

How Reforms are Reorienting Public Sector Hospitals in India

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Abstract:

Reforms in public sector health facilities particularly in hospitals in India became widespread mid-nineties onward and have been central to World Bank reforms. Public sector hospitals are facing the challenge of funding and ways to provide new and old clinical and non-clinical services. Increasingly public sector hospitals across the country have been exposed to series of quasi-market reforms arguing that public sector is less efficient and responsive. However, these reforms bear implications the way services are provided, for resource allocation (financial, technological) and workforce. In the recent years with stagnating public expenditure, capital investment in the hospital sector has emerged as an important aspect. The draft National Health Policy 2015 recommended 'reorienting Public hospitals' to adapt them to the needs of health insurance and create an environment of competition.

The focus of this paper is on the public sector hospitals since post reform hospitals as institutions have received little attention. This article examines how the dual process of user fees at the point of service delivery followed by Public Private Partnerships (PPPs) are restructuring public sector hospitals and exposing them to privatisation process and creating quasi-market structure.

The first section explores the user fee policies and using regional experiences its exclusionary impact is assessed in terms of access and utilisation. The second section maps the existing PPP models for hospital provisioning, management and construction. It is observed that user fees that was initially for services directly provided by the hospital have now become integral to the PPP based service provisioning even though it was deterred at the policy level due to its negative impact. PPPs have exposed public sector hospitals to complex arrangements with private sector and their associated risks. Even though the PPPs in the hospital sector are at its nascent stage already there are certain concerns related to costs, financing, comprehensiveness, quality, and regulation. Complexity of PPPs bear an impact on public sector hospital's management, infrastructure and overall functioning. Monitoring and regulation has become more difficult through contractual relationship with diverse set of private sector organisations.

In an overall low resource setting with weak governance like in India, user fees and PPPs in public sector hospitals together have led to change in values and gradually orienting these facilities towards a new culture. Firstly, they have created tiered provisioning of clinical care, fragmentation and monetisation of services that was erstwhile universally free irrespective of the patient's economic background. Secondly, early studies of these reforms indicate itemisation of each aspect of clinical care, and push for business. Thirdly, over a period of time private sector has expanded its foothold into the public sector hospitals. When commercialisation is gradually stepping into these health care facilities what remains to be seen is whether these hospitals will be able to safeguard the principles of universality, comprehensiveness and quality care

Introduction

Hospitals have evolved over time and services earlier provided through hospitalisation are given through the day care services. Within the health care system, hospitals receive major share of health budget and attention as well. They also consume the largest share of capital investment in the health sector. In India vast network of hospitals in tier II and III towns is managed and owned by the government. Over the past two decades public sector *hospitals* have met with stagnating public expenditure thus impacting i.e. on capital investment; service delivery (clinical and ancillary); technological and workforce; financial resources, and thus on its efficiency and capacity to provide care. National Rural Health Mission had focused on improving the primary health facilities but at the same time hospital system has too undergone changes with the newer laboratory technologies, greater diffusion of imaging mechanisms, and with advancement in the surgical and pharmaceutical techniques. The focus of this paper is on the public sector hospitals since post reform hospitals as institutions have received little attention. This article examines how the Public Private Partnerships (PPPs) are restructuring public sector hospitals and exposing them to privatisation process and creating quasi-market structure.

Using regional experiences this paper will examine how Public Private Partnerships (PPPs) are restructuring public sector hospitals and exposing them to privatisation process and creating quasi-market structure. The first section will provide an overview of international and regional financial institutions in redefining the role of the state in rolling forward new forms of provisioning through the private sector and push for PPPs in the hospitals. In the second section, existing models of PPP in hospital provision will be mapped. It will elucidate the varied degree of exposure to the private sector and the associated risks. Even though the PPPs in the hospital sector are at its nascent stage already there are certain concerns and will discuss issues related to costs, quality, comprehensiveness, and regulation. PPPs are emerging as a common mechanism in hospitals for procuring and delivering services. They bear a significant impact on public sector hospital management, infrastructure and overall functioning. In the hospital system for PPP based procurement of services, standard terms and conditions have been evolved but implementation, provisioning of care, and monitoring and regulation has become more complex through contractual relationship with diverse private sector organisations. In an overall low resource setting with weak governance like in India, PPPs in public sector hospitals together have led to change in values and gradually orienting these facilities towards a new culture where the 'superiority of private over public models of investment and service delivery' (Hellowell and Pollock, 2015) gains ground.

Hospitals in Public and Private Sector

During eighties public sector hospitals started being met with neglect in terms of expansion and up-gradation of services. The coordination between different levels of hospitals and primary health centres were casual. Lack of resources acted as an impediment to the improvement of medical care services. From the early eighties like reducing 'over dependence' on the state for medical care, harnessing voluntary and local efforts for health improvement, revenue generation by urban hospitals were recommended (GoI, 1981). Even though the seventh five year plan recommended to develop mechanisms to address non-communicable diseases through primary and secondary level care but lack of financial resources and adequate clinical workforce particularly anaesthetists stemmed the expansion of clinical services for non-communicable diseases and surgeries (GoI, 1990). Mid 1980s - 90s onward expansion of public sector hospitals began to decline with expansion of the private hospitals and nursing homes. In 2001 beds in public and private hospitals the share of beds were 60% and 40% respectively. Hospitals have more than doubled due to increase in the Community health centres post National Rural Health Mission intervention. The bed strength in public sector hospitals increased by 43% over the last ten years (2005-2014).

Based on 71st Round OPD consultation, across rural and urban areas public sector hospitals accounted for almost 17% of the treatments. Share of hospitalised treatment in public sector across different quintile classes varied from 29 % to 58 % in rural areas and from 19 % to 48% in urban areas (NSSO, 2015). The cost of care in public sector hospitals has also increased but much lower than that from a private sector hospital.

Year	Rural Hospitals		Urban Hospitals			
	No. of Hospitals	No. of Beds	No. of Hospitals	No. of Beds	No. of Hospitals	No. of Beds

2005	3964	111872	2256	292813	7008	469672
2014	16816	183602	3490	492177	20306	675779

Source: Health Bulletin of India, GOI (2005, 2014)

Over the last five years private hospital segment has grown at a rate of 25-30% in metro and tier I cities. In the public sector, government has developed tertiary hospitals in medical colleges. Among the 330 medical colleges more than half are in the private sector (http://planningcommission.nic.in/aboutus/committee/wrkgrp12/health/WG_2tertiary.pdf).

Role of International and Regional institutions

In the mid-1980s WHO's technical committee expressed its concern, particularly with regard to the public sector hospitals in developing countries who faced financial constraints. WHO expressed the need to consider, "how much should be spent on hospital care and how much on the other activities that promote health?" (WHO, 1987). This would help to prioritise resource allocation and give due attention to primary health care. If primary health care units can work as first level checkpoints then admissions would reduce with shorter stays in hospital thus, reducing the cost of care and enhancing effectiveness (WHO, 1987). In spite of WHO's own recommendation on usage of interdisciplinary approach to hospital development and build links with primary health centres it parted from this framework in the nineties. It focused as to how the district hospitals would aid in containing costs by acting as effective checkpoints with limited manpower and revenue generation and act as apex institution for the district (Roy, 2007).

Drawing from WHO's framework of district hospitals, other emerging body of knowledge and support from pharmaceutical, equipment, insurance companies World Bank focused on the need to redirect resources to health centres and district hospitals, define the functions of district hospitals. It argued that, Investments to support delivery of essential clinical services are best directed at health centers and district hospitals and at improving access in underserved areas. In the mid-nineties World Bank recommended strengthening of district level health services emphasising on public sector hospital reform. Subsequent health policies recommended market based reforms but not of '*comprehensive privatisation*'. Proposed to organisationally restructure public sector district hospitals by changing the relationship between public and the private sector, introducing cost containment mechanisms, revenue generating mechanism and increasing autonomy, hence laying out a reform format for secondary level hospitals.

The rationale for adopting and expanding Public Private Partnerships (PPP) emerges from the paltry budgetary allocation, widening gaps or inadequacies in the public sector service, increase efficiency by purchasing services from private providers and bring in private investment in areas where there is lack of financial resources. Followed by this International Finance Corporation (IFC) private sector financial arm of World Bank and regional bank like Asian Development Bank (ADB) have played an important role in promoting PPPs, doing advocacy for it, create institutional and legal capacities and help in project development, financing and selecting private providers at the national and sub-national level. This has enabled to further PPP in the infrastructure, legal and administrative reforms have been initiated at the central and state level for the uptake of healthcare infrastructure based PPPs. Another reason for the participation of private sector is its envisaging of its business prospect and its market expansionary capacity even within the social sector.

The private sector recognizes the enormous business opportunity of PPPs in India and has welcomed GOI's PPP initiatives. It has urged the government to publicize the size of the business opportunity for PPPs to the private sector, which is estimated to be much more than has been previously estimated (DEA and ADB, 2006).

The first state level PPP Policy of West Bengal in 2006 also identified the role of PPP in healthcare infrastructure. Public sector hospitals (secondary and tertiary) were one of the initial sites to begin with outsourcing of non-clinical services followed by PPPs in the high end diagnostics. By the second decade of this century PPPs in healthcare infrastructure were already being envisaged and feasibility of strengthening tertiary care infrastructure through PPPs was separately assessed. It pointed out that for PPP initiatives in tertiary care private operators will incur higher costs and for the investment to be realised it will go into long duration contracts.

‘However, tertiary care is not an easy business for private sector and they constantly look towards Government for support. With potential 25-30% EBITDA¹ margins in steady state, along with 25-30% ROCE, tertiary care is a highly attractive business, if executed well. However, operators need deep pockets and patience to succeed owing to long gestation periods. Land and building account for nearly one third of the total cost of setting up a hospital bed. (Gol, 2011).’

For large scale public capital projects it recommended to create ‘structure and enabling environment to plan and execute PPP effectively during the 12th Five-year plan’ (Gol, 2011). Five years after this Odisha has come up with Health Care Investment Promotion Policy 2016 that focuses on capital investment in the hospital sector. It grades hospitals based on their bed strength and the subsidy nature for the capital investment investor makes (http://health.odisha.gov.in/PDF/2016/Healthcare_Investment_Promotion_Policy-2016.pdf). The National Health Policy too talks about reorienting hospitals at the secondary and tertiary level through purchaser – providers split through scaling up private sector participation .

Public Private Partnerships in Hospitals: Services and Infrastructure

In the secondary and tertiary care hospitals across the different states the provisioning of non-clinical services (diet, cleaning, security work, washing of linens etc) and clinical (diagnostics, imaging; treatment procedures like dialysis) are now delivered through outsourcing and PPP mode. Since the mid-nineties this process has gained momentum. We see enhanced participation of the for-profit private sector particularly in public sector hospitals. Dialysis service have added to the private sector involvement. As observed there are different types of PPP. It ranges from a simple provision of services; management and operation and of both infrastructure, management and service provisioning. As the table shows private sector participates with differential responsibilities and risks (Table 1).

Types of PPP in the Hospitals

Types of PPP	Levels of Public Sector Hospitals	Public and Private Responsibility
Outsourcing of Non-clinical Supportive Services (Diet, Security, Cleanliness, Solid waste Management)	Teaching Hospitals, District Hospitals, Rural	Pub. Sector pays for free cases, provides land & private company employs staff
Outsourcing of Clinical Supportive Services (Pathology, Ultrasound, Radiology, CT scan, MRI, Medicines)	CHC, Rural hospitals, District Hospitals, Teaching Hospitals	Public sector pays for free cases, provides land & private company employs staff
Outsourcing of Clinical Services (Dialysis)	Districts hospitals, Teaching Hospitals	Pub. Sector manages the hosp., pays for the free cases, private company employs staff
Operate and Management	Teaching Hospitals	Private company manages hospitals, provides clinical and non-clinical services
Design, Build, Operate and Facility Management	Diagnostic Centres in RH/DH/TH, Teaching Hospitals	Private company designs, builds, and operates the facilities

It is now more than two decades that the ancillary services have been outsourced in the secondary and tertiary level hospitals in the country. Except Kerala, now we have widespread adoption of outsourcing and PPPs at the hospitals (10th CRM Report) to procure services and infrastructure. What is significant in the process is how it is

¹ Earnings before interest, tax, depreciation and amortization: EBITDA margin is a measurement of a company's operating profitability as a percentage of its total revenue. It is equal to earnings before interest, tax, depreciation and amortization (EBITDA) divided by total revenue.

changing the power relation between the public and private sector, shifting of risks and creation of new markets.

PPPs in Hospital Infrastructure

The decade long stagnant health expenditure bore an impact on capital investments in hospital infrastructure (Kutty, 2001). This was the scenario in other states as well. This led to huge pressure on the healthcare infrastructure. In the mid-nineties some of the major restructuring projects related to district health system particularly focused on secondary hospitals (district, sub-divisional and rural hospitals) in India were funded through the State Health Systems Development Project, World Bank.

In the first decade of the 21st century central government introduced new model of capital investment which means that private sector finances the design, built and or upgradation of the facilities in the public sector hospitals. In the eleventh five year plan gaps in infrastructure were identified and twelfth five year plan stressed on the need to invest on infrastructure. The National Public Private Partnership Policy 2011 recommended PPPs in the economic and social sector (health and education) as well.

The hospital based infrastructure projects are either in the pipeline or at the implementation phase. This kind of projects comprises of long-term contract (2 to 3 decade) between the public sector and group of private sector firms. In this model finance is raised by the private sector and is costlier since lending to the private sector is considered riskier than loaning to public sector. It means government is entering into long-term contracts with a consortium of for-profit providers and they may be vulnerable to the changes in financial markets. This raises several concerns as the for-profit motive of the private sector may offset the public interest of the public sector hospitals. The table mentioned below illustrates the different hospital based PPP infrastructure projects.

Table 1: Hospital Infrastructure Project through PPP mode

State	PPP Projects	Cost (Cr)	Type
Punjab	Greenfield Super Speciality Hospital, Bhatinda	99	DBFOT
	Greenfield Super Speciality Hospital, Mohali	118	DBFOT
	Punjab Institute of Medical Sciences	225	Concession BOT
	Diagnostics in 21 district hospitals	NA	NA
Maharashtra	Setting up and Running Trauma Center and Hospital, at Bopodi Pune	1	BOT
	Setting up and Running Trauma Centre and Hospital at Yerwada, Pune	1.5	BOT
	Development of Hospital Building at Indrayani Nagar Pradhikaran Sector No. 1 by MC Pimpri Chinchwad	2.5	BOT
	Diagnostics in 22 district hospitals	150	
Andhra Pradesh (IFC supported)	111 Haemodialysis Machines under Arogyasri Second Phase in Govt. Hospitals	NA	BOT
	Diagnostic Centres in 4 medical colleges (Kakinada, Kurnool, Vishakhapatnam, and Warangal)	NA	BOT
Odisha (IFC supported)	Odisha Affordable Healthcare Project (will build hospitals with 50-200 beds; with total capacity of 2400 beds)	Pvt investments b/t \$30-50 m.	DBFO
Meghalaya (IFC supported)	Shillong Medical College and Hospital	CAPEX grant of 95 crores & 29 acres of land on lease for 99 years	DBFOT

	Tura Government Medical College	NA	NA
Jharkhand (IFC supported)	Radio-imaging & Pathology services to 24 DH and 3 teaching hospitals (2015)	NA	DBFOT
Bihar	Development of Jayprabha Hospital, Kankarbagh, Patna as a Super Specialty Hospital	NA	DBFO
	Super-Specialty facility at IGIMS, Patna	NA	O & M

Source: From various Sources

These types of PPPs engage multiple technical and legal contracts through consortium based PPPs. This itself lends it to complexity. Experiences from UK, Australia shows that access to such complex PPP arrangements is difficult (Boardman, Greve, and Hodge, 2015). Presently researchers working on PPP in health sector have shared this similar experience i.e. lack of access to financial information and patient load from BPL category catered to and contract papers.

Performance of the Outsourced and PPPs in the Hospital Sector

PPP has been promoted over the traditional public sector procurement of services based on the fact that the efficiency of the private sector will be reaped in; improve governance, transfer risks to the private sector along with greater accountability. The literature in Indian context is beginning to emerge and by combining primary and secondary sources the following section explores the performance of PPPs in public sector hospitals in India.

User fee, Rationing and Free Access

In the PPP based diagnostic and imaging services user charges are levied. State government compensates the private sector for the services it provides free of cost to the below poverty line (BPL) patients. Studies from West Bengal showed that the private provider has the option to charge user charges separately government and private patients. Functioning of these services show that there are differential caps on these services i.e. a kind of rationing has been built in. There are caps on the number of free tests or number of patients who can be provided free care per month (Kumar, 2013; Roy, 2015, 2007). In diagnostic PPP units of district hospitals in West Bengal often the inability to provide certified BPL certificate created difficulties for the patients to access free care at the point of service delivery (Roy, 2015, 2007). In PPP based diagnostic units in West Bengal exemption rules were not displayed and the private providers reluctantly provided this information to the poor patients. In the Delhi Government hospitals for the PPP based dialysis units only patients with less than Rs. 3 lakhs a year, with National Food Security Card and those approved by the state government can avail free haemodialysis service but the rest had to pay for the services (Oxfam, 2017 a). The user charges were fixed at a rate less than the market rate but enough to give them business. The cost of repaying PPP diagnostic services was shifted to the patients.

In rural hospitals where pathology services have been outsourced in West Bengal and Bihar it is observed that pregnant women under the Janani Suraksha Yojana scheme were very happy with the diagnostic facility as it was within the rural hospital space. Lack of diagnostic facilities was one of the reasons which often deterred patients from utilising the government health facilities.

Very recently the policy on user charge has been revoked and services delivered through PPP will be available free of cost at the point of service delivery. Nonetheless, the procurement procedures through PPP are sustained either through the user charges reimbursed by the public sector to the private partner or through the annual payment by the government over a period of time. It is through this the private investor generates revenue and user fees will be fixed that will ensure business to the private provider. Since financing the private provider is costlier, the public hospital purchaser will have to bear the risk.

Quality of Services

The ancillary services like diet and cleanliness are an important aspect of quality care rendered to the patient. However, smaller studies and evaluation reports have continuously shown that quality is traded off through poor quality diets, understaffing, poor pay and under-qualified staff. Outsourced dietary services in the public hospitals of Mumbai were cheaper compared to direct provisioning but the quality of diet suffered (Bhatia and

Mills, 1997). Patients from different wards tertiary hospital, Kolkata raised frequent complaints regarding the lack of timely supply of meals, repeated shortages and poor quality of food (Roy, 2007). Seven years down the initial study a revisit to the five district hospital hospital kitchens it was observed that in four kitchens the standards of cleanliness was poor with poor storage capacities.

The 4th CRM Report too found inadequate orders for working and governing the contracts in the government hospitals of Orissa where laundry, cleanliness, sanitation and security were outsourced. It stated that *'the resources for the provision of cleanliness in toilets, common areas, canteen services, telecom assistance, signage, areas for attendants are grossly inadequate'*. The 8th CRM Report recommended the need to improve outsourced diet services through NGOs in Odisha. The 9th CRM report noted that under Janani Shishu Suraksha Karyakram there is a need to develop standard operating procedures for outsourced or in-house kitchen services. In case of outsourced sanitary services 7th CRM report informed regarding poor hygiene from the two states of Arunachal Pradesh and Bihar.

Many of the private operators do not have the expertise for hospital based diet and housekeeping. Cleaning equipment's, consumables are limited to broom sticks, phenyl, and water (Roy, 2010). With sub-contracts the problems deepen further. And it is observed that the same private providers continue to work for decades and over time monopolize on the hospitals. One of the common features of the ancillary contracts in public sector hospitals is that there is cost cutting through low wages, and policy of no pay for no work is followed along with no sick leave. Working conditions have little improved over the years.

In rural hospitals the empanelled PPs tend to establish collection centres instead of diagnostic centres (Roy and Gupta, 2011) and Bihar (6th CRM report). Thus the private sector save financial resources from developing a fully developed laboratory and continue to work through the business model of hub and spoke. These kind of arrangements bear an impact on the quality of care in terms of 'prolonged turn-around time and reporting time'. For the PPPs in the domain of imaging the age of machine is very critical, adopting safety measures like those assisting the patients need to wear safeguards or sometime in district hospitals mother's allowed with the children were not given any kind of safeguards. As reported in the Bihar study the diagnostic machines (Xray and ultrasound machines) used by the private operator were old and needed to be upgraded (Oxfam 2017). It corroborates the findings of 6th CRM report 'Outsourced radiological services do not meet Atomic Energy Regulatory Board guidelines, in terms of deployment of trained Radiographer/ X-ray technicians, Radiation safety norms, TLD² (Thermoluminescent Dosimeter) badges' (Gol, 2012).

The outsourced and PPP based diagnostic services in the public sector hospitals are meeting the gaps but there are lapses in quality which remains unaddressed.

Visibility and Power

In the public sector hospitals the entire operation and management are little under the PPP fold. In case of diagnostics like (CT scan, MRI) they have added to the existing services within the public sector hospitals. Hospitals are ultimately interconnected spaces, where each clinical and diagnostic and ancillary service departments are interconnected that bears an impact on the quality of care and patient outcome. Once the services are outsourced in case of existing in-house facilities of the same services they are either underutilised or they have become dysfunctional over time (Roy and Gupta, 2011). Functioning of outsourced and PPPs services show that even though they receive referral from the different hospital departments but little do they develop organic links with those in-house departments. For example the high end diagnostic units, digital X-ray services developed little linkage with the in-house radiology departments of the district hospitals and tertiary hospitals. As a result these diagnostic units failed to advance beyond service provisioning units. It was observed the main emphasis was in reaching out to the patients and meeting the patient targets rather than developing a link with the radiology units of the hospitals. As a result public hospitals are becoming sites where diverse private providers for their business are gaining visibility and control in the market.

² TLD badges are used to detect radiation at levels that can be harmful to humans. They emit light in amounts proportional to the radiation received.

Private Operate and Management of Public hospital / Units within Public hospital

Within the public sector hospitals as of now there are very few whose operation and management is done by the private sector. One of the first such venture was Rajiv Gandhi Super Specialty Hospital, Raichur whose contract was given to Apollo Hospital Enterprise Limited (AHEL) in 2002 to operate and manage till June 2011. The first evaluation report after a decade by the state government showed that this joint venture was not functioning efficiently. Firstly, the private operator commenced its activity nine months after the award of the contract. Out of 350 beds only 154 beds were used and around 96 beds remained unutilized. According to the norm 40% of beds should have been earmarked as general ward beds but only 11.42% beds were made available for BPL patients in the general ward. The hospital did not maintain any list of medical and non-medical equipment. The private provider outsourced the ancillary services to the local contractors and lack of regular monitoring made them less accountable to AHEL (Karpagam et al., 2013). The private partner accessed government facility for a decade and yet minimal service was delivered. The evaluation report by the Government of Karnataka, suggested not to renew the MoU and the super-specialty hospital was handed back to the state government.

In 2011, Uttarakhand government engaged Fortis Hospital to build and operate a 50-bed cardiac care unit (CCU) within the premises of Deen Dayal Upadhyay Hospital. The initial contract would be for 10 years. Under the contract, 25 in-patient beds (out of 50) would be reserved for BPL patients at government stipulated rates. The government reimburses services provided to the BPL patients and also agreed to pay Rs 99,200 per month per occupied bed as a grant. Thus, the participation of private sector through PPPs is guided through access to government facilities, land, subsidies and tax benefits.

Delay in PPP Projects

PPPs in different stages involve risks. Compared to the long delays in traditional procurement of civil works or delivery of services, PPPs are justified on the basis that there will be less of delays and cancellation of the projects. In the recent times there has been reporting of delays and cancellation of PPP projects that compounds the risks borne by the public sector. It was observed that in PPP based diagnostic (particularly imaging projects) in district hospitals, West Bengal that during the initial implementation phase there has been delay of 3 to 9 months.

To operate and manage Shillong Medical College and Hospital the contract was given to KPC Medical College and Hospital, Jadhavpur, Kolkata. IFC aided in developing the project papers, transaction and manage the bidding process. The state government would provide land for the project, a 40 percent capital subsidy for the construction phase of the project, and an operational subsidy for the first 12 years of operations of the project (http://www.meghealth.gov.in/tenders/Shillong_PPP_Project_Teaser_23_Feb_2012_v5.0.pdf). After three years of the signing of the contract in 2015 it was reported that the proposed Medical College will not be in a position to roll out the first batch of MBBS students by 2017 as proposed in the contract (<http://www.theshillongtimes.com/2015/01/31/shillong-medical-college-project-yet-to-take-off/>). The Hynniewtrep People's Federation fears that the project may not take up on time and the contents of the agreement has not been made public by the government (<http://www.ohmeghalaya.com/hpf-oppose-ppp-mode-for-shillong-medical-college/>). Similarly in Delhi under the PPP based haemodialysis service delivery for the cluster of three government hospitals a consortium of two private companies were awarded the contract. Later they expressed their inability to start their services. Thereafter, the state government debarred the two companies for three years from participating in any type of government tenders (<http://indianexpress.com/article/cities/delhi/govt-blacklists-firms-selected-to-install-dialysis-machines/>). In another case of PPP based diagnostic Centre in Civil Hospital, Bathinda even after two years the units did not start functioning. In between two companies were awarded contracts but refused to carry on services.

As observed in Canada, UK delays in PPP projects increase the overall costs and transaction costs. All this lengthens the time of implementation of the PPP and pose great challenge (financial and non-financial) for government as a purchaser and the patients. The government lands up in a weaker situation, transferring the risk for the long delays and proves costlier for the value for money. In case of cancellations of the awarded projects the concerned health department has to undergo new round of fresh tender bidding and selection, which entails administrative and transaction cost. These trends raise questions like whether risks related to delays and cancellation of such contracts could be addressed through traditional design, operate and manage contract or not?

Monitoring and Regulation

PPPs have contributed to the creation of new organisational structures. This has increased the responsibilities of public sector administration in terms of monitoring and regulation. It demands newer kind of relationship between the hospital administration, sub-regional administration and private partners. The district CMOH office in West Bengal and District Health Society in Bihar said that overall monitoring is weak (Roy, 2015 & Kumar, 2013). Similar pattern has been noted in Delhi as well. It was attributed to being overburdened and lack of adequate personnel. District health managers also highlighted that with multiple types of PPPs now in operation (service and infrastructure) at the institutional and district level, there is a need for separate monitoring agency that can work at different levels with adequate personnel. The Rogi Kayan Samitis till now have played a limited role. Administrators felt ill-equipped to monitor technical aspects of clinical contracts (Oxfam, 2017).

In West Bengal discussion with the consultants in health department and hospital administrator showed that lot of monitoring is increasingly based on the software based data that is shared by the PPP units with the respective hospital administration. In one of the tertiary hospitals where there are three PPP based diagnostic services with three different private companies, hospital administrators shared that they monitored based on the data feedback provided in the software package (Fieldwork, 2017). They also made visits to these units. PPP units have continued to work with on job trained technicians and there is little objection from the hospital administration. Overall monitoring of the PPP Units in the public sector hospitals is weak.

Increase in For-Profit Providers in Publicly funded hospitals and Roll back

PPPs are a form market expansion and commercialization of the public sector hospitals. In the public sector hospitals PPPs have proliferated through the for-profit sector. It has been sustained with diagnostic PPPs in 2000s and recently through infrastructure based PPPs. In case of service related PPPs, public sector hospitals provide a captive market for the for-profit companies with low marketing costs and the profit motive is optimised. Majority of the private providers are for-profit healthcare companies operating at the regional, national or international level. Some of the prominent for-profit players who have become partners in PPPs are Fortis, Apollo, Siemens, Ensocare and GE Healthcare, SRL Diagnostics, including regional diagnostic companies like Suraksha Diagnostic Pvt. Ltd., and Bhilai Scan & Research Ltd.

The nature of PPPs tells that public sector is particularly rolling back from diagnostic areas including basic tests, radiology, and imaging and treatments like haemodialysis, cardiac care etc.. This is gradually eroding the supportive services for clinical care from within the hospitals along with selective treatment. Thus, it is observed that certain areas of care within the public sector hospitals are emerging as investment sites for-profit companies. It is in this context important to remember that for-profit hospitals invest on 'selection of lucrative patients and services' as 'meeting community needs often threatens profitability' (Woolhandler and Himmelstein, 2004). They are 'are profit maximizers, not cost minimizers' (ibid).

Concluding Remarks

In low and middle income countries like India government hospitals play a critical role in the lives of people across class particularly for those who are from remote area, rural and urban slum and for those from socially and economically deprived section. The PPPs in the hospital sector in India is evolving from simple contracts to the use of private finance with complex contractual arrangements and with differing governance and accountability structure. This restructuring the public sector hospitals and are emerging as new sites of competition for the private sector and creating new complex organisational configuration. Simultaneously, rolling back of the public sector from certain services leads to greater reliance on the private sector. The direct provision of merit good is declining. The state administration is beginning to see this new structures but for the patients they are still invisible. With PPPs some of the older risks of the old procurement pattern continue to remain with the addition of newer risks.

Gradually with the increase in PPP services and infrastructure it is observed that even though the government selects the private providers but many of the processes like feasibility studies, developing tender papers, drawing up, negotiations and developing contract papers are done now by the private bodies or the quasi-

public bodies. State health departments have begun to play an oversight role to this entire PPP process. In some states standard protocols have been now developed and some are in the phase developing them.

With the coming up of the New National Health Policy 2017 PPPs are going to stay. The implications of PPP model vary with its complexity. Outsourcing and PPPs have not altogether helped public sector hospitals to get rid of the problems with regard to access, poor quality, understaffing, poor monitoring and delay. In some parts academic and civil society has begun to raise questions regarding the usefulness of PPPs within the domain of public hospitals. This has led to increased debate on the utility of PPP in a context where the state is itself weak in terms of regulating and monitoring the private sector in healthcare. Since PPPs are becoming the norm, policy makers and the state governments need to be cautious of higher costs it brings in as UK experiences of PPPs in hospital infrastructure shows that they are leading to higher costs (Hellowell & Pollock, 2010). There is need for greater research on the enabling factors (technical and legal) that is allowing PPPs to get institutionalized and embedded within the public policy framework and how public sector hospitals are getting affected by the financialization of PPP projects.

(This is a draft version.)

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