**Public Private Partnerships in Healthcare in India**

**Reflecting on 20 years of theory and practice**

**Challenges for PM-JAY[[1]](#footnote-1)**

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One of the big hopes and directions of health sector reform over the last three decades have been the Public Private Partnerships (PPPs). The nation now has over 20 years of experience of implementing PPPs in health-sector. There is a need to reflect back on this experience with PPPs and highlight challenges that we may face in the implementation various *avathars* of health insurance schemes in the Indian context, of which the most recent and largest is the National Health Protection Scheme, now named the Pradhan Mantri Jan Arogya Yojana PM- JAY

This paper is divided into three parts: Part 1 will provide an overview of PPPs in the discourse on health sector reform and Universal Health Coverage; and presents a critical interpretation of “strategic purchasing” and “expectations” of PPPs; Part 2 presents illustrations of PPPs in Secondary and Tertiary Hospital Care and lessons learnt from these PPPs; and Part 3 will discuss the challenges to be faced in the implementation of PM-JAY.

**PART 1: PPPs in the discourse of Health Sector Reform and Universal Health Coverage:**

The discussion on PPPs has a renewed importance at a time when Universal Health Coverage has become the main framework, within which goals, directions and processes of health systems are discussed. Officially, international organizations insist that Universal Health Coverage does not imply any one road- map and nations are free to choose their own road map. But three features characterize the discourse that comes along with this UHC concept:

1. It has limited or no discussion of what can be done to strengthen free or subsidized care by public providers; and equally important, it fails to discuss how health sector reforms promoted as part of a neo-liberal[[2]](#footnote-2) understanding were at least in part responsible for the poor performance of the public sector.
2. It insists on shifting the role of the government from being a provider to a purchaser of health care services. It argues for separating the Government’s role of purchaser from that of being a provider. Purchasing is supposed to replace the traditional role of ‘planning’, give government the levers of financial incentives for improving performance and build competition or contestability between public and private providers so as to make use of market mechanism for improving efficiency.
3. It believes that competition and choice is essential for ensuring quality of care and efficiency in health services, but acknowledging that there is market failure, calls for governments to make the purchase, on behalf of the users, from public and private providers or provider networks.

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| --- | --- | --- | --- |
|  | | Who is the Provider of Health Services | |
| Govt. Provider | Private Provider |
| Who is the payer for health services | Government  Pays | 1. Govt. hospitals providing free care. Most Govt. hospitals are like this. | B. Private hospitals paid by Govt on behalf of patient |
| Private Payer  (individual  or family ) | C. Government hospitals whose main source of funds is user fees | D. Private hospitals paid by individual patients. Most private healthcare is like this |

If we categorize all hospitals and health care facilities into four groups A to D as done in the table above, then we can understand that currently most hospitals are either in category A (if they are government owned) or Category D (if they are private). The direction of reform is to enlarge category B. This category B is obviously ’purchasing’. But health economists like to call the category ‘A’ also to be part of ‘purchasing’ sometimes referring to financing inputs based on a budget as direct purchasing. A part of the above discourse further recommends Government to ‘purchase’ from its own facilities by entering into contracts with them and reimbursing them for services that have been delivered.

How is purchasing done? One route is insurance- where private hospitals are empanelled, and after a patient has visited the hospital he or she is billed, but the bill is paid for by the government, usually by an insurance company through a Third Party Agency (TPA). But it could be paid directly as well. The former is called the Insurance model and the latter is called the “Trust” model. The other is through what are called public private partnerships, where government has a contract with a private agency, and the contract specifies how much they would pay for the services that the agency provides. These services may range from just some part of the care provided- like ambulance services or diagnostics, or it may be for all aspects of care.

Much of this was part of the earlier health sector reforms of the 1990s also. Promoting health Insurance was mooted by the World Bank as a form of promoting private markets in healthcare. Public private partnerships were promoted as a form of shifting from public to private providers. In the usual forms of privatization, payment is left to the consumers, but in these partnerships it is government who is the main or even sole payer.

What is new now is this term ‘strategic purchasing’.

**Strategic Purchasing: A new term and its multiple meanings:**

In published literature and in the policy community the term strategic purchasing appears with different meanings. For some,all purchasing is loosely termed as strategic purchasing, with only paying public providers directly being referred to as passive purchasing. Others state that strategic purchasing is meant to influence the structure and functioning of the market and/or achieve other strategic goals. In this understanding purchasing does not go merely by the market and the lowest rates available, but informed by a strategy to shape markets. Thus within India’s National Health Policy 2017 itself, there is more than one definition of what is ‘strategic purchasing’. In paragraph 13.6 of the Policy it is described thus:

“The health policy recognizes that there are many critical gaps in public health services which would be filled by “strategic purchasing”. Such strategic purchasing would play a stewardship role in directing private investment towards those areas and those services for which currently there are no providers or few providers. The policy advocates building synergy with “not for profit” organizations and private sector subject to availability of timely quality services as per predefined norms in the collaborating organization for critical gap filling.” (National Health Policy, 2017, section 13.6, pg 63),

The above description emphasizes government’s role in directing even investments of commercial private sector towards ‘critical gaps’ in healthcare as the ‘strategic purchasing’. But in the earlier part of the same policy, the ‘strategic purchasing’ is explained as follows:

“The policy envisages strategic purchase of secondary and tertiary care services as a short term measure. Strategic purchasing refers to the Government acting as a single payer. The order of preference for strategic purchase would be public sector hospitals followed by not-for profit private sector and then commercial private sector in underserved areas, based on availability of services of acceptable and defined quality criteria. In the long run, the policy envisages to have fully equipped and functional public sector hospitals in these areas to meet secondary and tertiary health care needs of population, especially the poorest and marginalized. Public facilities would remain the focal point in the healthcare delivery system, and services in the public health facilities would be expanded from current levels.” (National Health Policy, 2017, section 3.3 pg 11)

The presence of above seemingly contradictory and at the same time overlapping definitions of strategic purchasing in the same policy is not an error. It is reflective of one of the most contested areas in health policy, which is the question of the extent and scope of government as a purchaser of services as compared to government as provider.

In this note, we shall be considering the experience with different forms of contracting private sector to provide public services, which is what is usually referred to as Public-Private-Partnerships.

**Theoretical Expectations of PPP (Public Private Partnership):**

Public Private Partnerships are meant to close critical gaps- that much is clear. There is however much variation in what is called a gap and the extent of the gap, and therefore the scope of PPPs. To those who for reasons of ideology do not believe that public systems will or should *ever* deliver, PPPs are only a form of slowly and steadily shifting all healthcare, or as much of it as possible, into a “private-provisioning, government purchasing” mode. To others who think that public sector performance can be improved, PPPs can become an important route to ensure performance of public health systems.

The question for the latter is: “Why should the government ever choose to contract a private agency when it could have organized the services with its own workforce.” There are many explanations for this:

1. *“Incentive Environments” that “align agents with principal”:* PPPs are expected to perform better because they are governed by explicit contracts. In this understanding the main reason why public systems are dysfunctional is because public provider and the manager of a public facility get their salary irrespective of outcomes. They have no incentive to perform better, and indeed they may get into trouble if they try to innovate. Further there may even be poor clarity about what are the desired outcomes. The functioning of an organization and individuals within it is analysed as made up of principals (for whose benefit the organization is run) and agents (those who carry out the necessary functions). In healthcare system, the principal is the public, or service user. The principal is also the government, especially if the government is the payer. The agent is the hospital or healthcare manager. The manager is expected to work in the best interests of the beneficiary or the payer, but in reality the organization or its managers may have their own self- interests and priorities, which may overshadow the interests of the principal. The contract makes explicit the outcomes that the principal wants and then the terms of the contract are written such that payment is organized that the interests of the agent are now better aligned with the interests of the principal. Or in the language of this framework- the incentive environment is created that aligns the interest of the agent with the principal. The contract will offer rewards if the performance is good and impose penalties if the performance is poor or terms of the contract are breached.
2. *Efficiency*: A related set of reasons to argue for PPPs relates to the notion of efficiency. Here the belief is that if the private agency to provide the services is selected by competitive bidding, then we can get the lowest possible rate for the same level of outcome. Private agencies can do the same job as a public agency at a lower cost, because (i) their managers will make the workforce work harder and better and (ii) private agencies innovate- they can find new ways of doing the same job for less funds (iii) the behavior of providers and overall quality of service will be better and therefore they would attract more patients for the same level of funding.
3. *Organizational Capacity*: A completely different reasons for PPPs is to say that the government does not have the capacity to organize a particular service and therefore it expands its own capacity to hire in private agencies which can play that role. The lack of capacity could take the form of lack of persons with requisite skills and technical knowhow, or it could take the form of the presence or absence of enabling framework of rules and regulations for recruiting staff, for managing funds, for procuring technologies or commodities, for monitoring staff and so on. This reason is more consistent with the understanding of purchasing or PPPs for ‘critical gap closing.’
4. *Human Resources Gaps- especially specialists:* One argument for PPPs has been that close to 80% of specialists and even doctors are in the private sector- and we will need PPPs to harness their skills to achieve public health goals. *Because it is there: Another persuasive argume*nt for engaging with private sector is simply ‘because it is there.’[[3]](#footnote-3) When clos*e to 70% of patient* care is from the private sector, government policy cannot ignore its presence and its impact on people’s lives. Also within the private sector, there are many ethical providers who are making an effort at relief of suffering and the reduction of mortality. So there is a need to construct ways of engaging with private providers- and PPPs could be one important way. This argument could also be extended to infrastructure gaps.

Other ways of engaging with the private sector so as to support the ethical care provider and shape markets are regulation, insurance and through supportive training and guidelines.

However as reviews of PPPs in India have shown, there has been considerable lack of clarity within governments on the policy framework for PPPs in (a) terms of objectives and scope of the services to be delivered, (b) costing of the services, (c) performance indicators including indicators for quality, (d) payment mechanisms, (e) contract management, and (f) ensuring equity for the poor. In terms of performance a small body of research has emerged, but most of these are in the nature of documentation of specific PPPs, often commissioned by their funding agencies. There is little information on effectiveness in terms of health outcomes, or in terms of efficiency, or on longer-term sustainability. There is also little information on the impact of PPPs on public sector – draining away public health staff, or otherwise weakening or strengthening public sector provisioning. There is so much variation between different PPP models that is difficult to generalize.

**Part 2: Illustrative Examples of Strategic Purchasing for Secondary and Tertiary Care:**

The contracting of private agencies in what are called public private partnerships have been tried at many levels. The most common objectives is partnerships for secondary or tertiary care. Though there have been many efforts at PPPs for primary healthcare, none of these have gone to scale and sustained. There is also another category of PPPs where the main providers are public hospitals but only some ancillary of support service- like diagnostics, or ambulance services are outsourced. These have done better but are basically forms of public provisioning rather than purchasing care from the private sector.

In this paper, we shall present three case studies, one of outsourcing secondary care through a PPP contract, another relating to a tertiary care and the third related to use of insurance mechanisms for purchasing secondary and tertiary care. We limit ourselves to these models because the context of our presentation is learnings for PM\_JAY and the latter is exclusively focused on purchase of secondary and tertiary care. After presenting each case study we reflect on what governments have learnt and what they have failed to learn. We then move on to Part 3, for a discussion of fundamental policy challenges in the light of the expectation of PPP strategy under PM-JAY.

* 1. **PPP Case study: Outsourcing the Secondary Care Public Hospital : The Uttarakhand CHC outsourcing model:**

In May 2013, a PPP for outsourcing of community health centres was initiated through a Memorandum of understanding (MoU) between the Directorate of Health & Family Welfare (Government of Uttarakhand) and two private sector parties. Technical Assistance in this instance was by the Department of Economic Affairs (DEA), Government of India and Asian Development Bank (ADB) for promotion of PPP in the State. These PPPs clearly drew inspiration from the theories of contracting, incentive environments and principal-agent alignment. Selection is by tendering, bidding is based both on experience of provider but also on the financial bid, there are rewards for performance and penalties for non-performance. A cluster of CHCs outsourced; the contract duration was for five years. Clearly the highest quality of technical thinking had supported the preparation of the tender document.

The MoU outsourced 12 selected CHCs. One immediate reason stated for the outsourcing of the CHCs was to help closing the human resource gap in the rural facilities, where the government had failed consistently to provide medical staff, especially the specialists required for emergency obstetric care. Two private parties, Rajbhra Medicare Pvt. Ltd, New Delhi and Sheel Nursing Home Pvt. Ltd, Bareilly (UP) won the bid for 4 and 8 CHCs, respectively. These 12 CHCs are spread over 13 districts of the 2 divisions - Kumaon and Garhwal. One agency had extensive experience in running MMUs over 4 states and the other had the experience of managing a nursing home and a private university in the neighboring state.

One notable feature of this model was that the primary health centers and the sub-centers in the CHC area were not part of the contract. They remained with the government. National Health Programs that the CHCs were to perform also remained with the government. Only the hospital’s curative services- both ambulatory and in-patient were outsourced. They were to be paid a flat rate for each CHC based on their bid. Since the CHCs were of different specifications, the bidding was per square foot of floor area. Based on four performance indicators, which included institutional deliveries, and diagnostics carried out,, they were paid incentives. Some of the CHCs were very near urban areas and some were far- so as to give the private agency a good chance of success. Another interesting feature of the model was that user fees were allowed for many services, but this would be collected by a government worker- and not handed over to CHC. Since most of such user fees were around diagnostics, the agency anyway had an incentive for doing more diagnostics.

The PPP was officially launched in May 2013. By May 2014, this was being praised and other states were being welcomed to come and see the success story. By December 2014 there were complaints made on inflated output figures so as to earn more incentive. There were also complaints that the agreed number of specialist-staff were not there. Then complaints from the public arose regarding poor service. By about August 2015, the state stopped payments and in December 2015, just 30 months after signing the MOU, the contracts were formally terminated. But the story did not end there. The private agencies went to Supreme Court and by August 2016 got a stay order, but by November 2016, the court allowed the contract of one of the parties to be terminated with payment of dues. Then the program was all but abandoned.

The core of the problem was this. All that the CHC was able to provide was services which were on par with the government managed CHCs. Officers of the government monitoring the programme were quick to point out that the agency was failing on its core deliverables, viz. to position a number of specialists and deliver a certain range of secondary care services of which emergency obstetric care was the most important. By terms of the contract such a gap could attract penalties but not termination. But when the gaps were large, the government felt justified in ending the contract. Supporters of outsourcing could argue that other CHCs also had such gaps. To supporters of PPPs, the answer was to write better contracts. But we would hold that the problems why government CHCs were sub-functional, continue to act even when the ownership or management is transferred to private hands. *If government was unable to attract specialists to remote areas, private agencies with temporary appointments will also not be able to attract or retain them. Thus among the few specialists that the agency recruited were some retired officers and some interns*.

In fact the problems encountered by CHCs became worse with private management. There were more problems of coordination with the PHCs below and the district hospitals above, and there were more problems in support and referrals. There was also a clear gaming of the system with greater consumption of services attracting incentives while critical secondary care services that were really the need of the patients, were still not becoming available.

But did the government learn any lesson? Did the technical assistance teams learn any lesson? Now there are reports that a fresh effort at outsourcing CHCs is beginning. Earlier cycles of failures are being dismissed as consequent on individual factors and personality issues.

**Overview of Outsourcing Secondary Care Hospitals:**

There has been a relatively less intensity of effort to outsource community health centers and district hospitals (secondary level hospital care), though private agencies often express interest in the same, and there are repeated attempts from policy makers as well. Important examples of this are the outsourcing of two district hospitals in Karnataka.

This case study described above conforms to the general pattern is of an early declaration of success, followed by the rise of complaints at about 2 years and a slow down or cessation after three to 5 years- a pattern that we described with Primary level care outsourcing. But these repeated failures are inadequately documented and largely forgotten.

An interesting variant of this theme, which has had relatively better success, is the Memorandum of Understanding (MoU signed between the Deepak Foundation and the Government of Gujarat (GoG) in 2006 for operating the Mother and Child Care Centre in the Jabugam CHC, which is near Vadodara. This PPP has now been in existence for the past ten years. It is important to note that this PPP only caters to the maternal and child services, while the general outpatient and inpatient services provided in the same CHC is the responsibility of the government.

There are many differences between this model and the Uttarakhand model. The private agency brought in capital investment to build infrastructure as part of its CSR work. Initially even HR costs were shared, but now most of it is covered by the government, but with Deepak Foundation paying a top up salary to retain the sole gynaecologist that they have been able to recruit. The aim was to provide emergency obstetrics and new born care at the CHC level. And this it does, but with increasing difficulty in providing emergency services. It has been unable to secure a paediatrician. There was no process of tendering, no complicated contracting or expectation of contracting, no space for profit maximization. It just provided space to a private CSR agency to strengthen a public service. This is a niche contribution and they have not been able to scale it up.

Recently the NITI Ayog has renewed attempts to find possibilities for outsourcing district hospitals and Uttar Pradesh, as always, been a soft target for such efforts. However the private agencies seem interested in only the best running, most central hospitals- like the Dufferin hospital and most reluctant to go to more peripheral districts where the hospitals really need help. And the state government has to hesitate because the political and economic costs of outsourcing the good hospitals will be high. This experience has been reported from many other states in the past. Though private agencies are interested in taking over district hospitals, to establish medical colleges, this is talked about but seldom materializes.

One curious failure is the lack of efforts to harness the capacity of mission hospitals to provide hospital services and a very good range of secondary care services. The capacity of mission hospitals is estimated at about 60,000 beds and may equal that of all the district hospitals combined. They have a very good dispersal and many of them are in rural areas. They should require less monitoring. Some of them have joined in government insurance schemes. PPPs with them are very patchy- almost non-existent. One important example of a relatively successful case is the Ramakrishna Mission Hospital in Narayanpur, a remote tribal district in Chhattisgarh. But these are exceptions.

**Lessons to be learnt:**

Outsourcing public hospitals on management contracts is not working. And efforts at outsourcing district hospitals is likely to find that private agencies will accept only the more functional hospitals and for managing this they may need to be paid much more to run the same level of services- with no gains in either efficiency or quality of care. When it comes to more remote areas, the same problems that affect the performance of government management will affect the private agencies and they would have even less capacity to manage these.

**2.2. PPP Case Study \_ PPPs for Tertiary Care hospitals:**

**Apollo Indraprastha Hospital and the Delhi Government.**

One of the earliest prototypes of the standard model for PPPs with private corporate hospitals was the PPP with Apollo Indraprashtha Hospital, New Delhi.

In 1986, the Delhi Administration invited proposals to establish a multidisciplinary, super-specialty hospital on “a no profit no loss” basis. Two years later, the government leased a prime property to the Apollo Hospital group on a token payment of one rupee a year, to set up the Indraprastha Hospital. The hospital is a joint venture with the Delhi government. By the terms of the Agreement, the hospital was to provide free services to patients occupying at least one third of its 600 beds and to 40 per cent of those seeking outpatient care. In return the government provided 15 acres of land, and Rs 16 crore to set up the hospital.

Much later, a panel constituted by Delhi High Court in response to a PIL, found that the hospital had failed in its obligations. And this despite the fact that this was never seen as a philanthropic act, rather as a legal obligation to provide certain clearly specified services to people in return for a substantial financial subsidy to the company.

The underlying logic of such a PPP is quite different from the usual ones. Or else, why choose the center of Delhi already replete with both public and private hospitals to support with public funds such an initiative. As one article in Indian Journal of Medical Ethics puts it: “The media image of Dr Prathap C Reddy, the founder of the Apollo Hospitals Group, which has been in large part carefully crafted by the group itself, credits him with having brought modern multidisciplinary super specialty care to India for the benefit of patients.”(IJME, Jan-Mar 2010). When we reflect on the sober fact that most medical colleges in India, especially the national centers like AIIMS, PGIMER Chandigarh, JIPMER etc were always designed to be modern multi-speciality care, we can appreciate the extent of salesmanship that goes into securing their leading positions.

Clearly what is at work here is the desire of the Indian elite to have a world class medical facility which they can access without experiencing the crowds and the hassles of the leading government tertiary care institutes.

**Overview of the super-specialty Hospital PPP**

Government using the public land acquisition act first acquires the land. Modest compensation has to be paid to the landowners. But since many in urban slums, may have no legal title to the land, even payment could be avoided. Then it gives it to the private hospital owners at throwaway prices. In return free services have to be provided for anywhere from 10% to 40% of patients in different agreements- but this never materializes. Fortis, Escorts, Medanta- many major hospital groups have so benefitted by entering into signed agreements.

In addition to the land, such hospitals were also given import-duty and tax exemptions in return for similar free care agreements which also were not honoured. This again was brought to light by another court appointed panel in the 1990s.

There is a similar situation across all states. There are a large number of so-called charity hospitals in Maharashtra which received land and other benefits in return for free services. Such contracts began to get more sophisticated and varied in the last decade.

One such contract, much hailed by the then Planning Commission was the case of the Super-specialty hospital in Raichur, Karnataka. Here the hospital and equipment was transferred to a corporate agency winning the bid for operations management. Here is an an enthusiastic description of this model written in 2007:

“The Rajiv Gandhi super-specialty hospital in Raichur Karnataka, was built at a cost of Rs 600 million. This economically backward region of the state has no modern health facilities; so people are forced to travel long distances to seek specialist medical care. As government was unable either to deploy or retain specialist doctors, the hospital was lying unused. Apollo Hospitals Ltd, a corporate hospital chain, was seeking to establish its own hospitals in the region, but it was not sure about building a super specialty hospital. The respective dilemmas of the Government of Karnataka and Apollo Hospitals Ltd were highly conducive for establishing this partnership for mutual benefits. Through this partnership, the Government is able to provide free services to the poor, and Apollo Hospitals Ltd is able to establish its business operations without having to invest in constructing physical infrastructure. The corporate hospital is able to pay well for its staff so it could retain the desired manpower. The rates they could charge were to be 30% less than in their Hyderabad hospital.”

By 2009 this PPP was in trouble and in 2011 its renewal was not extended. There were three or four major reasons for this. First, it had failed to fulfill its obligations to provide free care to BPL patients - though there were number eligible patients under existing insurance schemes for the poor in operation. Secondly there was an over 50% under-utilization of capacity. Thirdly there were revenue losses partly because of inadequate capacity utilization and failure to attract insured poor patients or non-poor. There were also reports that the services available within were limited- and referrals to the larger corporate branch in nearby Hyderabad was frequent.

Yet another famous example is Fortis Heart Care Hospital established for providing advanced cardiac care and another similar corporate hospital established for providing gastro-enterology care in Raipur in the first years of the newly formed state of Chhattisgarh. Here again the costs of building and equipment were paid, the corporate agency was allowed to charge at “unspecified” market rates. Fortis was to keep 15% of beds to provide free care to poor patients, but even for them it was allowed to charge unspecified prices of drugs and consumables. Government employees were to be given 15% discount on unspecified list price. They were also to provide training to local personnel to take over the cardiology services over the year. In practice, only a very limited range of procedures was established, and much of the cases who needed advanced treatment had to be referred to Delhi. There was no evidence of any benefits extended to those who could not pay. This example too is clearly motivated by local elite who need an advanced care model near home- but not only do these models fail to deliver on care for the BPL which is used to justify the government funding- they even fail to deliver on the promise of care to the elite. The owners want more, the elite want more and both are unhappy. The poor never learnt that they had an entitlement in this facility- and therefore they do not notice its presence there. Last year (2017), the Fortis Heart Care PPP officially came to an end. The gastro-enterology PPP ended so soon after it started, that there is no memory left of it at all. The tertiary government hospitals meanwhile have developed capacity to provide many of the critical cardiac care services.

One interesting variant was an effort by International Finance Corporation which is an important player in such efforts. It supports private sector growth in many critical areas through subsidized loans to large corporate hospitals. These can be best understood only as part of its efforts to develop hospital chains – or in other words consolidation within the hospital and health care provider space. One example of this is a $50 million IFC financing package to Apollo Hospitals for creating Apollo Reach, a new low-cost hospital chain, that is billed as treating both low and high income patients; with higher fees paid by wealthier patients cross-subsidising lower fees by the poor. This is initially to set up 15 tertiary-level healthcare facilities to provide oncology, radiology, neurosurgery, and other state-of-the-art medical services in underserved areas and then expand its network to provide specialized health services in smaller cities and semi-rural areas. The usual narrative accompanies it- it will bring specialists to local communities, and will cost 30% less than in large urban hospitals and above all it is a viable business model.

**Outsourcing for tertiary care - the theory-practice interface**

It is not clear what economic or management theory supports these schemes. Clearly these go well beyond the sophistications of contracting and incentive environments. Indeed there is nothing in the literature on health reform that comes anywhere close to, let alone support this model.

Such PPPs can only be understood as an effort to be seen to be using public expenditure to help private healthcare industry to grow further and within that to push for consolidation around larger players. Clearly what is happening after each round of failure is that instead of giving up or slowing down, further concessions are advanced. And if it does not work- it does not seem to matter. Even the pretense of wanting health outcomes is wearing thin in the most recent PPPs of this category.

**Case Study- 3: Purchasing Secondary and Tertiary Care through insurance mechanisms:**

Since 2003, state governments have been introducing Publicly Funded Health Insurance programs. The first of these was Arogyasri, which was for tertiary care in the then united Andhra Pradesh. In 2008, the central government introduced the Rashtriya Swasthya Bima Yojana, an insurance program whose focus was coverage for secondary healthcare. By 2014 close to 19 states had either put in place their own PFHI or had opted to implement RSBY in their state. Sometimes both.

Government of Chhattisgarh initiated implementation of RSBY in 2009 in 6 districts of the state and this was expanded in rest of the districts in 2010. In 2012, the state decided to make the scheme universal by making the non-BPL families also eligible for enrolment. The state used its own resources to fund the premium for them. This addition of enrollment to the scheme was called ‘Mukhyamantri Swasthya Bima Yojana’ (MSBY). In October 2017, the state increased the annual sum assured per family (vertical cover) from Rs.30000 to Rs.50000. Around 200 new procedures were added.

And in 2018, when Government of India launched its PFHI called Pradhan Mantri Jan Arogaya Yojana (PMJAY), the Government of Chhattisgarh, joined the same by signing a contract with the central government and started its operations in the state in September 2018. This scheme provided for annual sum assured per family of Rs.500,000, and has no restriction in enrollment in terms of the number of members in a family. All 10.74 crore families classified as poor or deprived according to the Socio Economic Caste Census (SECC) were eligible.

Chhattisgarh’s implementation of PFHI is a good model to study since it has one of the highest coverages in terms of proportion of population who are entitled to coverage, in terms of proportion of hospitals empanelled, and since it has one of the largest packages of care (805 procedures) that includes over 30 dental care procedures, normal deliveries and pregnancies at one end and considerable elements of tertiary care at the other. It also has put in place a state health agency exclusively for managing this scheme.

Chattisgarh’s PFHI is also relatively well studied with a number of peer reviewed publications based on large household surveys available. The findings of these are a cause for great concern, if not alarm. None of these studies show any significant financial protection of increase in access to care. They do however show a major shift of services from public to private sector in areas where public sector had the capacity to perform.

For example before RSBY, the state was conducting close to 100,000 cataract surgeries annually, Around half of them were done government surgeons. Non-profit hospitals conducted the rest. Government paid Rs.750 per surgery at NHM rates to NGOs or willing private hospitals. When RSBY started in 2010, the price was Rs. 6000 per cataract surgery. Cataract surgeries in government hospitals fell from 53178 in 2010-11 to 12627 in 2016-17. The private sector grew in same period from 50083 to 116238 cataract surgeries. Share of public sector fell from 51% to 10%. Public hospitals sent claims for less than 10% of the surgeries they performed. Private hospitals claims were close to 100% of surgeries there.

This large-scale shift to private sector is across most disease conditions. About 87 % of the claims go to private sector. But the distribution of this is most iniquitous. Over half the claims are made by hospitals from only two districts and the bottom 18 districts account for less than 2 % of claims. Even within districts claims are very skewed. In terms of disease conditions too there is little match of claims filed with epidemiological information on causes of hospitalization. There is also a change in the nature of treatments offered. For example two-thirds of all deliveries for which claims are filed by private hospitals are for C-sections.

But perhaps the most disturbing and recurrent finding across all these studies is the complete lack of any level of financial protection- with catastrophic health expenditure on account of hospitalization remaining unchanged.

Another disturbing feature is that costs of care even with public hospitals remain the same, or increase as public providers increasingly shift to more market-defined behaviors.

**Lessons from the experience:**

Strategic purchasing through insurance was expected on theoretical grounds to bring about increased access and financial protection to meet healthcare needs and to do this more efficiently than public provisioning alone achieved. It was meant to shape markets so that these catered to healthcare needs. None of the studies show any evidence of this happening. Rather, the pattern is one of supply side determined care. There is no evidence and it seems unlikely from what we know, that this can result in better health outcomes.

Strategic purchasing in national policy was meant to be a form of critical gap closing, where purchase supplements, rather than substitutes for public healthcare. Again the findings of these studies indicate that private sector is most interested in those procedures where public sector has developed both the demand and the capacity to deliver services. Neither geographically, nor in terms of disease conditions do claims come from areas where the gaps in public healthcare delivery are the most.

In terms of total costs of healthcare, there is no efficiency gain either since the reimbursement paid out to hospitals has in practice become supplemental to the out of pocket expenditure that was earlier incurred instead of substituting for it.

There is little doubt that routing a major part of the public expenditure on healthcare through the private sector, has led to a stimulus to private sector investment and profitability, but as of now there is little evidence that it has led to progress towards the main objectives of public health.

The strategy of purchasing is a form of intervention, which is trying to compensate for market failures by the government becoming the purchaser and by setting prices right. But a political economy lens would lead us to consider some more fundamental issues. In the private sector the production of healthcare takes place at terms where healthcare is a commodity and the requirement is catering to consumer demand, or shaping consumer demand so that the exchange value can be maximized. In the public sector, the material needs of providers are taken care of by salaries and allowances, and the producer is ring fenced from market forces. The decisions he or she takes will have no consequence for earnings. As Julian Hart characterized it, healthcare is produced as a “gift” where only its use value counts.

In nations where social insurance and purchase from private sector dominates like in Japan, France, Germany, Canada and so on we have universal healthcare systems operating with a single payer with a high degree of regulation on both prices and protocols of care, so that influences of market forces on clinical decision making are limited if not eliminated altogether. But in the Indian context purchasing is being introduced without a regulatory framework in place and without the strategies, norms and culture that are required to ensure that the provider does not get to decide what care is provided, and where the access to affordable healthcare is seen as an entitlement that flows from citizenship.

**PART 3: DISCUSSIONS: CHALLENGES FOR PM-JAY**

There are several design elements of PM-JAY that its leadership is engaged with can be listed as follows:

1. Identifying beneficiaries/ enrolment process;
2. Arriving at a benefit package;
3. Networking of private providers – empanelment process
4. Negotiating Rates for procedures / diagnostics
5. Making the claims process efficient
6. Incentives for public providers empaneled under this scheme;
7. Create a well functioning Grievance Procedure.
8. Establishing a well functioning Implementation body :
9. Deciding on whether purchase should be through a Trust or through commerical insurance companies:

All these above issues relate to design and operationalization of an insurance scheme or a PPP contract. But the larger question is whether purchasing care would supplement care provision by public facilities and help close critical gaps in service provisioning (especially for services in rural and remote areas and for under-serviced urban poor)- or will it merely shift services currently available with public providers to private providers at greater costs to both the patient and the system?

Important corollaries to this question are whether

1. Purchasing care is a more efficient form of providing a certain set of services as compared to public service delivery?
2. Will the purchasing approach be more robust in improving access and financial protection against catastrophic health expenditures as compared to provision of free or subsidized care by public providers?
3. Will purchasing lead to a great quality of care, better responsiveness to patient needs, and greater competition and choice for patients?
4. Would the government be able to create the institutional capacity required for such large-scale purchase?
5. How government would prioritize the goals of providing support to private investment in healthcare (as for example was discussed in the Apollo case study) with respect to the goal of increasing access and financial protection for the marginal sections, in difficult to reach areas.

These are early days for the PM-JAY and despite an enthusiastic roll-out and even more enthusiastic publicity, one has to wait longer to see how it shapes up. As per its website and press briefing, released in the context of the conversion of the National Health Agency into a National Health Authority, by January 1st of 2019, in the three months of its existence 41.45 lakh e-cards had been issued, 16, 157 hospitals empanelled, 5.29 lakh beneficiaries had submitted claims and 537 crores had been paid against these, which works to about Rs. 10,000 per beneficiary. Though these figures appear large, with respect to targets they are modest, though considering how early it is, not unreasonable gains. However, the content of reporting does not indicate whether any or all of the problems noted in the earlier designs of publicly funded health insurance programs or in PPPs are addressed.

We do know that the second most frequent procedure for which claims are coming in are cataracts- for which public sector capacity is good, and where there were pre-existing PPPs that offered these services at a fraction of the rate that PMJAY is reimbursing for. We also know that there is a shift of such services from public to private sector, thereby underutilizing the existing capacity in public sector.

We do know that the rates and benefit packages provided are comparable to CGHS or better, but considerable sections of private healthcare are unhappy with rates and either not coming in or are pushing for higher rates.

We do not know of any mechanisms that have been advertised that try to address the well known problems like double-billing, supplier-driven consumption patterns with denial of care to certain types of care and certain sections of people.

From the case studies we discussed we would draw three main lessons for PM-JAY:

1. Governments would have to necessarily plan for a much greater emphasis on improving access in services. Our first case study shows that the problems that constrain public sector provisioning in most of India’s rural areas, are also a problem for private sector- and it is not shifting of ownership, or mode of financing that is key but the better organization of service delivery.
2. Where government transfers public funds to private hands, or provides a demand side stimulus to a set of largely commercial private providers, there is no reason to believe that they would be more effective or efficient than public providers in providing services. It is important for private sector to make its investment and government should not be reimbursing the full costs of services but marginal utilization costs.
3. There have to be active mechanisms to ensure that capacities that are built by purchasing care supplement and not substitute public services. Active policies to prevent a shift of existing services or the weakening of public provider capacity would be required.

References: [To be added]

1. Presented at the “Conference on Political Economy of Contemporary India”, organized by IGIDR, Mumbai, 8-9 January 2019. [↑](#footnote-ref-1)
2. There is considerable body of literature on why a complete “faith on market forces as the norm and means” for efficiency gains in the context of health sector is a highly misplaced one. [↑](#footnote-ref-2)
3. (Sir Edmund Hillary when asked why he climbed Mount Everest, is said to have replied: because it is there.) [↑](#footnote-ref-3)