sections). Since 2013, EPPs are paid 3,80,000 for every 100 deliveries. In other words, the state government bears the medical expenses to allow poor women to avail of free institutional deliveries.

Evaluation based on quantitative data

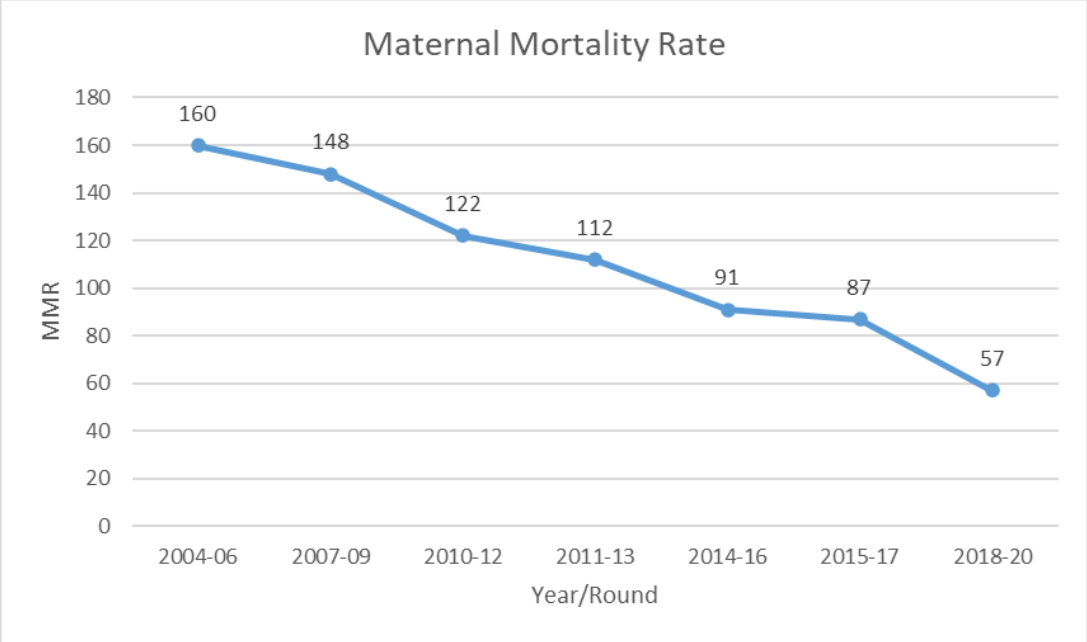
Data provided by the State Government from the Sample Registration Survey (SRS) points to a significant fall in MMR from 148 in 2007-09 to 87 in 2015-17, which is a 41% decline over a decade. In the 2018-20 round, the MMR came down further to 57. These figures are summarised in Table 1.

[4] The scheme was launched on a pilot basis in 2005 and was launched state-wide only in 2007

[5] MMR is defined as the number of maternal deaths during a given time period per 100,000 live births during the same time period (WHO)

Maternal Mortality Rate	Period/Round of SRS
160	2004-06
148	2007-09
122	2010-12
112	2011-13
91	2014-16
87	2015-17
57	2018-20

Table 1: *MMR figures in Gujarat*
Source: *Sample Registration Survey, Census of India*



Graph 1: *MMR figures in Gujarat*
Source: *Table 1*

The state government has used these figures to validate the efficacy of the scheme. State government data[6] points to an increase in institutional deliveries from 63.24% (of all deliveries) in 2005-06 to 99% in 2018. Now, the question is to what extent have these positive developments been driven by the

[6] See https://gujhealth.gujarat.gov.in/chirnajivi-yojana-gujarat.htm

Chiranjeevi Yojana? To know this, it is necessary to isolate the effects of this programme on institutional deliveries from other factors.

Some studies have done so and their results are worth reviewing: Mohanan et al (2013) in their study of Gujarat's institutional delivery rates from 2005 to 2010 concluded that "the *Chiranjeevi Yojana* programme was not associated with changes in the probability of institutional delivery (including delivery at private institutions), maternal morbidity or delivery-related household expenditure." The authors note that their conclusions have differed from previous evaluations which, in their view, did not account for increases in institutional deliveries caused by unrelated factors.

De Costa et al (2014, 6) similarly found that during the period between 2007 and 2010, CY "did not contribute to a spurt in private sector deliveries. Private sector deliveries were rising sharply even before CY began; the program did not change the rate of increase." Nevertheless, the authors observed that CY deliveries constituted 15% of all the deliveries in the state during the period of study. Caesarean-section deliveries also increased from 2% to 6% in the target group of women. The researchers later concluded that the programme has, on the whole, contributed towards improving emergency obstetric services in the state for BPL women (de Costa 2015, 436).

Wide regional disparities were also observed in the implementation of the scheme with variations across districts (Ng et al, 2013) coupled with the fact that most private providers enrolling for the scheme were from urban areas (de Costa 2014, 6).

Other researchers have made a more positive assessment of the programme. For example, it has been found that CY helped significantly increase the geographical availability of comprehensive emergency obstetrics care (Vora et al 2015). As a result, women enjoyed access to emergency obstetric care at more reasonable distances from their homes.

Evaluation of the quality of results under CY

So far, very few studies have tried to assess the quality of maternity care received under CY (Lanzara 2021, 8). Acharya and McNamee (2009, 15) pointed out that, based on their study in Surat district, most private practitioners viewed CY as a charitable programme and most of those who enrolled were either young, freshly trained gynaecologists or old practitioners nearing the end of their career. The well-established private providers rarely enlisted for the programme. This observation has been made in other studies as well (such as Ganguly 2014; Lanzara 2021 etc).

EPPs have also complained about the inadequacy of the amount paid to them as compensation by the government (Acharya and McNamee 2009, 15) vis a vis the costs they incur, especially in dealing with complications. As a result, a high degree of attrition by the EPPs has been observed (Ganguly 2014, 4).

Studies also differ in their assessment of the satisfaction of beneficiaries with the quality of care they received. Bhat et al (2009) reported 89% beneficiary satisfaction in CY owing to good quality services as facilities. Vora et al (2018) found that quality of care, measured along several metrics, was better at private CY facilities than at public maternity care centres. On the other hand, it has been found that beneficiaries often had to incur out-of-pocket expenses for medicines, which have not been covered properly under the package (Bhat 2009). There have also been reports of EPPs admitting only regular cases and diverting cases with potential complications to public facilities (Acharya and McNamee 2009, 15). The reason given is usually that they are not adequately remunerated by the government for handling complex cases.

Mukhyamantri e-Eye Kendram (Andhra Pradesh)

Need and Concept

The Mukhyamantri e-Eye Kendram programme (MeEK) is a PPP between the Government of Andhra Pradesh and Apollo Telehealth Services (ATHS), a unit of Apollo Hospitals Group. It was launched on 1st February 2018. It is essentially a tele-ophthalmology project, i.e., providing eye-care remotely by setting up vision centres in remote areas that use information and communication technology (ICT) tools to transmit patient data to central assessment units and receive reports and prescriptions from them.

Tele-ophthalmology is, in fact, a part of a larger and growing domain of tele-health (or tele-medicine) which seeks to provide healthcare services by connecting people in remote rural areas to specialists in faraway urban centres who can provide expert consultation and diagnostic services. The MeEK project is said to be the first of its kind in the country so far as PPPs are concerned (Ganapathy and Reddy 2021, 219). It has not been as extensively studied by evaluators as the other schemes examined in this paper.

The rural-urban divide in India's healthcare has already been referred to. The disparities run even deeper when one considers specialised services like pathology, dermatology, paediatrics etc. In the case of ophthalmology, the doctor-population ratio has been estimated to be about 1:100,000 population and this ratio is expected to be worse in rural areas with estimates ranging from 1:219,000 to 1:250,000 (Singhvi 2023 and de Souza et al 2012). This acute shortage of eye-care in rural India leads to a high rate of vision impairment. This was the issue that MeEK sought to address by making cheap eye-care accessible to remote rural areas in Andhra Pradesh.

Under this scheme, 115 vision centres were set up across 13 districts in the state. These were to be manned by the staff of ATHS. Each centre has a paramedical ophthalmic officer and an equipment assistant. Advanced ophthalmic equipment has been made available for eye-screening in these centres.

Readings are sent and reports/assessments are received digitally from the remote specialist staff Apollo (Ganapathy and Reddy 2021, 219). The government has created an online dashboard where the details of the services provided (along with statistics) are available in public domain[7].

Evaluation

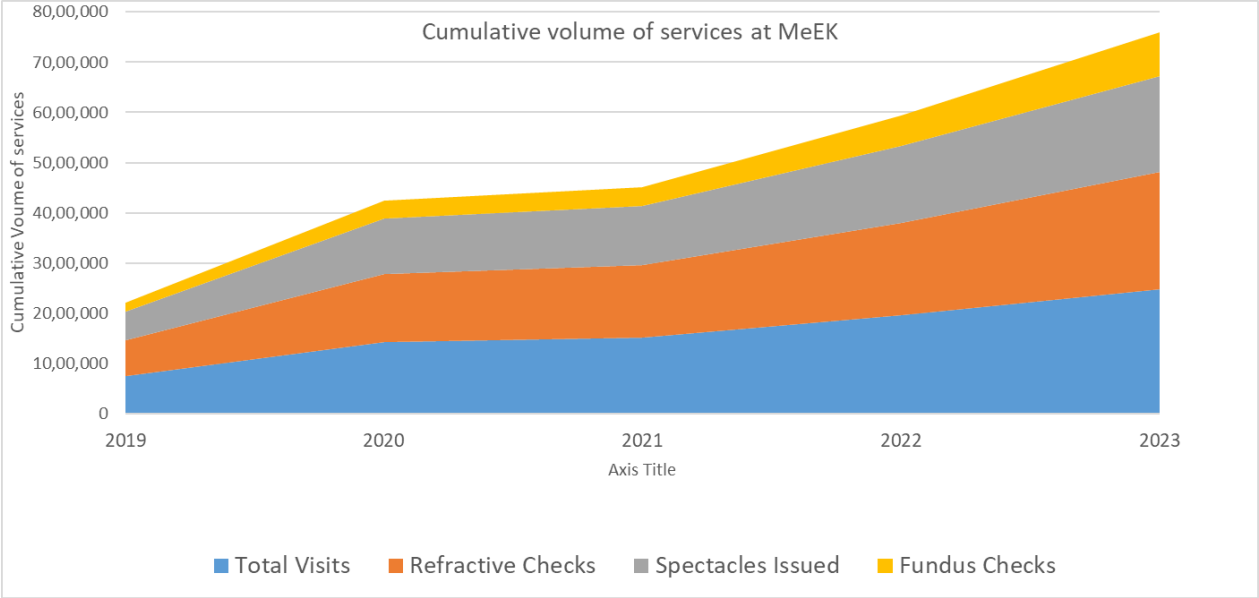
The only data that is available is what is posted on the above-mentioned dashboard. Based on the figures available therein, Table 2 has been made to summarise the volume of four key eye-care services rendered in the MeEK centres:

Data/Year	2019	2020	2021	2022	2023
Total visits	755,385	1,435,802	1,526,346	1,958,035	2,474,216
Refractive checks	708,006	1,348,515	1,433,534	1,843,966	2,335,352
Spectacles issued	577,808	1,109,103	1,179,373	1,527,213	1,904,396
Fundus checks	176,818	346,615	379,487	607,546	883,692

Table 2: Volume of different services provided by MeEK centres in Andhra Pradesh
Source: based on cumulative figures available on http://enethraap.phc.ind.in/index.php
Note: All figures are cumulative and were recorded as they stood on 1st February of each year. Therefore, marginal increase for each year would be = (Current Year) - (Previous Year)

In the five years of its operation, the number of patients who have been treated under this scheme, as can be seen from Table 2, is nearing 2.5 million. Nearly 2.4 million refraction tests have been performed and close to 2 million spectacles have been delivered to patients. If we were to consider the growth of these figures, then the marginal increase in patient visits in 2020 was an impressive 680,417. It was the lowest in 2020-2021, with only 90,544 patients served during this one-year period. This is likely to have been caused by the pandemic which had severely curtailed people's access to eye-care (for e.g., see Low et al 2022). However, the number of visits picked up pace from 2021 and MeEK centres served another 431,689 (4.3 lakh) patients in 2021-22. Another 516,181 patients visited these centres in 2022-23. On the whole, the data patient shows a growing patient inflow. This also suggests a widening acceptance of tele-ophthalmology among rural people which itself could be an indicator of its efficacy.

[7] Link to the government dashboard: http://enethraap.phc.ind.in/index.php



***Graph 2**: Volume of different services provided by MeEK centres*
***Source**: Table 2*

This paper had to rely entirely on state government data for its evaluation. Hence, it is important that independent evaluations are made by research institutions just as in the case of Chiranjeevi Yojana. Qualitative data about patients' experiences and the quality of eye-care have also not been gathered in any study so far. This is a key area for future research and is essential for making sound recommendations for improving this scheme.

However, existing research (see Sharma et al 2020) on tele-ophthalmology in India has identified some problems with this form of tele-health. First, it has been found that diagnostic images transmitted to reading centres are often of poor quality which makes them hard to assess. Lack of adequate training in tele-medicine is another factor that has marred the quality of tele-ophthalmology initiatives. Whether the latter applies to Apollo's personnel can be found out only through independent, on-ground third party evaluations.

Rashtriya Swasthya Bima Yojana (RSBY)

Need and concept

The formulation and implementation of RSBY was spearheaded by Shri Anil Swarup, an IAS officer who was then a Director General at the Ministry of Labour and Employment, GoI. It is a smart-card-based national health insurance scheme launched in 2008 and is targeted towards the poor.

From 2018, RSBY has been subsumed under the Ayushman Bharat - Pradhan Mantri Jan Arogya Yojana (AB-PMJAY)[8].

At the time the scheme was conceptualised, nearly 78% of healthcare expenditure in India was out-of-pocket expenditure (Swarup 2019, 45). For the poor, unforeseen health expenses can not only eat up a large chunk of savings but also reduce their income-earning capacity by physically impairing them or by halting the education of children (so that education expenses can be diverted to pay hospital bills). In other instances, they rely on debts at high interest rates, inevitably falling into debt traps (Swetha 2020, 92). To sum up the predicament in one statistic, "the financial burden imposed by health related spending could raise the proportion of people living below the poverty line in India by as much as 3.3 percentage points" (MOHFW 2005, 23). GoI had tried to combat this problem through a national health insurance policy in 2003 but it involved only public insurance companies which kept the programme from any tangible level of success (Swarup 2019, 48).

To address these issues, RSBY was proposed as a remedial welfare policy based on a PPP model. The initial target population were BPL households but the scheme was subsequently expanded to many categories of unorganised workers. In each district insurance companies, both public and private, are empanelled under the scheme. These insurance companies tie-up with public as well as private hospitals. They are also responsible for registering families under RSBY.

Beneficiaries receive biometric smart-cards. When a claim is to be made, the card is to be swiped in the empanelled hospital and a notification would be sent to the insurance company to settle the claim. Claims can be made for bills upto ₹30,000 per annum for a specified list of common diseases that require hospitalisation. The smart-cards are valid across the country which helps migrant workers. The premium payments are shared by the Centre and the State governments.

Evaluation

Private insurance companies empanelled under RSBY were able to make a profit (CII-HOSMAC n.d., 42). Private hospitals had also agreed to package rates lower than market rates presumably because it allowed them to fully utilise their beds (Swarup 2019, 54). The scheme has a cap of 30,000 for cashless claims to discourage private players from recommending unnecessary medical procedures/operations.

The scheme has been found to have impacted more than 36 million families across the country (Malhi et al 2020). The average incidence of hospitalisation has increased in the districts where the scheme was implemented (CII-HOSMAC n.d., 42). There is some evidence that the scheme has helped in

[8] Answer by the Minister of State in the Ministry of Health and Family Welfare to "Unstarred Question No. 4110, to be answered on 24th March 2023"

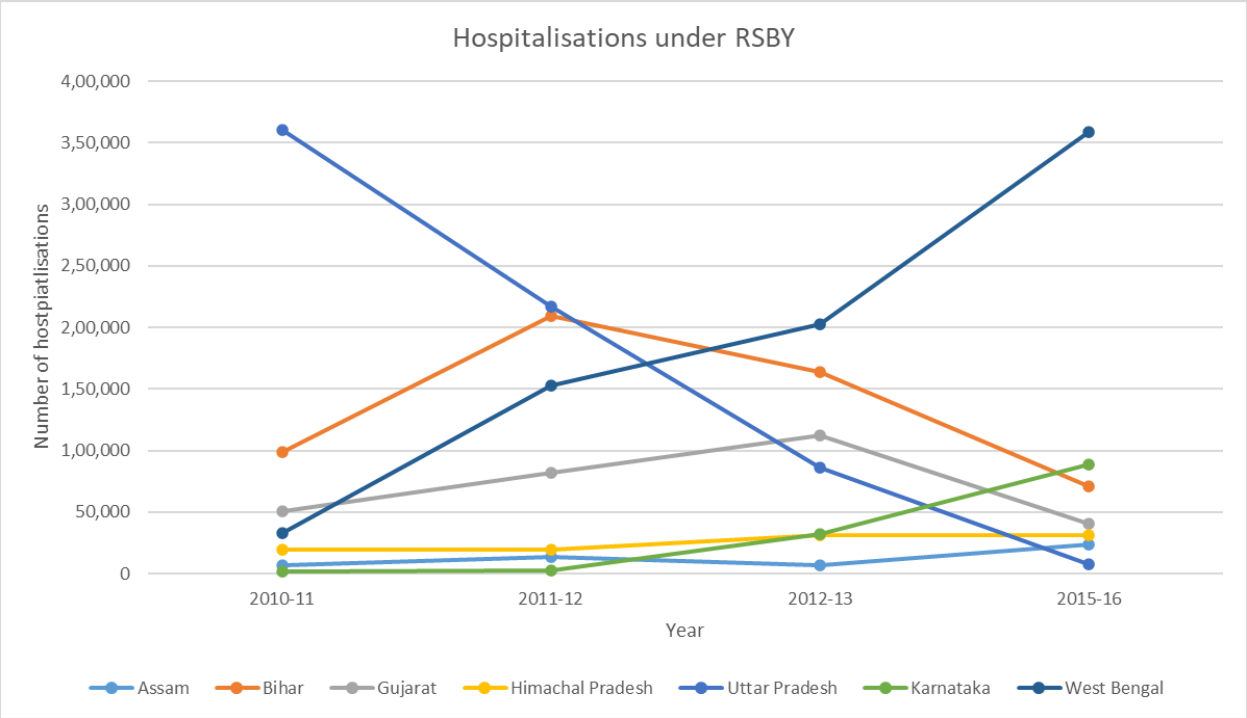
increasing access to hospitalisation (Johnson and Krishnaswamy 2012, 25). One study by Dror and Vellakkal (2012) points to an "impressive success" in increasing access to hospitalisation. The researchers in this study compared the hospitalisation rate of the lowest income strata in 2004, when it was at 1.24% with the hospitalisation rate of RSBY beneficiaries which was at 2.09%, suggesting a 69% increase. However, the hospitalisation figures show considerable disparities across states and have not been stable across time either, as can be seen from Table 3:

State/Year	2010-11	2011-12	2012-13	2015-16
Assam	7,224	13,253	6,717	23,783
Bihar	98,570	209,191	164,043	71,351
Gujarat	50,402	82,328	112,138	40,271
Himachal Pradesh	19,774	19,543	31,195	31,612
Uttar Pradesh	360,144	216,927	86,455	7,461
Karnataka	1,999	2,528	32,185	88,571
West Bengal	33,054	152,626	202,667	358,493

Table 3: *Hospitalisation cases under RSBY in selected states*
Source: *Data published by Press Information Bureau*[9]
Note: *figures for 2013-14 and 2014-15 could not be located*

An important area that needs to be assessed is the impact of RSBY on the medical expenses of the beneficiaries. Johnson and Kumaraswamy (2012, 22) report that RSBY has helped bring down outpatient expenses by nearly 15% and total medical expenses by 8%. Now, outpatient expenses make a huge dent on overall expenses. It is likely that the increased access to hospitalisation (and by extension, timely in-patient care) has helped reduce long-term out-patient expenses. This can be appreciated if we compare it with a situation without a scheme like RSBY, wherein the poor are likely to avoid hospitalisation owing to high costs.

[9] https://pib.gov.in/newsite/PrintRelease.aspx?relid=94817 and https://pib.gov.in/newsite/PrintRelease.aspx?relid=144960



Graph 3: *Hospitalisation cases under RSBY in selected states*
Source: *Table 3*

However, many studies have criticised the exclusion of out-patient expenses from the RSBY package. In other words, RSBY covers only hospitalisation i.e., in-patient care. This has been shown to adversely affect RSBY beneficiaries by adding to out-of-pocket (OOP) expenses. Expenditure on medicines alone forms a large bulk of OOP expenses. As one study notes, "The burden of outpatient expenditures that account for the bulk of OOP healthcare spending is mostly unaffected and utilization of outpatient care may even have increased on account of RSBY" (Karan et al 2017, 90). This is because the increased incidence of hospitalisation brings with itself an increase in associated expenses like diagnostic tests, medicines etc (Malhi et al, 2020). It is worth noting that the government has started pilot projects in two districts for covering outpatient expenses in RSBY (Johnson and Kumaraswamy 2012, 25).

Areas of Concern in Healthcare PPPs

An analysis of PPP initiatives in healthcare reveals several areas that demand the attention of policy makers. These pertain to the design of the PPP projects, the relationship between the government and the private partners and the scope of the benefits provided to the targeted population.

Neglect of primary healthcare

Most of the PPP projects in healthcare tend to focus on secondary or tertiary healthcare. Primary healthcare at the local level rarely enters the area of private providers' interest, except that of NGOs. Indeed, at the primary level, the partnerships are mostly with non-profits (Nundy et al 2021, 16). It is not difficult to see why. For-profit private sector providers find secondary and tertiary healthcare more lucrative than primary care (Rajasulochana and Maurya 2020, 9). But it is primary care that has a large impact on the health status of a population given its proximity and its role in arresting the development of diseases through prevention. The predominance of NGOs in serving at the village levels (primary care) is constrained by problems of funding. The for-profit sector's involvement at primary levels is also discouraged by the lack of enabling infrastructure (CII-HOSMAC n.d., 59).

Lacunae in the contracting process

It has been pointed out that the process of selecting the potential private sector partners is compromised by a lack of information about the quality and competence of the private providers. Anil Swarup (2019, 53) refers to complaints received during the roll-out of RSBY about the empanelment of ill-equipped hospitals having sub-standard hygiene conditions. The private healthcare sector is vast and fragmented, ranging from large superspeciality hospitals to small clinics to 'fake doctors'. We certainly cannot assume that the entire gamut of private providers would be able to offer better services than public healthcare institutions. Mechanisms of accreditation of private hospitals need to be strengthened. Another issue with respect to contracting is the lack of healthy competition. Studies have shown how personal and political connections play a key role in the awarding of contracts so far as PPPs are concerned and the healthcare sector is no exception (Roy 2021, 131). This puts incompetent providers in charge of delivering crucial healthcare services to a population that often has few other alternatives.

Reducing Out-of-pocket expenditure

Government interventions in healthcare must primarily focus on relieving the financial burden of healthcare spending on the poor. In other words, the aim should be to reduce out-of-pocket expenses on healthcare. But efforts to do so have fallen short of considering some important factors that add to such expenses. For instance, in the Chiranjeevi Yojana, medicines are not covered in the package rate determined by the government. As a result, BPL women who avail the benefit of CY are made to pay for medicines. Further, there were cases where the transport expenses of the beneficiaries were not reimbursed by the hospitals even when this was a part of the CY scheme (Roy 2021, 129). Similar is the case with RSBY where outpatient expenses on medicine, testing etc. need to be paid by the poor beneficiary families. In many cases, private providers are unwilling to provide diagnostic (testing)

services free of charge or at subsidised rates even when a scheme exists to this effect, or charge extra payments from the patients (129).

Inadequate performance measurement

The templates for PPP agreements designed by the PPP Cell at DEA do contain provisions for monitoring of projects but these are very broadly defined and do not offer much guidance on constructing performance indicators. Reviews of PPP projects in healthcare have often noted the absence of built-in performance indicators (Nundy et al 2021, 53; Rajasulochana and Maurya 2020, 10-11). Record keeping and regular in-house monitoring in empanelled private hospitals were also found to be weak (Roy 2021, 132). Monitoring becomes important in PPPs to ensure that private providers are not avoiding their obligations. For example, data on referrals made by private providers in Chiranjeevi Yojana need to be examined to see if they are diverting complex cases to public centres to avoid spending on complex treatments (Bhat et al 2009).

Recommendations

Despite the challenges in implementation and questions about its ability to deliver quality healthcare, PPPs remain an important aspect of health policies at the central as well as state levels. This push for PPPs is not wholly unfounded as they cannot be completely dispensed with either. Given the constraints on public spending and the limitations on access to public healthcare, involving private players has become necessary. PPPs in healthcare are here to stay but the task that lies ahead is to ensure that they are able to deliver in areas where the public sector has failed to deliver on its own. To this effect, here are some policy recommendations based on the analysis presented so far:

1. It is suggested that the Government of India bring out a definitive and comprehensive 'National Policy on Public Private Partnerships in Healthcare'. While the PPP Cell set up by the DEA has already prepared detailed manuals for PPP projects, it is important for GoI to lay down clearly the objectives that PPPs are expected to achieve with respect to healthcare. Such a policy document should also create a regulatory framework for the effective governance of PPP projects. Minimum standards of healthcare delivery under PPP mode need to be established.
2. It is proposed that community engagement at the local level be encouraged. This would serve multiple purposes. Community participation can help increase awareness about PPP schemes and overcome the reluctance of the poor in availing the benefits thereof. The role of the community can be most effective in primary healthcare PPPs where NGOs figure predominantly. They can help effectively monitor the working of the private service provider. Bangladesh has experimented with Community Clinics which are primary health centres built

on lands donated by the community and are fully managed by them (Riaz et al 2020). This has helped expand access to basic health services among rural people.

3. The coverage of schemes such as Chiranjeevi Yojana and RSBY needs to be expanded to cover outpatient expenses such as medicines, diagnostic tests etc. As has been pointed out in this paper, the poor often have to bear the burden of these expenses on their own which challenges the very idea of reducing out-of-pocket medical expenditure of the poor. Even the upgraded AB-PMJAY does not cover outpatient charges. It is strongly suggested that such expenses be also brought under the scope of health insurance schemes.
4. The reluctance of private players in providing primary healthcare in villages is the result of poor infrastructure which makes many regions hard to access. In such a situation, tele-medicine can offer a viable alternative by reducing heavy transport expenditures. However, this requires the extension of high speed internet facilities to remote rural areas. It is suggested that primary health centres be equipped with telecommunication facilities suited to seamlessly transmit patient data for evaluation and receive reports digitally.
5. It is recommended that independent evaluations of PPP schemes must be encouraged. This would be facilitated when comprehensive and good quality data is made available by those in charge of administering the schemes at the ground level. The example set by the Andhra Pradesh government by setting up a dashboard where statistics of the MeEK scheme are updated in the public domain may be emulated in other PPPs as well. Peer-reviews by empanelled hospitals of each other's performance in providing services under a PPP can also be considered as a monitoring mechanism.
6. It is suggested that a standardised evaluation framework be constructed for each segment of healthcare PPPs (such as diagnostics, general health insurance, maternity care and so on) in consultation with private, government and community stakeholders. This would help in drawing sound comparisons in the performance of different private providers and help in making better choices while selecting future private partners/contractors.

Suggested Regulatory Framework for PPPs in Healthcare Sector

India has not adopted any national policy on PPPs in the healthcare sector for the purposes of direction and regulation. The following points are intended to lay the broad contours of a regulatory framework governing healthcare-related PPPs. They may be expanded upon in a national policy on the same:

1. The framework must lay down rules governing the tendering process. This should involve specifying the eligibility of private providers (PPs) for entering into a contract with a government entity. Eligibility must be defined in terms of number of years of experience in

providing healthcare services, past record of delivering on contracts and accreditation granted by the National Accreditation Board for Hospitals (NABH). These criteria are bound to vary from one sector of healthcare to another. Private players offering more specialised healthcare services would naturally be required to fulfil more demanding eligibility criteria and possess higher grades of accreditation.

2. The tendering should be based on the principles of fair competition, transparency, equal treatment, reliability, confidentiality, public opinion scrutiny, efficient use of the resources, satisfying the identified public needs under suitable conditions, and in a timely fashion. All efforts should be taken to avoid PPPs in domains where no serious competition exists, so as to prevent private monopolies. To this end, the PPP Cell (under DEA, Ministry of Finance) must involve the Competition Commission of India while considering PPP proposals for approval.
3. The PPP cell should develop a shelf of PPP projects that could potentially be undertaken in every sub-sector within healthcare. This must be done keeping in mind the current and future healthcare requirements of the country. Evidence on the past performance of PPPs in every sub-sector of healthcare shall guide the conceptualisation of new projects to ensure that only such PPPs are undertaken which would deliver value for money and not burden the public exchequer.
4. Funding of healthcare-related PPP projects usually takes the form of user-charges, annuity payments to private providers, or compensation based on fixed package rates. The compensation-rates must be regularly revised taking into account the rising costs of healthcare services. To prevent the misuse of these payments by private providers by prescribing unnecessary procedures, penalties must be instituted for such practices, should they be identified during periodic evaluations.
5. Guidelines for the auditing of the government entities involved in infrastructure PPPs have already been formulated by the Comptroller and Auditor General in a document entitled 'Public Private Partnerships in Infrastructure Projects: Public Auditing Guidelines' (2009). A similar set of guidelines must be formulated for healthcare related PPPs. Auditing must extend to the selection of the private entity through a fair tendering process, adherence to the terms of contract, provision of healthcare at reasonable costs, imposition of costs beyond what was allowed under the agreement etc. Social audits, along the lines of what is practised in the context of MGNREGA, can be instituted to involve the community in assessing local healthcare initiatives in the PPP mode.
6. To prevent the concentration of PPPs at secondary and tertiary levels of healthcare, private providers may be incentivised to operate Primary Health Centres (or Health and Wellness Centres under Ayushman Bharat programme) through tax benefits similar to what is provided for setting up hospitals in rural areas.

Conclusion

Public Private Partnerships have become and are expected to remain an integral component of the national healthcare system due to the inherent limitations of the public health infrastructure. But the policy-push for PPPs should not be based on mere expectations of the private sector's efficiency and innovation. In other words, PPPs must be favoured in various domains of healthcare based on evidence that they are attaining the outcomes for which they are meant, namely (a) expanding access to good quality healthcare at all levels: primary, secondary and tertiary, and (b) relieving the poor of the burden of out-of-pocket healthcare spending.

In this paper, three PPPs in healthcare have been examined to understand how far they help in meeting these objectives. While all three have certainly expanded access to services like private maternity care, hospitalisation (in-patient care) and ophthalmology. However, inadequate resource allocation by the government has led to the exclusion of outpatient expenses, OOP expenditure on medicines, insufficient compensation to private providers for offering free services etc. Monitoring of the schemes is another area that needs attention and can benefit from the active involvement of local communities to ensure accountability.

In sum, PPPs have the potential to deliver decent healthcare to millions of Indians if their implementation is based on a transparent, evidence-based approach.

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