Evidence-based Planning––A Myth or Reality: Use of Evidence by the Planning Commission on Public –Private Partnership (PPP)

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Abstract

Public–private partnerships (PPP) are being touted as the way forward for health care in the country as demonstrated by the draft chapter of the 12th Five-year Plan for health. The planning commission refers to the Rajiv Gandhi Super Specialty Hospital, Raichur, as 'evidence' of 'good' PPP without mentioning the multiple problems identified in this model, as documented in an evaluation report by the Government of Karnataka. The concerns raised by the evaluation team and the failure of the Planning Commission to take cognizance of these concerns are discussed in some detail in this article. Some of the issues identified with the PPP model of health care in Raichur are the absence of third-party evaluation,

poor utilisation rates, lack of measurable benefit to the BPL population and poor governance and accountability systems.

Keywords
Public–private partnerships, Rajiv Gandhi Super Specialty Hospital, 12th Five-year Plan, evidence, Karuna Trust, Karnataka State Health Systems Resource Centre, KSHSRC, policy-making, Karnataka

Introduction

Public–Private Partnerships (PPPs) have been at the centre of health service delivery debates over the last few years. Aggressively supported by the international and national medical experts, it has acquired a key position in alternative health planning. There are those too who argue that the risks within PPP are couched in the positive terminology which is, in fact, an entirely different framework of thought underlying the policy of partnership with business. They claim that there are better and safer alternatives if we are serious about the protection, respect, facilitation and fulfilment of people's fundamental right to the highest attainable standard of health (Richter, 2004). Ignoring the conflicting thought processes, it has become a veritable trend in Indian planning to talk of evidence-based policy. Yet, it is not infrequent for single case studies to be built up as the basis for large-scale implementation (Pricewaterhouse Coopers, 2007). For example, the draft chapter on health of the 12th Five-year Plan quotes examples of PPPs and the Rajiv Gandhi Super-specialty hospital (RGSH), Raichur as a 'potential model for tertiary care through Public Private Partnership' (Planning Commission, 2012).

The Department of Health and Family Welfare considered various options to run the hospital. These included running it as a departmental hospital, an autonomous institution, as a joint venture with the private sector, or managed either by a profit or a non-profit sector. A cabinet meeting in August 2000 approved the option of inviting non-profit private sector to run the 350-bed hospital. A committee was formed to work out the modalities of the hospital vide GO No. HFW (PR) 292 WBA 2000 dated 25 October 2000. Finally, Apollo Health Enterprises Ltd. (AHEL), Hyderabad, signed a partnership agreement with the Department of Health and Family Welfare as represented by the Commissioner. A governing council was set up with representatives from the DoHFW and AHEL (vide GO No. HFW (PR) 292 WBA 2000 dated 8 August 2001). The RGHS was started in Raichur in northern Karnataka, India in August, 1997 on a 73 acre campus. It was inaugurated in October 2000.

This partnership was in effect since 2002 and was to expire in June 2011. In view of this, the state government decided to study the outcome of the joint venture project. It constituted a committee with five officers. The evaluation

team comprised six members—including the director of the State Institute of Health and Family Welfare (SIHFW), the Joint Director of the Department of health and family welfare, the Chief Finance Officer of the NRHM, the deputy CFO and health care financing consultant of the Karnataka State Health Systems Resource Centre (KSHSRC).

The main objective of the evaluation was to review the functioning of the hospital and the outcome of the partnership. The team visited the hospital and reviewed the service contract, data on utilisation of the facility, audited financial statement, government orders, base files and documents including the initial proposal. The team also looked at the overall functioning of PPP as a model of tertiary care. They looked specifically at whether the services were provided as per the MoU, compliance of AHEL with the terms and conditions of the contract, examining the inventory and stock register for equipment provided by GoK as well as those procured by AHEL, whether AHEL has provided a statement about services provided to Below Poverty Line (BPL) patients, the cost of services to BPL patients and subsequent claims reimbursed by the government. They also specifically looked to see if there were instances of Above Poverty Line (APL) charges being levied on BPL patients and any instances of denial of services to BPL patients. An analysis was also done on the revenue generated to the hospital from the treatment of APL patients the average monthly operating cost and whether any financial loss has been incurred by the RGSH. This evaluation report has been unavailable in the public domain and had to be obtained only by filing a Right to Information (RTI) application.

This article is based almost entirely on this evaluation report. It was felt by the authors that critical evidence as seen in this document has not informed the decision of the Planning Commission to project the RGSH, Raichur, as a good model of PPP in tertiary care. The RGSH at Raichur is a single case that is being taken as a basis for large-scale handing over of tertiary care services to the private sector. The Planning Commission made no effort to present any evidence to support their claims of this hospital being a potential model of tertiary care. Totally contrary to their claims, it turns out that the Planning Commission failed to take into consideration concerns raised by the evaluation report of the Government of Karnataka, Department of Health (GoK, DoH) about the effectiveness, accountability and accessibility of the RGSH, Raichur. Neither did it take into consideration the large-scale opposition to the hospital by the community, leading ultimately to a termination of the contract between the Government of Karnataka and the RGSH, Raichur (Government of Karnataka Department of Health and Family welfare in collaboration with Karnataka State Health System Resource Centre, 2011; IBN Live, 2012).

The RGSH was paid a One Time Grant (OTG) of ₹950 lakhs to Apollo hospital enterprise Limited (AHEL). A total of 70 equipments were procured by the hospital authorities costing a total amount of ₹34,647,243.00. A total of 40 non-medical equipments were purchased by the hospital costing ₹10,276,140.00

from the OTG. Further, RGSH authorities procured 28 items of computers and related items worth ₹10,031,033.00; 11 items of furniture worth ₹4,633,331.00 and 3 vehicles at a cost of ₹2,085,459.00 out of the OTG.

Some salient points that emerged from the evaluation report are described below:

Absence of Third-party Evaluations

No third party evaluations have been conducted on this hospital for the previous 10 years by either of the partners, so there is no baseline data to assess if there had been any change in the project performance or the quality of services. The performance of the hospital therefore had to be assessed by proxy indicators over a period of 10 years. The date of the contract was 1 July 2001, but services commenced only on the 13 April 2002.

No Rise in Utilisation Rates

The overview of the hospital performance (Table 1) shows that the hospital has not showed the desired rise in utilisation and the number of inpatients and outpatients has been relatively constant over the last 10 years.

The bed occupancy rate has been showing a steady decline over the last 10 years from 85 per cent in 2002–03, when the hospital was first taken over under PPP, to 58 per cent in 2010–11 (Figure 1).

The hospital has generated ₹4,899.41 lakh from non-BPL sources such as APL patients, corporate and schemes such as Vajpayee, Arogyashree and Yashasvini. The APL billing has also shown a downward trend over the last two years with the hospital working at sub-optimal bed usage of 57 beds. So even as an income

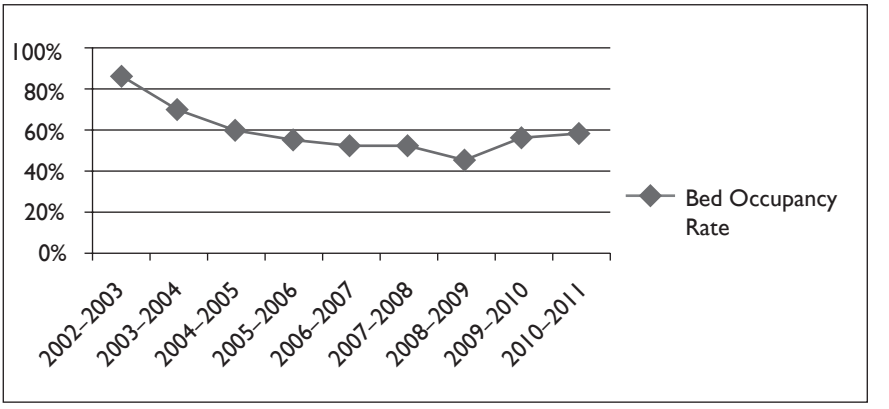

Figure 1. Bed Occupancy Rate from 2002 to 2011, RGSH, Karnataka
Source: RGSH hospital data, GoK, DOH April 2011.

Table 1. RGSH Statistics and Performance Indicators

Performance Indicator**	2002–03	2003–04	2004–05	2005–06	2006–07	2007–08	2008–09	2009–10	2010–11
No. of out-patients	8,498	8,917	10,624	13,453	14,771	12,179	11,935	12,274	12,203
No. of in-patients	1,947	2,274	4,188	5,463	5,401	3,894	4,608	4,712	4,945
Total bed capacity as per agreement	350	350	350	350	350	350	350	350	350
No. of functional beds	200	200	200	200	200	200	200	200	200
Bed occupancy rate	85%	70%	60%	55%	52%	53%	45%	56%	58%
No. of surgeries	278	1,537	1,663	2,172	3,053	2,185	1,660	1,042	1,229
Population of Raichur (in lakh)*	17	17	17	18	18	18	19	19	20
Population of Gulbarga Division (in lakh)*	97	99	101	103	105	107	109	112	114

Source: *Census, 2001, ** RGSH, Raichur.

generation model, this PPP model has not succeeded. The evaluation team attributes this to sub-optimal utilisation of beds, poor cash flow management, incorrect and unrealistic assumptions for designing the revenue model, weak management and weak monitoring. The evaluation team also states that in such partnership models, the private partners should be responsible for achieving service quality benchmarks and assume the risks for delays and cost overruns in the project, including issues related to human resources and efficiency in service delivery.

No Measurable Benefit to BPL Population

One of the key objectives for setting up this hospital was to provide quality health care to patients below the poverty line in the districts of Gulbarga division. Although the BPL population forms more than 67 per cent of the total population, the utilisation by BPL at the in-patient facility has shown a sharp decline from 94.7 per cent in 2002–03 to 21.4 per cent in 2010–11 (Figure 2).

The out-patient usage has dropped from 92.8 per cent in 2002–03 to 7.5 per cent in 2010–11 (Figure 3). Although the initial contract envisaged a 350-bed

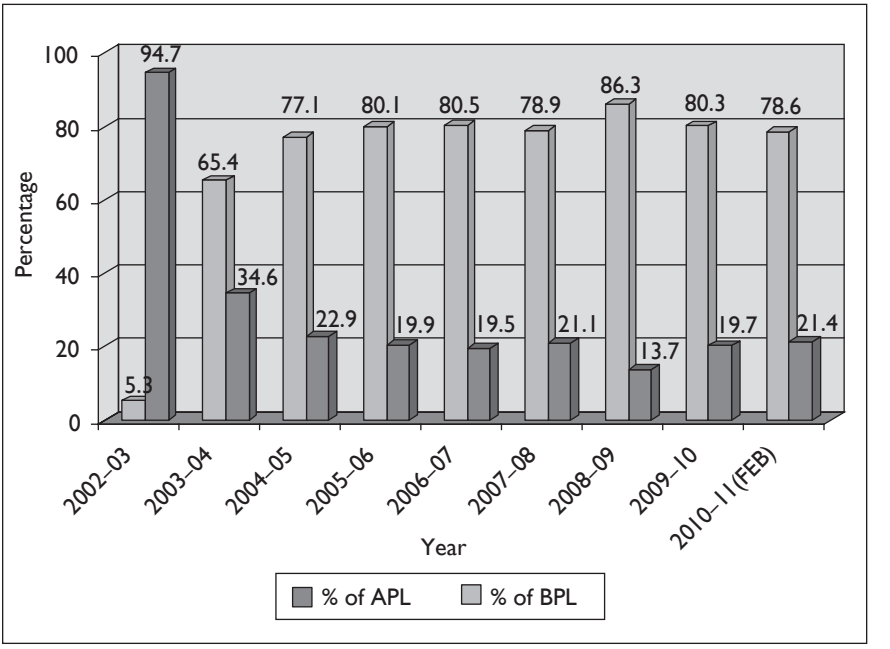

Figure 2. Percentage of In-patients from 2002 to 2012 with Break-up of APL and BPL, RGSH Raichur

Source: RGSH hospital data.

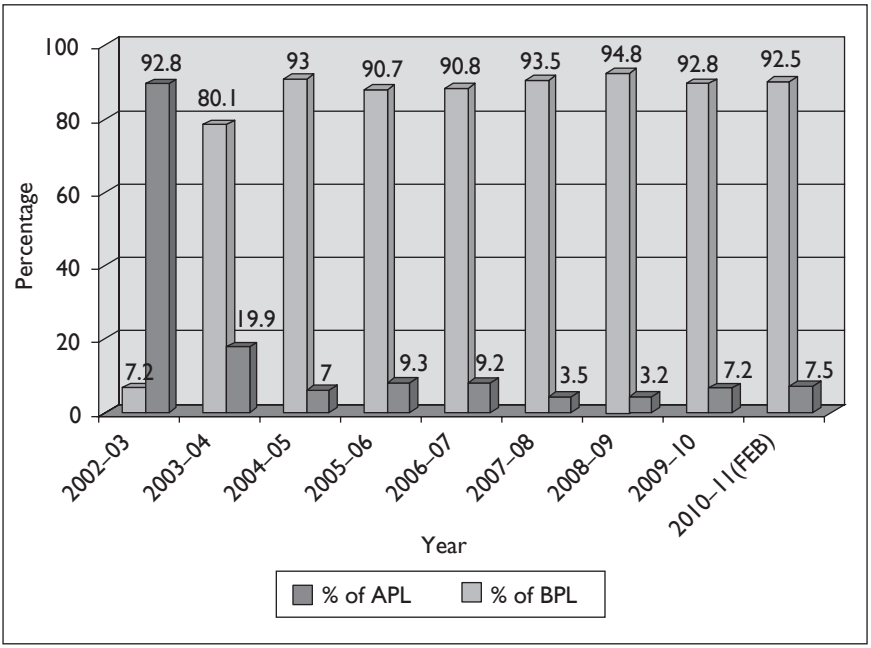

Figure 3. Percentage of Out-patient Details from 2002–11, RGSH
Source: RGSH hospital data, GoK, DOH April 2011.

facility, a physical verification by the visiting evaluation team showed only 154 (44 per cent) functional beds. Of the 350 beds, according to the agreement, 140 (40 per cent) beds were to be earmarked as general ward beds. It was however found that only 40 (11.42 per cent) beds had been made available in the general ward for BPL patients. This is also reflected in the minimal provision made in the budget for marketing and awareness generation about the scheme for BPL patients. The original objective of providing quality services to patients below poverty line has not at all been met and this evidence must become critical in handing over public services to private players. This would need a rigorous external evaluation instead of being recommended as a good model of PPP.

Higher Tariffs Being Paid by BPL Patients as Compared to APL

The hospital had generated ₹4,899.41 lakh from non-BPL sources. This includes APL patients and corporate making Above Poverty Line (APL) category patients the prime source of revenue for the hospital. A comparison of average in-patient billing for APL and BPL patients (Table 2) shows that the average APL billing is low as compared to the average BPL billing. Though the revenue generated in

Table 2. Comparison of Average IP Billing for APL and BPL Patients, RGSH

Financial Year	Total BPL IP Patients	Total APL IP Patients	Avg. BPL IP Billing (₹)	Avg APL IP Billing (₹)
2002–03	1,844	103	1,702.03	3,644.93
2003–04	786	1,488	12,060.20	6,194.83
2004–05	959	3,229	2,011.62	5,555.59
2005–06	1,088	4,375	15,972.35	3,084.02
2006–07	1,054	4,347	14,444.17	8,988.47
2007–08	823	3,071	15,095.44	20,986.27
2008–09	630	3,978	21,754.63	9,419.13
2009–10	927	3,785	19,061.81	9,764.49

Source: RGSH hospital data, GoK, DOH April 2011.

absolute figures from APL source is higher than that of BPL patients, the calculation on the average billing indicates that BPL patients are paying higher tariff compared to APL. The revenue model of RGSH was intended to break even by the third year of operation, but according to the income and expenditure statement, the hospital has not been generating any profit since its inception.

An analysis of the RGSH BPL claims admitted by the local audit circle reveals that there is a discrepancy in the total number of BPL claims for out-patients and in-patients between the details provided by RGSH authorities and that of the admitted claims by the local audit circle (LAC). For instance, the number of BPL out-patients as per the hospital authorities for the year 2002–2003 and 2003–2004 was 7,888 and 1,775, respectively, while the BPL claims admitted by the LAC were 10,806 and 36,427, respectively. Similarly, the in-patient number as per the hospital authorities was 1,844 and 786, while the claims by the LAC are 485 and 2,310, respectively.

Poor Governance and Accountability of the PPP Model

According to clause 2.4 of the service contract agreement, specialty services were to be mentioned in the annexure. However this annexure was not available either with the hospital authorities or anywhere on the hospital premises. There is no clarity on what specialty services are expected and what have been actually delivered.

The service contract agreement had no mention of measurable outcomes to assess effectiveness of clinical and ancillary services. The only contract was about the takeover, maintenance and smooth operation of the hospital. This goes to show how little importance has been paid to quality control when handing over tertiary care to a private player. Yet the planning commission is ready to push this model as a way forward for the country.

The contractor had outsourced maintenance, security and housekeeping services. However, of the 84 equipments available in the hospital, 10 had not been

functioning since 2007. No log books were maintained by the hospital for any of the equipment and neither were reports available of Annual Stock Verifications. Although recommendations had been made in 2007 to improve inventory management, these recommendations had not been implemented. This leads to a very complex set of contracts and sub-contracts that is difficult to monitor and regulate. It is observed that the large private provider who is entrusted to manage and provide services brings about multiple small local private contractors nested under it that further challenge the process of evaluating the performance, and accountability of the sub-contracted party.

Although the governing council was expected to meet every six months, they had met only 10 times in the last 10 years. The approval of the governing council had not been sought as stipulated in the service contract to engage a chartered accountant firm for the hospital accounts.

The service contract was initially drafted by the Committee for operationlisation of the OPEC hospital, vide GO No. HFW (PR) 292 WBA 2000 dated 25 October 2000. The finance department had made certain observations and suggested amendments to the service contract. However, this amendment had not been signed by both parties. Subsequently, Apollo hospitals objected to amendments made in the past leading to a deadlock between Apollo hospitals and the Government of Karnataka.

As per the audited statement of the hospital, no profit has been generated by the hospital from the period 2002–10 and as per a GO HFW/64/CGM/2002 dated 21 March 2002, in the years when no net profits are earned, the governing council can allow payment of annual service charge to the contractor out of the surplus pool account. It was then resolved that ₹241.64 lakhs for 2002–03 and ₹858.65 lakhs for 2003–04 shall be released by the government for revenue loss incurred. This indicates that apart from paying for setting up the hospital, the government also becomes liable if the hospital does not generate profits. This is not a sustainable model in the long run and can hardly be the way forward for a stable health care delivery system.

The government of Karnataka as per the agreement had procured and handed over several medical and non-medical equipment including furniture, fixtures and computers to AHEL to operationalise the hospital. The hospital has not maintained an inventory of assets which reflects inappropriate managerial capacity.

The hospital did not have any grievance redressal mechanisms in place. Although the Deputy Commissioner of Raichur, as a representative of the owner (Government of Karnataka), is expected to monitor adherence to the contract, the minimum assured beds and the payment of BPL claims have not been monitored. The monitoring of hospital equipment lies with the Karnataka Health Systems Development and Reforms Project (KHSDRP); BPL claims by the Deputy Commissioner, Raichur and other hospital administrative issues through the Commissioner, Health and Family welfare leading to lack of co-ordination and effective monitoring.

The evaluation report by the Government of Karnataka, has suggested that the MoU not be renewed and the super-speciality hospital be handed back to the government. This concern has been further strengthened by a community-led protest against Apollo hospital managing the tertiary hospital. Following the community pressure, the hospital has been handed back to the Government of Karnataka and the MoU with Apollo has been terminated.

Although the RGSH evaluation conducted by the Government of Karnataka has shown the PPP model in the very poor light, the GoK has still gone ahead and brought out a PPP policy for the state and guidelines on implementation. The PPP policy of Karnataka makes no mention of the roles, duties and obligations of the private player and instead offers to

> provide all the essential state level clearances to enable implementation of PPP, formulate specific policies for providing specific incentives and co-ordination with the Infrastructure Development Department (IDD) and other government agencies involved in PPP implementation and also set up suitable mechanisms for facilitating efficient acquisition of land for such projects. (KSHSRC & Deloitte, 2012)

Many of the lapses highlighted by the evaluation report are serious and would be even more disastrous if implemented on a large scale at a nationwide level as envisaged in the draft chapter of the 12th Five-year Plan. The fact that the reports prepared by the government itself are being ignored and false gains are being projected only adds to the puzzle. Furthermore, 'evidence' of the RGSH as a model for tertiary care been growing from strength to strength and is now being promoted as the way forward for health care in the country. No effort has to be made either by national or international bodies to look at the evidence objectively and independently within the policy framework. A failure to do this raises issues about the very nature of evidence-based planning which is becoming highly subjective and partial towards the private partners.

Discussion

Over the years since 1990, PPPs have acquired an important place in public policy including health policy. The arguments are the paucity of state resources, the potential of overcoming weaknesses of the public sector by lending 'efficiency' and the availability of its vast net of providers and services to bring about the evasive 'equity' (Venkatraman & Björkman, 2006). Since then, several studies examining the functioning of PPPs for different clinical, diagnostic and ancillary services across different levels of care have pointed out problems and the need to address them but policy discussions have taken little cognisance of these (Acharya & McNamee, 2009; Ravindran & Fonn, 2011; Roy, 2007; Roy & Gupta, 2011). Given the variety of PPPs, these reviews cover a range of PPPs, involving private practitioners, social franchising, government programmes and small as well as large hospitals. While in Britain the evidence regarding undermining

of the NHS due to private involvement has been meticulously presented by Pollock and others (Leys & Player, 2011; Pollock, 2005), in India it is still getting consolidated. For example, the state level CAG report of Gujarat (the Chiranjeevi scheme) and the NIHFW evaluation of PPP-based Institutional delivery scheme under the Janani Sahayogi Yojana in Madhya Pradesh and Mamta Scheme in Delhi show poor functioning of empanelled private providers. These private providers were hesitant to work in the rural areas and in the urban fringes. Expectant mothers from the BPL category either did not receive the service or had to make out of pocket expenditure. These studies also pointed out that the private providers were not equipped to handle Emergency Obstetrics (EmOC) which was one of the main objectives of this scheme as they fell short of blood bank and anaesthetists (NIHFW, 2008, 2010). Outsourcing of ancillary services in West Bengal has shown that it does not automatically 'translate into a better work attitude and culture, and that monetary issues governing the contract such as cost-savings appear to overshadow the quality of work and rights of the labour' (Roy, 2010).

A review of 45 clinical social franchises, located in 27 countries of Africa, Asia and Latin America, found that franchising did not widen the range of reproductive health services and had mainly focused on contraceptive services with no extension of coverage to new areas. In almost two-thirds of the franchises, the full cost of all services had to be paid out of pocket and was unaffordable for low-income women (Ravindran & Fonn, 2011). Similarly, involving private practitioner in tuberculosis control has been pushed to no avail given the disinterest of practitioners in tracing drop outs and in providing full information to patients regarding the national programme and the availability of free tests (Unger et al., 2010).

When we look at PPPs in hospitals, we find a range of responses some of which are rather critical. A study of PPP-based diagnostic services in rural hospitals in West Bengal has showed exclusionary effects due to restrictive exemption and waiver policies under the PPP framework (Roy & Gupta, 2011). Apart from the smaller institutions, there has been a thrust to bring in the corporate sector into the super-speciality hospital sector (Chakravarthy, 2010). Of these, there are those who are in it independently and those who enter through PPPs. Concerns expressed regarding such partnerships have been expressed by Bennet who has argued that these partnerships are related to the use of illegitimate or unethical means to maximise profit, less concern towards public health goals, lack of interest in sharing clinical information, creating brain drain among public sector health staff, and lack of regulatory control over their practices (Bennet, 2004). There is evidence that even super-specialty hospitals based on PPP model have problems as they could not keep the promises they made in their MOUs. For example, Indraprastha Apollo Hospital, New Delhi, is a PPP and is the fourth largest corporate owned hospital in the world constructed at a cost of $44 million in 1996 on 15 acres prime land worth an estimated $2.5 million given by the Delhi government free of cost (at a token lease rent of ₹1 per annum). Apart from this,

the Delhi government invested $3.4 million in construction of the hospital and contributed $5.22 million as equity capital apart from tax and duty waivers. In lieu of this public subsidy, the agreement was that treatment for one-third of the beds would be made available free of cost to poor patients. The Justice Qureshi committee, which reviewed the working of by 27 private hospitals in Delhi including Apollo, found that this hospital provided free in-patient care to only 2 per cent of its patients. The Committee was of the view that these corporate partnerships use the tag of 'efficiency' as a promotional strategy and for pushing technology and prices which actually leaves out large numbers reducing efficiency. Also, the term 'poor' and free treatment have not been clearly defined making it easy for institutions to get away with restrictive definitions according to their convenience. In fact, despite being a high level committee set up by the government of National Capital Territory, this Report itself was never tabled by the Delhi Government (Qadeer & Reddy, 2010). There are 500 such hospitals in the country and the public subsidy at stake is in the range of at least ₹10,000 crore (High court of Delhi, 2009; Kumar, 2009). In fact this very chain of the Apollo Enterprise Ltd was invited to help manage the RGSH. According to a study between 2002 and 2011, the coverage of BPL families declined, the services too reduced in scope and the bed strength declined from 350 to 250 (Venkatraman & Björkman, 2009). This set of 'evidence' has played no role in the policy making process of the Government.

The other example quoted by the Planning Commission is of a PPP between Karuna Trust and the Government of Karnataka for the management of primary health centres. The case study published in the *Lancet* cannot be used as evidence because the author was also a trustee of the NGO and the *Lancet* had no policy in place for declaration of conflict of interest by journalists. (Karpagam et al., 2012). No independent external evaluation has been conducted by the state government on this model.

Much is talked about evidence-based policy but except for the initial period of planning where Nehru and Mahalanobis attempted to introduce rationality of welfare and a scientific methodology in planning (as reflected in the 2nd Five-year Plan), rational planning for welfare has become a victim of neoliberal market ideology (Qadeer, 2008). Policy-makers, who are, in principle, responsible for the rich as well as the poor of the country need to take a good hard look at the quality of evidence to ensure that they make informed choices. It is important for the Planning Commission to understand what it means by 'evidence'. If the Commission really wishes to use evidence as a basis for its planning of health care, then it will have to re-examine the examples it quotes. It will also have to take into consideration all the existing studies and literature on PPP and the very pertinent concerns that are being raised. Till then, the motives of the Commission in pushing for these models of tertiary health care will be suspect.

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