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Reluctance of medical personnel to work in rural areas and the imperative to functionalize peripheral health services; are public private partnerships the answer: an evaluation of the proposal to give community health centers (chcs) on ppp mode in Uttrakhand State of India

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ABSTRACT

Non-availability of doctors willing to serve in rural areas is a big roadblock in making the rural health services fully functional in the country to provide adequate primary and secondary level curative services to the people. Apart from many reasons like the lack of development and facilities in rural and remote areas, the main reason for the doctors' unwillingness to serve in the rural areas seems to be the fact that medical profession has become captive of the elite sections of the society. This coupled with market oriented growth of health care in the country has led to the practice of medicine being viewed as a lucrative career option for the well- to- do sections of the society rather than as a means to fulfill the more laudable social objective of health care. The government of the state of Uttrakhand in India has taken initiative to give some of the best equipped Community Health Centers (CHCs) in the state on PPP (Public Private Partnership) mode in order to provide assured secondary level health care to the people in rural and remote areas of the state. This article makes a public health and economic analysis of this PPP venture which is currently being rolled out in the state.

According to our analysis the PPP proposal does not address any of the fundamental reasons for government's inability to functionalize its rural health facilities on its own. Rather it will lead to further decimating government's ability to provide these services on its own in the long run. The proposal proactively seeks to drive a wedge between preventive and promotive care on one hand and curative services on the other which is not a wise public health strategy. The economic rationale of the proposal is also questionable and may render it unfeasible sooner than later.

Keywords:*Public Private Partnerships, Community Health Centers, Uttrakhand, Doctors*

INTRODUCTION

Uttrakhand is one of the EAG (Empowered Action Group) states subject to higher focus under National Rural Health Mission (NRHM) for improving its relatively weak public health infrastructure and health indicators. The Department of Medical Health and Family Welfare (DoMH&FW), Government of Uttrakhand is responsible for providing preventive, promotive and curative health services to a population of about 1,01,16,752 (2011 census). Since its formation as a separate state in November 2000 the state has vastly improved its public health infrastructure to provide three tier healthcare services to the people of the state. However, there remain many formidable constraints in running the available facilities to their maximum potential - an acute shortage of trained medical personnel, especially allopathic doctors (both

graduate medical officers and specialists) remains the biggest obstacle in fully operationalizing higher level services and to provide 24 X 7 curative care outside of bigger cities. Availability of doctors in the rural health set up is a problem in almost every state of the country.

In Uttrakhand, various efforts of the state government to deploy doctors in its public health facilities, especially those in difficult to reach and relatively remote hilly / mountainous areas have not met with particular success. To remedy this situation the state government has resorted to a strategy of Public Private Partnerships (PPP) in health sector under which the medical facilities are sought to be given over to private parties to provide services. Technical inputs for formulating the procedural and institutional mechanisms for implementation of the PPPs in the state are being provided by consultants available with the state under the aegis of a tie up with the Asian Development Bank (ADB).

In the 2013-14 Program Implementation Plan (PIP) for the implementation of National Rural Health Mission (NRHM) in Uttrakhand the state had proposed to give as many as 16 CHCs (Community Health Centers) on PPP mode. As part of the proposal a conscious decision was taken by the state to invite bids from private for profit health care providers that have experience in running hospitals providing specialized clinical services, to manage and provide similar services at different CHCs in the state. As per the proposal while the state shall fully underwrite the capital and operational expenditure in running the CHC, the private party shall be responsible for management of the facilities and service provisioning under the overall supervision of the medical superintendent of the CHC who shall be a government doctor. Such an arrangement has been described differently as 'Performance Management Contract Model' as referred to the case of management of PHCs by Karuna trust in Karnataka, management of CHC by Shamlaji Hospital in Sabarkantha district, Gujarat and the Rajiv Gandhi Super-Specialty hospital, Raichur, Karnataka,[1]or simply as 'Contracting Out' model of PPP[2].

This paper evaluates the proposal for giving CHCs on PPP mode in the state with a view to examine the feasibility of implementing such PPPs in difficult to serve areas and whether this can be an effective answer for overcoming the present constraints in functionalizing health facilities in these areas. Accordingly we draw appropriate lessons for policy.

MTHODOLOGY OF EVALUATION

Evaluation of the PPP proposal entailed detailed study of secondary sources of information, such as 'Request for Proposal' document concerning contracting out of CHCs on PPP mode and the relevant reports of NSSO (National Sample Survey Organization) concerning health expenditure by households. Besides this interviews were conducted with different stakeholders including senior state government officials, the PPP expert of the Asian Development Bank (ADB) in his advisory capacity to the Uttrakhand Government on PPPs and as the chief architect of the proposal under study, the representatives of the private parties to whom contracts were awarded for different CHCs and the doctors and the staff of different CHCs during the visit to the state to specifically evaluate the PPP proposal and during subsequent monitoring visits to different districts of the state. The CHCs that were covered included – Nowgaon, Thailsain, Munsiari and Kapkote in Uttarkashi, PauriGarhwal, Pithoragarh and Bageshwar districts respectively.

PRELIMINARY OBSERVATIONS

Of the different CHCs in the state, 30 CHCs, distributed across the state have been upgraded to conform to Indian Public Health Standards (IPHS) with respect to the availability of physical infrastructure. From among these 30 CHCs the state decided to outsource the services of selected CHCs located in almost all the districts of the state. In discussions with the State health officials and as per the averments made by the principal secretary health of the Government of Uttrakhand, the state intends to "privatize" (expression used by the principal secretary during a meeting in the Ministry of Health and Family Welfare, Government of India.) more CHCs if the current initiative is found to be successful. **Table 1** gives the list of the 16 CHCs that have been given over on PPP basis initially, as four distinct packages.

Table 1. The PHCs to be given over on PPP basis initially

Package	District	Location
Package 1	Chamoli	Gairsain
	Pithoragarh	Munsiari
	Bageshwar	Kapkote
	Nainital	Garampani
	Rudraprayag	Jakholi
Package 2	Almora	Chaukhutia
	Champawat	Lohaghat
	Udham Singh Nagar	Bajpur
Package 3	Dehradun	Sahiya
	Dehradun	Raipur
	Uttarkashi	Naugaon
	Tehri	Thatue
Package 4	PauriGarhwal	Pabau
	PauriGarhwal	Thailsain
	Haridwar	Bhagwanpur
	Tehri	Hindolakhal

Source:Directorate of Medical Health and Family Welfare[3].

Each package consists of CHCs located in both the plain areas as also the hills. As per the discussions with the PPP expert advising the state, this arrangement has been designed keeping the following two objectives in mind:

- As the patient load is much less in the hills compared to that in the plain areas, the proposed arrangement may enable the private operator to make good the lesser number of patients and hence lesser revenue from the hill CHCs by the larger number of patients coming to the plain CHCs.
- As the doctors are hesitant to work in the hill areas, this arrangement, it is expected, shall enable the private operator to rotate doctors from the plain CHCs to the hill CHCs on a short term basis and thereby ensure delivery of services in the hill CHCs.

The RFP document for this proposal mentions that the CHCs shall be given on "Operation and Maintenance basis for an initial Concession period of five (5) years extendable by another five (5) years subject to fulfillment of agreed service levels[4]." The RFP document further ordains that:

"The Applicant should have at least 3 years' experience in Operation and Management (O & M) of healthcare services in Hospitals or Nursing Home or Community Health Centers (CHCs) or PHCs. Such hospitals or Nursing homes or Community Centers should be in running conditions on the day of the bid[5]."

OBJECTIVES OF THE PROPOSED PROJECT

1. "To manage, operate and maintain selected Community Health Centers in Uttrakhand as per IPHS (Indian Public Health Standards) standards.
2. To provide value-added specialized services over and above the prescribed guidelines as per the local medical and health needs of the population.
3. To adhere to guidelines issued by Govt. of Uttrakhand from time to time including upgrading of the Hospital in the services being provided and training[6]."

ROLE OF PRIVATE PARTNER

1. "Manage the Community Health Centers (CHC) and services in as-is-condition without any break in the continuity of clinical services.

2. Provide OPD and IPD services including emergency, drug dispensing and diagnostic and radiology tests and procedures as per prescribed standards.

3. Upgrade the facility and manage the same as per the prescribed standards.

4. Add specialized services / beds for procedures over and above those prescribed by the DoMH&FW as per the local demand.

5. Recruitment and management of all human resources including their salaries and all responsibilities and liabilities as per existing labor laws.

6. IT-based Management Information Systems.

7. Maintenance of all movable and immovable assets of the hospital.

8. Abide by the existing policies of the Government.

9. Undertake all statutory responsibilities[6]."

SERVICES TO BE PROVIDED AT COMMUNITY HEALTH CENTERS (CHC)

1. Outdoor Patient (OPD)
   a) Medical OPD
   b) Surgical OPD
   c) Pediatric OPD
   d) Obstetrics & Gynecology OPD
   e) Dental Care Services
2. Indoor Facility
3. Anesthetic Services
4. Investigative Procedures
   a) Ultrasonography (in selected CHCs)
   b) X-Ray
   c) Pathology
5. Safe Water Supply & Basic Sanitation
6. Collection & Reporting of Vital Statistics
7. Reproductive and Child Health
   a) Mother & Child Care
   b) Pre, Intra & Post Delivery Services
   c) Family Welfare Services (Sterilization, Free Distribution of Oral Pills &Condoms)
8. Referral Services

Following activities have been kept out of scope of work of Private partner:

a. Medico legal cases
b. *Promotion and management of Government health schemes*(emphasis ours).
c. Ambulance services
d. Collection of user charges
e. Major repairs due to ageing and natural disaster

Before we proceed any further it would be prudent to consider the various reasons for which doctors and other trained medical personnel are reluctant to serve in the more peripheral areas for this seems to be the raison d'être for this PPP proposal in first place.

REASONS FOR DOCTORS REFUSING TO WORK IN RURAL AREAS

As per the rural health statistics of 2011 in rural areas of the country there was 76% shortage of doctors, 53% shortage of nurses, 88% shortage of specialist doctors, 85% shortage of radiographers and 80% laboratory technicians.[7]Even though the reasons for reluctance of trained medical personnel to serve in the rural areas are generally well known, it would be helpful for the purpose of our analysis to recapitulate these over here. In this regard some of the common reasons as perceived by doctors themselves are as given in **Table 2**

Table 2. More common drawbacks of working in rural areas as perceived by medical students (n = 201)

Likely drawback	N*(%)
Infrastructure facilities absent	123 (61.2)
Lower salary	33 (16.4)
Low standard of living	28 (13.9)
Limited professional experience	25 (12.4)
Lack of sanitation	14 (7.0)
Lack of educational opportunities for children	13 (6.5)
Limited technology	10 (5.0)
Lack of recreational facilities	6 (3.0)
Absenteeism of support staff	5 (2.5)
None	3 (1.5)
Security issues	2 (1.0)
Substandard housing	2 (1.0)
Have to live away from own family	2 (1.0)
Possible effects on own health / illness	2 (1.0)

**Multiple responses permitted. Source: Saini et. al. (2012)*[8]

Even though some of the issues mentioned in **Table 3** can be addressed in the short term, but the rest are linked to the overall social and economic development of the concerned district, state, region or country and as such may be outside the purview of the health department alone to address. However, there are other more pervasive issues, as discussed below, behind the reluctance of the medical personnel to serve in the rural areas, especially in the context of the process of economic liberalization in the country.

ELITIST SOCIAL BASE OF MEDICAL PROFESSION

With the rise of modern / western medicine in the country the medical profession in the country has become almost the exclusive preserve of the elite sections of the society who have the physical and economic access to the means for acquiring knowledge of allopathic medicine. This also gave a particular elitist slant in the development and delivery of healthcare in the country that privileged the urban areas at the cost of rural areas '[9].

The urban-rural and curative-preventive dichotomy i.e. presence of big hospitals to provide curative care in the cities and limiting largely preventive care in the rural areas, overwhelming concentration of medical professionals again in the bigger cities and towns as compared to the rural areas testifies to the elitist orientation of medical practice in the country. Worse still more than 50% of the doctors posted in the rural areas are absent from their duty[7].

IMPACT OF COMMERCIALIZATION OF MEDICAL PRACTICE

The private for profit medical care in India today comprises 80 percent of the healthcare in the country[9].Even earlier, but especially since the beginning of the pro-market economic reforms in the 1990s for profit commercial orientation has become firmly grounded in the practice of medicine with the new corporate healthcare sector becoming its beacon light. Commercial mechanisms in the provisioning of health services such as increasing imposition of user charges have become dominant even in the public health services. Jacob states – "changes in the social and financial climate may have also resulted in major shifts within medicine[11]."He writes that "the changed culture within medicine appears pervasive and, in many ways, irreversible and that Medicine in India today looks less of a vocation and more of a business opportunity.Thus, commercialization of healing illnesses and infirmities, may represent a global trend, or effect of globalization on the holistic aspects of Indian medical vocation[11]."

The growth of corporate healthcare while on one hand providing unprecedented economic packages for a few top notch medical professionals have kindled entirely new set of aspirations and values among doctors, medical students and other grades of medical professionals[12].

CHANGING NATURE OF MECIAL EDUCATION IN THE COUNTRY

Figure 1 below presents the picture of growth of medical colleges in the country. In 2006 both the private and the government medical colleges were tied at 131 each; however, it is remarkable that from strength of 47 colleges in 1995 private medical colleges reached a figure of 131 within a decade's time. Nobody need testify to the exorbitant cost of gaining education in these colleges with there being a number of exposés of how seats are actually auctioned in these colleges for exorbitant sums that are beyond the capacity of ordinary Indians. Simultaneously, there has been a steep hike in the cost of education even in the government medical colleges. With these developments the possibility of students from the subaltern sections of the society rising up the social ladder by acquiring publically subsidized medical education became all the more distant and social profile of medical graduates passing out from various medical schools became all the more restricted to the urbane, prosperous and well to do sections of the society who were least likely to serve in rural areas or be enamored with social objectives of medical profession.

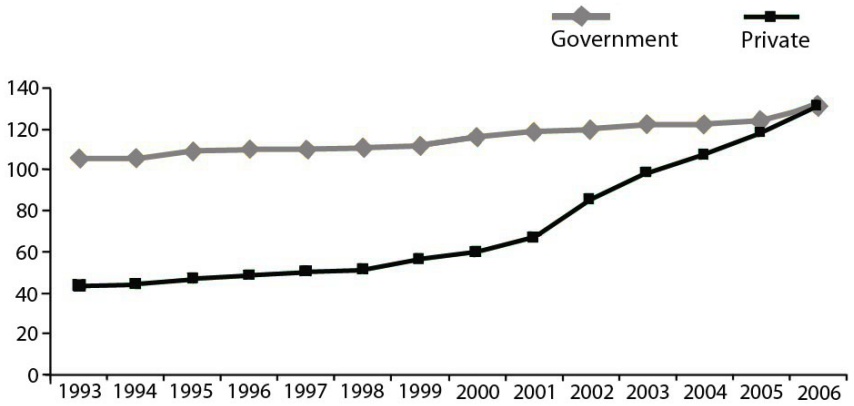

Figure 1 Growth of government and private medical colleges in the country

Source: Medical Council of India quoted in National Knowledge Commission (Undated)[13].

With the increasing consolidation of private for profit curative healthcare in the country, there has been an emphasis on privileging high end technology both as desirable medical interventions and as a means of generating profit / revenue. On one hand this shifts the focus from developing and

trying to prioritize simpler and more effective technological interventions for tackling the health problems for the majority of poor Indians, while on the other end higher and higher technology pushes the trend towards specialization and super-specialization in medical education and care which has become the best bet for an economically rewarding career. Resultantly, medicine has come to be viewed as a 'recession free valued career choice'[14]. Pressures of such career preferences also keep medical graduates away from looking towards rural areas.

EMERGENCE OF PRIVATE FOR PROFIT SECTOR AS THE DRIVER OF HEALTH SERVICES SYSTEM DEVELOPMENT

The private for profit healthcare in the country today constitutes more than 80% of the health services system. Increasingly, it is the growth of the big corporate hospitals that is defining the vision of how to develop the clinical care services for the people and not just at the tertiary level but even at the primary level of medical care. One of the leading exponents of private sector healthcare in the country, Dr.Naresh Trehan, MD of Medanta Medi-city at Gurgaon, neighboring Delhi, has this to say regarding the direction of development of health services:

> "If governments, whether State or Central, want to provide 'sasta and badhiyailaz' (affordable and quality treatment) for every layer of society, right from BPL to the rich, then the infrastructural facilities like land, power, water etc. should be given to private sector for setting up medical colleges and hospitals."[15]

Without going into any substantive issues regarding this direction of development of health services, suffice it to say over here that these developments have consequences for the aspirations and career choices of doctors. Again the following quote ofDr. Trehan shows the limitations this growth of healthcare in India has led to in terms of sending allopathic doctors to serve in the under-serviced parts of the country.

> "Then comes the tertiary and that has two big disadvantages for the government. One, it takes a large investment to create good tertiary care hospital; Second, the super-specialists' salaries, which do not come under the realm of the government's salary systems. One thing that other countries have done very well, who signed the Alma-Ata Declaration of 1978 with India, in which they declared that we shall provide minimum standards of healthcare to all our citizens by the year 2000, is that the governments have turned from providers of healthcare to buyers of healthcare. Because private providers, if done properly, can do it much more efficiently."[16]

These developments have meant that now the government has to compete with private sector in terms of attracting doctors, specially the specialist doctors by paying them huge salaries. While no doubt the government should provide decent wages for the doctors commensurate with their qualification and a decent middle class life style. Additionally, such wages should be defined relative to the overall economic conditions of the people and society at large. But the salaries being offered to a select group of doctors by the for profit private health sector catering primarily to the affluent sections of the society distorts and vulgarizes the concept of a 'decent wage' and makes it difficult of the public sector healthcare to man its services.

Having elucidated these trends, we are in a much better position to judge the likelihood of the present PPP proposal bearing fruits, and if we have reason to feel confident of such a possibility, none could have any grudge.

BENCHMARKS LAID DOWN FOR RECRUITING MEDICAL PERSONNEL IN THE CHCs

The RFP (Request for Proposal) lays down the minimum requirement of the following clinical staff:

Table 3. The requirement of clinical staff per CHC

Clinical staff	Numbers
• General surgeon	1
• Physician	1
• Obstetrician & gynecologist	1
• Pediatrician	1
• Radiologist	1
• Orthopedic	1
• ENT surgeon	1
• Anesthetist	1
• Eye surgeon (1 for every 4 CHCs)	1
• Dental surgeon	1
• General duty medical officer	1
	2

Source: DoMH&FW, 2012, 26[17]

Apart from the clinical staff the RFP places minimum staff requirement for paramedical and other support staff, details of which are not being given here. **Table 4** gives the minimum academic requirements and work experience expected of the clinical staff to be engaged by the private operators at the CHC. To say the least the requirements asked for are really ambitious. However, the question is will these be met?

Table 4. Minimum qualification and experience for the clinical staff

Position	Minimum Qualification / Experience
General Surgeon	MS with over five years of experience.
All Specialists	Relevant PG degree MD/MS/DGO/DOMS/DA with minimum five years of relevant experience
Radiologist	MD / DMRD / DMRE or equivalent.
Staff Nurse for OT	A registered nurse with suitable degree / diploma in nursing having at least five years' experience in OT.
General duty medical officer	MBBS having at least five years' experience.
Dentist	BDS with at least five years of experience.
Other nurses	A Registered nurse with suitable degree/diploma in nursing having at least five years' experience.
Pharmacist	A Recognized Diploma in relevant field.
Laboratory	Technicians DLT with at least five years' experience.

Source: DoMH&FW, 2012, 33[18]

The bidding process for all the aforementioned packages had been completed and the contracts awarded to different bidders by the time of this study.

In the past, the state has tried to fill the vacant posts in two ways – one, by taking the doctors on contract basis through walk in interviews and second, through selection process for regular vacancies of doctors in the state health services conducted through the State Public Service Commission; and it need be said that the positions have been available for asking. However, these efforts have borne little

fruits, especially with respect to engaging specialist doctors. Attempts to even engage them on a higher salary through contract employment mechanisms have proved to be a failure.

Given such a situation, and all the reasons (discussed above) for which doctors are unwilling to work in difficult areas, it is natural to ask as to how the private parties that have been contracted in to run the facilities will manage to get doctors with specified qualification and experience? It need be mentioned here that the market worth of say a General Surgeon or an Orthopedic or ENT surgeon with five years' experience would any day be much more than what public health system can afford.

There is no clause in the RFP document of this project that addresses any of the reasons mentioned above for which doctors do not generally like to serve in rural areas. Furthermore, in as much as for profit private sector is being solicited to bid for running these CHCs on 'Operate and Manage' basis, the interest of the contracted in party in making curative health services available to the people can be retained only if doing so also ensures a neat profit for it. The difficulty in ensuring such profits could be one, on account of low volumes of patients and secondly, on account of people in these remote areas not having much of paying capacity to facilitate such revenues.

As has already been pointed out – it is hoped that regular presence of general and specialist doctors at these facilities can be ensured first by recruiting specialist doctors by offering high remuneration and secondly, by rotating doctors between the CHCs located in the plain and the hill areas. But at the end of the day the private operator need to first make enough money from this PPP to pay attractive packages to the doctors. Given this necessary condition of making enough profit from this PPP project, we shall attempt a detailed analysis of the economics of this proposal to judge its feasibility and desirability.

POLITICAL ECONOMY OF THE PROPOSED PPP MODEL

As per the RFP document the government shall provide two kinds of grants to the private provider – Operating grant and Capital grant[19].

OPERATING GRANT

Operating grant shall be towards the day to day running of the CHC and shall accordingly be divided into two types – Fixed Operating Grant and the Variable Operating Grant.

FIXED OPERATION GRANT

Fixed operating grant shall be in lieu of fixed expenses regarding "housekeeping, laundry, waste management, hospital administration, manpower, Out-Patient-Department expenses, In Patient Department Expenses and emergency etc."[19]This will include utilities like electricity and water consumption, repairs and maintenance and other such expenses. These expenses along with the salary component of the doctors, paramedical and the supporting staff shall be quoted in terms of rupees per square feet of the built up area of the CHC. The party quoting lowest price shall get the contract and its quoted expenses shall be made good by the state government irrespective of the number of patient footfalls at the CHC.

Though it cannot be clearly discerned from the provisions of the RFP, but as per the cost benefit analysis of the project explained by the PPP expert at the state government's PPP cell who has designed the framework of this PPP, the most important and crucial provision of the agreement is that the fixed cost quoted by the private operator shall include the profit margin (say of 15% to 20%) over and above his / her actual fixed cost of operating the facility. This shall be demonstrated later in the paper by reproducing the exact cost benefit analysis done by the PPP expert. ***Inter alia this means that once their bid is successful the private operator makes an assured profit irrespective of the number patient footfalls in the facility;*** something the operator cannot even dream of with respect to the hospitals directly owned and operated by him / her.

Since the prescribed strength of doctors and other staff is the same for all CHCs irrespective of the population catered to by the facility, the built up

area and the number of patients coming to the facility, under this scheme of things the fixed operating cost quoted by the private operator shall have to be higher for a CHC catering to a lesser population, with lesser number of patients and lesser built up area. For example, the CHC at Munsyari in district Pithoragarh caters to a population of 51,245; has a monthly O.P.D of 1083; a monthly I.P.D of 36 and a built up area of 125 sq. meters; while the CHC at Kapkote in dist. Bageshwar caters to a population of 82,000; has a monthly O.P.D. of 2846; monthly I.P.D of 110 and a built up area of 1,700 sq. meters. Inspite of such yawning gaps in the requirements of facilities and manpower as per the population and patient attendance, the fixed operating cost of CHC at Munsyari shall have to be much more than that of the CHC at Kapkote to meet the expense for fixed staff strength and other operating costs.

Such an arrangement is not just counter intuitive, but also counterproductive as we shall examine later.

VARIABLE OPERATING GRANT

The following items shall be covered under the variable operating grant:

- Number of actual diagnostic procedures performed in a month – X ray, Ultra Sound, ECG and Pathology.
- Number of actual maternity cases delivered in a month.
- Number of minor accident/injury cases treated.

It needs to be noted here that the state government levies user charges for various investigations and procedures at its facilities which are revised upwards by 10% every year. However, the private bidder shall be free to quote its own rates for various investigations and procedures which may be more or less than those charged by the government for the same. The patients utilizing the services of the CHC shall have to pay the government imposed user charges, while the government shall pay to the private operator at the rates quoted by him / her. The B.P.L (below poverty line) patients shall be exempt from paying the user charges.

The variable operating grant is like added perks for the operator to increase his / her profit over and above that which is already ensured as part of the fixed operating grant. As per the state PPP consultant "variable grant has been designed as an incentive for the operator to try and increase his revenue by ensuring greater number of patient footfalls in the facility, lest they get used to simply collecting the monthly fixed grant and the profit that comes with it." Thus the larger the number of footfalls the more shall be the number of investigations or procedures performed resulting in higher revenue.

This assumption could be naïve for it negates the economic character of the kind of private parties that have been sought to be engaged as operators and managers of the CHCs and the milieu in which they shall be operating. While government may be motivated by higher ideals of improving the health care delivery for the people, the private operators are not encumbered by any such burden. Neither are they the kind of big corporate houses operating in the cutting edge harsh economic environment to increase their market share. These operators are there to make money and make it the easiest way, especially when they know that they would never have been into this if the government did not ensure their profit. Moreover, they shall be operating for long periods of assured returns in an environment with a very weak presence of any health care let alone a cutting edge competition.

As we shall see shortly with the help of our own back of the envelope calculations, the private operator also knows very well that his / her engagement in this PPP can never lead to setting up their own hospital in the area that shall be commercially viable and thus provide a standalone opportunity in the medium or the long run. So not only are the private operators out to make money, but they also know that this shall have to be done while the present PPP policy is in force i.e. provided they manage to start operating the facilities in first place.

The author visited the state during the first week of May 2013 to confer with the senior health officials in the state, the medical and paramedical personnel at facility level and the private operators for assessing

the present PPP proposal. By that time the bidding process was complete and the private operators had already been selected. Packages 1 and 2 and Packages 3 and 4 had been awarded to Sheel Nursing Home Pvt. Ltd Bareilly and Rajbhara Medicare Pvt. Ltd respectively.

The RFP document lays down that "It would be deemed that prior to the submission of proposal, the bidder has "among other things" made a complete and careful examination of the various aspects of the Project including but not limited to:

(i) the Project site
(ii) existing facilities and structures
(iii) space availability
(iv) water availability
(v) the conditions of the access roads and utilities in the vicinity of the Project site
(vi) conditions affecting transportation, access, disposal, handling and shortage of the materials."[20]

Yet it is rather queer that none of the parties that had been awarded the contracts for the different packages had actually cared to visit the facilities whose turn around had been assigned to them. When the author visited the CHC at Naugaon in district Uttarkashi which is included in Package 3, the medical superintendent of the CHC told that the private concessionaire had informed to visit the facility on two occasions, but each time he failed to turn up without even caring to intimate the same to the facility. Likewise the concessionaire had failed to visit the CHCs at Pabau and Thailsen in district Pauri Garhwal.

On two other subsequent visits to the state by the author two more CHCs outsourced on PPP basis - CHC at Munsyari in district Pithoragarh and Kapkot CHC in Bageshwar district were visited in June and in August respectively. Here too the government doctor sat the facilities complained that it seems from the attitude of the private operators that they have little interest in taking over the running of the CHCs. At both these facilities a manager of the private operators had paid a cursory visit after much pursuit by the government staff of the CHCs. There is much anxiety among the government staff managing the facilities for now; whether they should undertake any new initiatives or not? Such a state of affairs has already adversely affected the functioning of these facilities.

We shall consider what has kept the private operators from taking over the facilities a while later; for now let us examine some of the other features of the PPP terms and conditions.

TENDENCY FOR OVER-INVESTIGATION AND OVER-TREATMENT

The terms and conditions of the PPP leave enough scope for the private operator to seek to increase his profit by increasing variable portion of the grant through excess investigations and procedures or treatments for the patients that may not be indicated; this in turn highlights the need for a mechanism to exercise constant vigil over the operator for the quality of treatment.

Besides, the PPP expert instrumental in designing the entire project told – that the operators are already operating their own tertiary / secondary care hospitals in bigger cities of either Uttrakhand or in other neighboring states; for example the operator contracted in for operation and management of Packages 1 and 2 – Sheel Nursing Home, runs a chain of nursing homes in Bareli in Uttar Pradesh. They may refer the patients requiring some specialized treatment to their established hospitals. As it is the people from the hills have to travel to bigger hospitals either in the state capital Dehradun or outside the state for availing such specialized treatment. So they might as well go to the bigger hospitals of the provider they already know.

The problem here is that whether the patient is being referred for the right indication, or is being referred even for a treatment that should be provided by the operator at the CHC itself? The pretexts for doing so could be many, for example lack of availability of specific kind of instruments, specialized investigations or concerned specialist or the surgeon's refusal to operate unless there is proper blood bank support. Such pretexts can be galore if the oversight supervision can be managed suitably by the operator. The result could be that

instead of optimally functionalizing the CHCs, the private operators may merely use them as an opportunity for generating more business for their own health facilities.

COST OF PROCEDURES AND CONSUMABLES

Under the variable grant the RFP document has sought quotations from the bidders under three categories: **Diagnostic services** including X-Ray, Ultrasound, ECG and Pathology Test; **Maternity cases** and **Accident cases**. There is no mention of any charges for a number of different procedures that the CHCs would be required to perform such as - Minor plastic operation, Minor wound repair and stitching, Lumber puncture, Tracheotomy, Tonsillectomy, Repair of hernia, Appendisectomy, Abdominal laprotomy etc. Going by the limited categories of diagnostics and procedures for which quotations have been invited under the head of variable costs, cost of many of the consumables required for a number of other surgeries may not have been included in the bidding cost of fixed grant.

When this point was raised with the state PPP expert, his answer was that "90% of the cost to the operator for performing these procedures was on account of the cost of surgeon / doctor and other staff; and this cost has already been taken care of through the fixed grant." He also said that "if we were to account for each and every procedure then the cost benefit analysis of the whole project would become unwieldy."

The question here is how big is the remaining 10%; who will pay for it and at what rates? It is common knowledge that there are consumables required for various kinds of surgeries or non-surgical medical procedures, the cost of which can range from a few hundreds to thousands of rupees. In the far off hills the availability of these consumables is a big question in the best of times. The problem can be lessened to an extent if there were a state wide corporation to make these consumables available in the remotest of the areas; however, that apparently is not the case in the context of this PPP proposal for CHCs.

The government may pay the cost of consumables for the BPL patients, but not the APL (Above Poverty Line). Will the operator provide these consumables for the APL? If yes, then at what cost? How will it be ensured that the cost remains reasonable? While it is possible that the cost of consumables may be collected by the government on case to case basis and compensated to the private operator at the end of the month; however, there remains a concern for the out of pocket expenditure to the patients? Could it be that since the details of the cost for different procedures has not been worked out, the operator shall provide services only for maternity cases and minor accident injuries or other such treatments, while for anything more substantive the patients shall be referred again to district hospitals or to the bigger facilities in the plains?

These are some of the most pertinent questions answers to which cannot be located in the RFP and by PPP expert's own admission, shall make the arrangement too complicated. Yet such uncertainties may actually lead to defeating the purpose of making affordable and comprehensive curative care available to the people near to their homes due to the possibility of the private player leveraging these lacunae to his / her benefit.

CAPITAL GRANT

As per the agreement between the government and the private provider the DoMH&FW is obliged to provide all equipment and infrastructure in the CHCs as per the IPHS (Indian Public Health Standards.) In case there is any shortfall in equipment (medical equipment only) or infrastructure that costs upward of Rs 2 lakhs, such a gap shall be covered by DoMH&FW by one time grant.

MECHANISM OF PAYMENT

Regarding the mechanism of payment to the private operating party, the RFP document lays down the following provisions.[21]

- The CPS (Chikitsa Prabandhan Samiti' i.e. Treatment Management Committee) / RKS (Rogi Kalyan Samitis i.e. Patient Welfare Societies)of the CHC shall be responsible for collection of all charges from the patients for diagnostic tests, maternity cases, minor

accidents, other procedures, consumables and medicines.

- A record of the following shall be maintained by both the CPS and the private operator:
  - Number and type of diagnostic procedures, maternity cases, minor accidents and other procedures conducted.
  - Bed occupancy.
  - Consumables and medicines given to patients on payment during a month.
- At the end of the month CPS and the Concessionaire will tally the record of the individual diagnostic tests, maternity cases seen and procedures done by the Concessionaire during the month and the corresponding user charges collected by the CPS.
- The Concessionaire shall be paid fixed and variable operating grant every month as per the computation shown in **Table 5**. This however shall be subject to achieving certain Key Performance Indicators (KPI) that shall be based on the following criterion:
  - Proportion of total number of man days for which clinical staff was absent from work, out of the total number of man days for clinical staff depending upon the designated strength of clinical staff and the number of days for which the facility was functioning.
  - Proportion of the total number of man days for which the paramedical and other support staff was absent, out of the total number of man days for this category of staff depending upon the statutory strength of this staff and the number of days for which the facility was functioning.

Table 5. Formula for calculation of total monthly grant towards the operator

Sr. No.	Name of Procedure	Actual No. of Procedure per month	Amount of government support applicable for respective year	Total amount payable per month (Rs)
		(a)	(b)	(c) = (a) x (b)
1	**Diagnostic services[1]**			
A	X-Ray			
B	Ultrasound			
C	ECG			
D	Pathology Test			
2	**Maternity cases[1]**			
3	**Accident cases[1]**			
4	**Fixed Grant**	Area 1 (sqmtr)		
	Rs per sqmt of built up area**	Area 2 (sqmtr)		
		Area 3 (sqmtr)		
		Area 4 (sqmtr)		
		TOTAL		Total fixed grant
	Total Monthly Grant Payable	**1 + 2 + 3 + 4**		

Source: DoMH&FW, 2012, 37 &127.[22]

***The amount of total Fixed Grant is quoted Rs per sqmt of built up area per annum. For the purpose of monthly payment the amount of Fixed Grant quoted by the bidder per annum for respective years shall be divided by 12.*[1]*The government will not guarantee any demand for diagnostic tests or procedure and the entire demand risk is to be borne by the Bidder.*

- Total number of days of stock out for each critical consumable that has affected or disrupted service delivery during a month as a proportion of total number of days for which these consumables ought to have been available i.e. number of days for which facility was open multiplied by the total number of critical consumables.\
- Total number of days when the downtime of critical equipment exceeded the benchmark downtime of that equipment as a proportion of the total benchmark downtime days of all the critical equipment

An average KPI score will be calculated for a given month and the reimbursement will be made to the private operator as per the average KPI score as shown in **Table 6**. Ideally the average KPI score should be as low as possible. What is important to note is that the KPI score is based on the attendance of the medical and paramedical staff and availability of consumables, while quality parameters have been kept out of performance assessment.

Table 6. KPI score and the corresponding payment

S. No.	Average KPI score	Percentage of total reimbursement to be paid to the operator every month
1.	0 – 5%	100%
2.	6 – 10%	95%
3.	11 – 15%	85%
4.	16 – 20%	75%
5.	> 20%	60% (With show cause and explanation.

Source: DoMH&FW, 2012, 147.[23]

The scheme of things presented in this section is very fine on the face of it; only what is not certain is whether it will actually work out this way. At least some of the possible difficulties can be apprehended at this stage.

Exchange of money between two parties by its very nature is a contentious issue, especially if the contentions arise over the exact number of investigations done or procedures performed. Can it be expected of the medical superintendent that he / she will himself / herself maintain a daily record of exact number of investigations and procedures performed and then tally it with that of the private operator; or there shall be need of separate staff for this, in which case how much staff; will this not lead to duplication of effort in as much as there shall have to be two sets of people (one from the government and the other of the provider) to do the same task?

The state officials in Dehradun seemed to be hopeful that this will work out seamlessly; however the doctors and the staff at the facilities were not as certain. In fact in an off the record conversation, one of the officials at the health directorate in Dehradun frankly averred that the private operators are well connected people. If the government administrator at the CHC were to deduct any payment for non-performance, they can manage instructions from Dehradun to the local administrator to release the payment.

Implicit in the hope of success of this scheme is the assumption that the private operator shall be able to find medical personnel, paramedical and supporting staff and ensure that they all are available at their work stations as and when required; that all the essential supplies and equipment shall be available and perform as per the requirement. These are precisely the factors because of which the government has not managed to run these institutions. So what is it that the private operator will do differently to make things work?

EXERCISING OVERSIGHT OVER PRIVATE OPERATOR

We have already enumerated earlier the possible ways through which the private operator could seek to increase the variable grant and there by his profit. Apart from ordering unnecessary investigations, over treatment and using the CHC as a referral point for sending patients to self-owned bigger hospitals in larger cities, the operator could also resort to practices like discharging the admitted patients prematurely. After the first few days when revenue can be generated through investigations and treatment the patient becomes redundant from the point of generating extra revenue and a new admission would be more welcome.

The RFP document does provide for "continuous medical audit of all the CHC's" by the DoMH&FW to "ensure that only necessary diagnostic procedures are recommended by OPD and there is no over medication & diagnostic procedures" (DoMH&FW, 2012, p 30).[24]However, the document itself is silent on the modalities / mechanism to be followed in this regard, apart from the fact that given the present stage of its development and the acute shortage of trained medical personnel, the health system in the state is struggling to make its various facilities functional. Monitoring and evaluation of these facilities for maintaining the quality of care is still a far cry.

Before the present proposal to give CHCs on PPP mode, there have been other PPPs in health sector in the state that are already operational. However, upon specifically enquiring from the medical officer in charge of PPPs in the health directorate of the state, there has been no independent assessment of these PPPs in the state till now. The only assessment has been through the routine service delivery data, which also emphasizes the revenue generated and the numbers of B.P.L patients treated under these PPPs, leaving aside factors like the quality of services and out of pocket expenses to the patients.

The mechanism for oversight pre-supposes the regular functionality and capability to exercise vigilance over the private operator on part of the CPS at all of the outsourced facilities.

Though there are no large scale studies that have assessed the functionality of the CPS / RKS in the state, but at least one study conducted in 2008-09 found that in the CHCs in Nanital and Udham Singh Nagar districts the RKS consisted of "unmotivated members burdened with additional responsibilities" (UHFT Medical College, 2008-09, 11)[25]and "RKS at health facility were not actively involved because of lack of knowledge related to objectives and functions of RKS" (UHFT Medical College, 2008-09, 12).[26]

Moreover, exercising oversight is not a simple matter of de jure delegation of authority but a de facto exercise of power facilitated through answerability of the staff. When the doctors, paramedical and other staff involved in providing the clinical services at the CHC shall be answerable to their immediate employer i.e. the private operator, the nature of oversight exercised over them by the government appointed medical superintendents can at best be equivocal.

THE ECONOMIC FEASIBILITY OF THE PROJECT

The details given in **Table 7** can help us in having an approximate idea of the revenue that the private operator can generate from each facility based on the expected O.P.D and hospitalizations at the facility and the cost to the patients per O.P.D. and hospitalization case. In this respect the following facts are available from the NSSO 60th round survey:

- As of 2004, for the state of Uttrakhand (rural) 89 percent of all persons reporting ailment in a recall period of 15 days sought treatment for the illness. Of these merely 18 percent sought treatment from government facilities while 82 percent went to private providers.[27]
- Of the total number of patients requiring hospitalization in rural areas of Uttrakhand, only 43 percent of the patients sought treatment from public facilities.[28]

Table 7. Details of population covered and the service delivery data per CHC

Package	District	Location of CHC	Population covered	Average monthly OPD	Expected OPD cases in the entire population per month[1]	Average monthly IPD	Expected hospitalizations for the entire population per month[2]	Deliveries conducted
Package 1	Chamoli	Gairsain	59,729	1992	6212	36	85	106
	Pithoragarh	Munsiari	51,245	1155	5329	36	73	10
	Bageshwar	Kapkote	82,000	2846	8528	110	116	19
	Nainital	Garampani	10,000	850	1,040	22	14	-
	Rudraprayag	Jakholi	86,000	1087	8,944	105	122	16.5
Average			57,795	1,426	6011	62	82	30
Package 2	Almora	Chaukhutia	47,540	1975	4,944	-	67	26
	Champawat	Lohaghat	65,000	8534	6,760	20	92	130
	Udham Singh Nagar	Bajpur	1,78,482	4680	18,562	219	253	190
Average			97,007	5063	10,089	119	137	115
Package 3	Dehradun	Sahiya	28,624	1,040	2,977	29	41	12
	Dehradun	Raipur	80,000	4,800	8,320	150	114	11
	Uttarkashi	Naugaon	77,390	1,783	8,049	234	110	94
	Tehri	Thatue	58,562	1,545	6,091	72	83	26
Average			61,144	2,292	6359	121	87	36
Package 4	PauriGarhwal	Pabau	65,000	2,468	6,760	42	92	8
	PuriGarhwal	Thailsain	26,746	2,618	2,782	36	38	14
	Haridwar	Bhagwanpur	2,25,881	4,500	23,492	-	321	341
	Tehri	Hindlakhal	55,774	1,545	5,800	45	79	24
Average			93,350	2,783	9,708	41	132	97
Overall average			77,324	2,891	8042	86	109	69

Source: Figures for average monthly OPD and Average monthly IPD are triennial average of the figures for the years 2008, 2009 and 2010 given in the RFP document.

[1] This is calculated as per the finding of NSSO 60th round report which stated that for Uttrakhand (rural areas) the number (per 1000) of persons reporting ailment during last 15 days was 52.[29] On this basis we have calculated the expected incidence of morbidity for the entire population for a period of 15 days and doubled that figure to get morbidity per month. [2] Calculated on the basis of the finding that incidence of hospitalization per 1000 population in Uttrakhand (rural) is 17 for a recall period of 365 days[30] i.e. 1.42 per 1000 population per month. Therefore monthly incidence for the total population covered by the CHC = 1.42 x Total population covered / 1000.

- Medical expenditure (excluding expenditure on conveyance, food and other such incidental expenses) in treatment of every non-hospitalized case was 0 for government hospitals and Rs 453 per case for all (government as well as private among others) hospitals put together.[31]
- The average total medical expenditure for each hospitalization case in public sector facilities was Rs 3,238 during a recall period of 365 days.[32]

Some of the expected O.P.D and I.P.D. cases coming to public health facilities shall also be treated either at PHC or the Sub-centre. Given these facts, if we make most liberal assumptions that at least 50 percent of the O.P.D and I.P.D cases shall come to the CHCs, then we can do some back of the envelope calculations to judge the likely revenue that can be earned by the private provider per month at 50 percent of expected O.P.D and I.P.D cases in the total population. The results of this are being presented in **Table 9**. The calculations have been done, first by taking the average cost of medical treatment (per O.P.D and I.P.D case) as

given in the NSSO 60th round report for the state of Uttrakhand, and secondly by assuming a more moderate medical cost of Rs 100 and Rs 1000 per O.P.D and hospitalization case respectively. The revenue so generated should be more than the cost incurred by the provider towards the fixed and variable expenditure in running the facility.

Table 8. Poverty status and poverty band, 2004-05

Poverty status		% of population	DPCE (Rs)
1.	Extremely poor	6.4	9
2.	Poor	15.4	12
3.	Marginally poor	19.0	15
4.	Vulnerable poor	36.0	20
5.	Middle-income	19.3	37
6.	High – income	4.0	93
7.	Poor and vulnerable (1 to 4)	76.8	16
8.	All	100.0	46

Note: DPCE = daily per capita consumption expenditure. Source: Kannan, 2010.[33]

A look at the figures in shall suffice to understand that the average medical expenditure incurred by the patients per O.P.D. and I.P.D. case as per the NSSO 60th round report is exorbitant. A whopping 77 percent of the population in the country subsisted on an expenditure of less than Rs 20 a day and an expenditure of just Rs 93 a day sufficed for one to be classified as High income. It would be expected that availability of efficient treatment at the level of CHCs should bring down the cost to the patients.

Table 9. Possible revenue generation from the outsourced CHCs

Package	Location of CHC	50 % of expected OPD cases in the entire population per month	50% of expected hospitalizations for the entire population per month	Total revenue (O.P.D. & I.P.D cases @ Rs 453 &Rs 3,238 per case respectively)	Total revenue (O.P.D. & I.P.D cases @ Rs100&Rs1000 per case respectively)
Package 1	Gairsain	3106	42	15,43,014	3,52,600
	Munsiari	2664	36	13,23,360	3,02,400
	Kapkote	4264	58	21,19,396	4,84,400
	Garampani	520	7	2,58,226	59,000
	Jakholi	4472	61	22,23,334	5,08,200
Average		3005	41	14,94,023	3,41,500
Package 2	Chaukhutia	2472	33	12,26,670	2,80,200
	Lohaghat	3380	46	16,80,088	3,84,000
	Bajpur	9381	126	46,57,581	10,64,100
Average		5044	68	25,05,116	5,72,400
Package 3	Sahiya	1488	20	7,38,824	1,68,800
	Raipur	4160	57	20,69,046	4,73,000
	Naugaon	4024	55	20,00,962	4,57,400
	Thatue	3045	41	15,12,143	3,45,500
Average		3179	43	15,79,231	3,60,900
Package 4	Pabau	3380	46	16,80,088	3,84,000
	Thailsain	1391	19	6,91,645	1,58,100
	Bhagwanpur	11746	160	58,39,018	13,34,600
	Hindlakhal	2900	39	14,39,982	8,14,500
Average		4854	66	24,12,570	5,51,400
Overall average		4021	54	19,96,365	4,56,100

Referring to the Tables 3 and 4 above we can make some rough calculations for the cost of engaging the doctors (specialists and simple graduates) of specified experience. We have assumed a minimum salary of 1 lakh per month for a specialist each in General Surgery, MD Medicine, Obstetrics and Gynecology, Pediatrics, Radiology, Orthopedic Surgery and ENT; a salary of Rs 80,000 per month for the Anesthetist, Rs 25,000 per CHC for an Ophthalmic Surgeon (1 for 4 CHCs) and Rs 60,000 per month for 2 G.D.M.Os and one Dental Surgeon. Even at these most conservative estimates the total cost of doctors alone per CHC comes out to be Rs 9.85 lakhs per month.

We can add to the figure of 9.85 lakhs the likely cost of engaging other paramedical and support staff, the provision for supplies for daily use like that required for cleaning, gloves, syringes etc. and fixed cost for utilities like electricity, water, regular maintenance etc.It can be seen that if we consider the revenue generated at the enhanced medical expenditure per O.P.D and hospitalization case as reported in NSSO 60th round then 6 CHCs (Kapkote, Jakholi, Bajpur, Raipur, Naugaon, Bhagwanpur) will be in a position to generate surplus; 7 CHCs (Gairsain, Munsiari, Chaukutia, Lohaghat, Thatue, Pabau and Hindlakhal) may just breakeven; while 3 CHCs (Garampani, Sahiya and Thailsain) shall incur loss. Taking the revenue generated at reduced cost of Rs 100 and Rs 1000 respectively per O.P.D and I.P.D case we can see that none of the CHCs shall generate a surplus.

Hence, if we try to provide the services at the CHCs at a cost that is affordable to the people, none of these facilities can run profitably, while providing these services at market prices(the higher cost considered here is also of the year January to June 2004 i.e. almost a decade back; if it is considered at today's prices the commercial cost of providing these services shall be much higher) to the people runs the risk of making these services unaffordable for a considerable section of the population.

There are some important lessons to be learnt from the calculations made above. In case of hill areas where the population is sparse if the staffing pattern for medical personnel per CHC, as prescribed in the ROP for the PPP proposal, is maintained then there may not be enough patients per specialist doctor to justify the expenditure for the same. It would have made better sense to have a one specialist e.g. for surgery for two adjacent CHCs. The duty of the specialist could have been divided between the two CHCs on designated days while making arrangements for mobility of doctors between the facilities or use efficient referral transport system to shift patients requiring specialist care between the CHCs. Similar possibilities could also be explored with respect to the paramedical staff. This would have helped in reducing the running cost for CHCs.

The question then arises whether the government can afford to provide health services through this arrangement on a long term basis? If the assessment done by the PPP cell of the Uttrakhand Government is to be believed, then not only that the government can afford to run the CHCs on PPP basis over long term, but shall also gain considerable financial mileage.

COST- BENEFIT ANALYSIS OF THE PPP PROJCET

Table 10 given below shows how much money Uttrakhand government shall be saving per package after outsourcing these facilities to the private operator in comparison to the net outflow of money from the government if it were to run the facilities itself with the full strength of the required staff.

Table 10. Cost analysis of project developed by the government vs. PPP
Unit of value: Rs in crores

Description	Government outflow over 10 years		Savings to the govt. on PPP mode
	Govt. project	PPP mode	
Package 1	78	64	13
Package 2	45	34	11
Package 3	63	54	9
Package 4	61	49	12
Total	247	201	46

Source: Uttrakhand govt. PPP cell

It is very important for us to understand how there figures were arrived at and the rest of the section is devoted to this. We have picked up the cost-benefit analysis done for the CHC at Chaukhutia in district Almora by the state PPP cell. Similar analyses have been done for all other CHCs being given on PPP mode for a period of 10 years to give the projections given in **Table 10**. However, we shall consider analysis only for the first year of operation of Chaukhutia CHC under PPP so as to simplify the computations for better understanding.

FIXED COST TOWARDS MANPOWER

Table 11 below shows the fixed expenses related to the engaging medical and paramedical professionals and other supportive staff. There are three aspects that need be noticed here:

1. The difference in the compensation to be paid to different categories of personnel - While the overall remuneration due to the medical professionals shall increase by 26.7% under PPP mode that for the paramedical and supportive staff shall decrease by nearly 20%. Personally the author views that the paramedical and other supportive staff also deserve a decent living wage, especially in the current economic scenario in the country. There certainly does not exist a case for further reducing their salaries; however, for the purpose of the analysis presented here we shall not deliberate on this aspect.

It can be noticed that in Uttrakhand the salary of a government specialist doctor is very low in comparison to that of a specialist doctor in private sector. Though not reflected in **Table 12** but as per the submissions of the doctors at some of the CHCs in the state the difference in salaries is meager between a specialist and a graduate medical officer of sufficient seniority. On conversation with some representatives of the private operators to whom the contract for running different CHCs has been awarded, their main strategy towards enticing specialist doctors to work for them is to offer enticing financial packages that somehow have not been possible for the government to do. This could well be one of the factors, albeit a small one, for the specialists to not join the public health services in the state.

Table 11. Fixed cost for medical, paramedical and supportive staff under government management and under PPP

Medical Personnel	Number of staff/CHC	Government (1st year estimate)		Private operator (1st year estimate)		Support manpower	Number of staff/CHC	Government (1st year estimate)		Private operator (st year estimate)	
		Monthly salary/ CHC (ooo)	Yearly cost/ CHC (lakhs)	Monthly salary/ CHC (ooo)	Yearly cost/ CHC (lakhs)			Monthly salary/ CHC (ooo)	Yearly cost/ CHC (lakhs)	Monthly salary/ CHC (ooo)	Yearly cost/ CHC (lakhs)
Block Health Officer	0	65000	0.00	65000	0.00	Staff Nurse	10	25000	30.00	20000	24.00
General surgeon	1	60000	7.20	100000	12.00	Lady health visitor (desirable)	0	15000	0.00	15000	0.00
Physician	1	60000	7.20	75000	9.00	Public Health Nurse	0	15000	0.00	15000	0.00
Obstetrician &Gynaeocologist	1	60000	7.20	75000	9.00	Maternity assistant (ANM)	2	20000	4.80	15000	3.60
Pediatrician	1	60000	7.20	75000	9.00	Pharmacist	1	15000	1.80	15000	1.80
Radiologist	1	60000	7.20	75000	9.00	Pharmacist -Ayush	0	15000	0.00	15000	0.00
Orthopaedic	1	60000	7.20	75000	9.00	Laboratory Technician (Lab + Blood Bank)	1	12000	1.44	12000	1.44
ENT surgeon	1	60000	7.20	75000	9.00	Radiographer	1	12000	1.44	12000	1.44
Anesthetist	1	25000	3.00	45000	5.40	Dietician - desirable	0	12000	0.00	12000	0.00
Public Health manager	0	25000	0.00	25000	0.00	Ophthalmic Assistant / Refractionist	0	15000	0.00	15000	0.00
Eye surgeon (1 for every 4 CHCs)	0.25	60000	1.80	75000	2.25	Dental assistant	1	15000	1.80	15000	1.80
Dental surgeon	1	45000	5.40	45000	5.40	Cold chain & vaccine logistcassis.		10000	0.00	10000	0.00
General duty medical officer (GDMO) (lady)	2	45000	10.80	45000	10.80	Dresser	2	5500	1.32	5500	1.32
Ayush Medical Officer (desirable)	0	30000	0.00	30000	0.00	Ward boys	4	7000	3.36	6000	2.88
General duty medical officer (GDMO) (ayush)	0	30000	0.00	30000	0.00	Sweepers	4	7000	3.36	5000	2.40
Part time canc surg	0	25000	0.00	25000	0.00	Guard	3	7000	2.52	5000	1.80

cian (desirable)									
Total	11.25	71 lakhs	90 lakhs	Dhobi (washerman)	2	7000	1.68	5000	1.20
Total expenditure on manpower under government			137.84 lakhs	Mali (Gardner)	1	7000	0.84	5000	0.60
Total expenditure on manpower under PPP			143.52 lakhs	Aya (Female nursing attendant)	3	6000	2.16	5000	1.80
				Peon	2	7000	1.68	5000	1.20
				OPD attendent	1	8000	0.96	5000	0.60
				Registration clerk	1	8000	0.96	7000	0.84
				Data entry operator	1	10000	1.20	8000	0.96
				cooks	2	8000	1.92	5000	1.20
				Account/admin assistant	1	10000	1.20	8000	0.96
				Multi rehabilitation worker	0	10000	0.00	8000	0.00
				Counselor	1	10000	1.20	8000	0.96
				Driver	1	10000	1.20	6000	0.72
				Total	**45**		**66.84 lakhs**		**53.52 lakhs**

Source: The cost-benefit analysis performed by the state PPP cell.

What is inexplicable is – what has prevented the government from taking a second look at the pay structure of the doctors employed in the public health services of the state; especially so when even the increased salaries of doctors to be employed by the private operator are going to come from the fixed grant that shall be paid by the government to the operator.

2. Secondly, the cost of Rs 143.52 for manpower under PPP is only the cost towards the employees of the private provider and does not include the expenditure to be incurred by the government towards the salaries of its own staff to be maintained at the CHC for the purpose of supervision of the CHC and to perform other statutory functions like attending to the public health work, attending to the medico-legal cases, collection of the user fees and maintaining accounts, maintaining and keeping account of the drug supplies etc. The cost-benefit analysis as provided by the PPP cell does not account for the expenditure towards the salaries of this government staff that shall remain at the CHC under the PPP.

3. As we shall see later, apart from the financial cost there are likely to be other costs to the public health services in the state in the form of gross underutilization of the government staff, or even difficulties in the smooth delivery of services due to conflict between dual staff structure under one roof.

VARIABLE AND OTHER FIXED COSTS UNDER PPP PROJECT

Intuitively speaking we can assume that the cost towards utilities like electricity / power consumption, water, repairs and maintenance, miscellaneous expenses, cost of soft furnishingand cost of furnishing to be replaced annually should be almost the same, or at least not vary hugely to make a meaningful difference in the fixed cost for running a CHC under government management or in a PPP mode.

Likewise, it can be expected that once under a PPP, the private operator shall provide the services of the CHC even during evenings and night in order to maximize his / her variable revenue; though there is no reason to believe as to why the services cannot be provided round the clock under a government management provided the full strength of medical, paramedical and other supportive staff can be ensured as is being presumed in case of a PPP. Given these premises, Table 12 below gives an account of the variable and the fixed costs for managing the CHC at Cahukhutia in district Almora under government management and in PPP mode. The costs are being shown only for the first year of the PPP.

As per the HMIS data the total O.P.D patient attendance at Chaukhutia CHC is 23,695 annually. Given that the CHC has 30 beds, the total bed days in a year would be 10,950. Taking average duration of stay to be 5 days, the maximum number of in patients can be 2190. At the rate of 80% occupancy the total number of in patients treated at the CHC per year would be 1752.

Table 12. Computation of the variable and fixed government grant due to the concessionaire

	Public Sector Comparator (i.e. government operated)							Under PPP	
Variable / Fixed	**S. No.**	**Procedure or service / Expenditure. head** (a)	**Average numbers*** (b)	**Revenue / procedure**** (c)	**Cost / procedure** (d)	**Yearly revenue from procedures/ services** (e) (b x c) / 100000 (in lakhs)	**Yearly costs for different procedures / services** (f) (b x d) / 100000 (in lakhs)	**Revenue / procedure or service** (g)	**Yearly revenue due to the operator (variable + fixed grant)** (h) (b x g) / 100000 (in lakhs)
Variable revenue and expense	1.	X – ray	1255	100	50	1.26	0.63	60	0.75
	2.	Ultrasound	763	375	220	2.86	1.68	264	2.02
	3.	ECG	1535	200	100	3.07	1.54	120	1.84
	4.	Pathology	1272	50	20	0.64	0.25	24	0.31
	5.	Maternity case	936	2500	325	23.4	3.04	390	3.65
	6.	Accident case	509	2000	1000	10.18	5.09	1200	6.11
	7.	Admissioncharges	1752	55	0.00	0.96	-	-	-
	8.	Bed charges	1752	35	0.00	0.61	-	-	-
	9.	Dietary services / day	1752	100	60	8.8 (b x c x 5/100000)	5.26 (b x d x 5/ 100000)	-	5.26 (assuming the same cost as under government)
Sub-total(variable revenue & expense)	10.	-	-	-	-	51.8	17.5	-	19.94
	11.	2nd shift revenue (calculated @ of 50% of revenue from 1 to 5)***	-	-	-	15.61(to be ignored when computing revenue under govt. management)	-	-	4.32#
Sub-total (10. + 11.)	12.	-	-	-	-	67.41	17.5	-	24.26
Fixed expense	13.	Personnel salary	-	-	-	-	137.84	-	143.52
	14.	Capital equipment	-	-	-	-	5.00	-	5.00
	15.	Utilities	-	-	-	-	x	-	x
Sub-total (fixed expense)	16.	-	-	-	-	-	142.84 + x	-	148.52 + x
	17.	Total margin (@ 15% of the total	-	-	-	-	-	-	22.3 + 15x/100

		fixed expense of the operator)							
Total Fixed Grant (16 + 17)	18.	-	-	-	-	-	142.84 + x	-	170.82 + 15x/100 + x
Total grant (Fixed grant + variable grant = 12 + 18)	19.	-	-	-	-	-	160.34 + x	-	195.08 + 15x/100 + x
Net outflow from the government (Total grant – total revenue)	20.	-	-	-	-	-	108.54 + x (here we have deducted only first shift revenue)	-	127.67 + 15x/100 + x (here we have deducted both the 1st & 2nd shift revenue)

Source: All the figures are from the cost-benefit analysis for Chaukhutia CHC in district Almora provided by the state government's PPP cell.

*Notes: *The average number of investigations has been calculated for both the O.P.D and the I.P.D. cases based on the HMIS data for the CHC. **These are the actual rates levied by the state government in its facilities. ***It is assumed that the private operator shall run an extra shift in the CHC in order to increase its variable revenue. In the cost-benefit analysis provided by the PPP cell the 2nd shift revenue has been calculated @ of 50% of the revenue generated in the first shift for all the services except accident services. Why accident services have been excluded in measuring 2nd shift revenue is not clear, hence we have simply followed the way it has been done by the PPP cell.*

#In the analysis provided by the PPP cell the extra cost due to the private operator because of extra investigations / procedures done in the 2nd shifthas not been included. We have added a cost of Rs 4.32 lakhs annually on that count over here.

Given the aforementioned assumptions and the fact that the expenditure on utilities cannot be in the negative, we can see that the net outflow of money from the government coffers is much higher when CHC is given on PPP mode. Presuming that the cost of the investigations and procedures to either provider is the same, the variable cost earmarked for the private operator has been kept artificially lower than that for the government. For example, while the revenue generated by the government is Rs 155 and Rs 2175 per case for ultrasound and maternity cases respectively, the margins for private provider for respective cases are only Rs 44 and Rs 65. May be in the beginning the private providers may quote lesser price for the investigations and procedures as this shall be over and above their assured margin from fixed grant, but in subsequent years they would definitely try to equal their variable revenue to that charged by the government. We have deliberately avoided factors like depreciation and tax deduction etc. to keep the scheme of things as simple as possible; besides, the rate of depreciation and tax deduction ought to be the same for both the providers.

Still the net outflow of money from the government under PPP as derived in Table12 is a gross underestimate because this does not take into account the salaries of the government engaged staff that shall still remain at the CHC. Apart from this, as has already been discussed, there remains ample scope for hiking of costs by the private provider due to the costs for a number of treatment procedures remaining undefined.

Taking all these factors into count there seems little scope for achieving the kind of results as shown in Table 10. But then this has been done, at least in the books and **Table 13** explains how.

Table 13. Differences in the costs under Government management and under PPP

Expenditure category	Under Government management	Under PPP
Electricity	4.0	4.0
Water	0.1	0.1
Miscellaneous expend.	13.8	2.5
Repairs & maintenance	12.0	6.6
Administration	8.0	1.0
Cost of soft furnishing	1.95	1.95
Cost of furnishing to be replaced every year	0.21	0.21
Total	45.36	21.62

Source: Cost benefit analysis for Chaukhutia CHC, dist. Almora done by PPP cell

Apart from the aforementioned differences in the costs between government management and under PPP, Rs 10.35 lakhs have been deducted from the total revenue generated from user charges by giving the reason that the government does not do optimum collection because of freebees, which is ultimately a loss to the revenue.

There are however quite a few contentions involved with the differential costing under government and PPP management. No plausible reason has been given as to why the miscellaneous expenditure under government management should be nearly 5.5 times that under PPP, why the cost of administration under government would be eight times than that under PPP or why repair and maintenance under government will be approximately double that under PPP?

On enquiring specifically from the state PPP expert, it was told that miscellaneous expenditure under

government included the expenditure for supervisory visits of state officials to the CHC or by the CHC doctors to more peripheral facilities. Does it mean then that such supervisory functions shall be given up once the CHC is managed on PPP mode; and if so, then how can it be possible to ensure that the private operator is fulfilling the functions that it is supposed to perform, or for that matter how will the government doctors at the CHC fulfill their responsibility for public health functions which necessitate visits to the field areas and supervision of PHCs and health sub-centers?

The higher repair and maintenance costs were alluded to informal payments that are involved in government set up. Likewise the presumed efficiency of the private sector was the reason forwarded for lower administrative costs under PPP.

It is important to ask here - why should efforts not be make to tackle these reasons when the same expenditure can be met at a lower cost?Deduction of Rs 10.35 lakhs as less collection risk amount from the overall revenues under government management while not doing so under PPP management is totally egregious here as in both the cases user charges shall be collected by the government. If government is wasteful in collecting charges under its own management then it shall also be inefficient in collecting user charges under PPP.

If we plough the above figures for cost of utilities and the 'less collection risk' into the net financial outflow of the government under government management of CHC and under PPP as derived in Table 13, then the respective figures we get are Rs 164.25 and Rs 152.53 lakhs i.e. the net outflow under government management becomes Rs 11.72 lakhs more per year. Hence the claim that the government stands to gain considerable financial mileage from the PPP proposal is simply misguided.

FINDINGS FROM A VISIT TO THE STATE TO ASSESS THE PPP PROPOSAL

The author made a visit from 1st to the 4th of May to the state specifically for assessment of Uttrakhand government's proposal to give 16 CHCs on PPP basis. Apart from the discussions with state level officials at Dehradun, visit was made to the CHC at Naugaon in Uttarkashi district and the CHCs at Pabau and Thailsen in Pauri district. Later visits were also made to two more CHCs handed over on PPP basis at Munsyari in district Pithoragarh and Kapkote in district Bageshwar as part of state monitoring visits to the state of Uttrakhand. The gist of the discussions held at state level, and with the doctors, technicians and employees at the facility level during these visits are being presented herewith.

THE PREVAILING CONFUSION

There remains a lot of confusion and apprehensions among the state health employees regarding the administrative structure that shall prevail at the CHCs once PPP is implemented, their own position in that structure and the roles and responsibilities of the private provider. Some of the questions in the minds of the health staff were:

- Who will administer the CHC?
- Will the existing staff of the CHC stay there or shall be transferred to other facilities? In case the staffs were to be transferred, many had apprehensions regarding the posting they will get.
- What specifically would be the responsibilities of the private operator? For example who would be responsible for handling medico-legal cases?
- How will the public health functions be carried out? Who for example shall be responsible for maintenance of the cold chain equipment; whether the private provider will assist in controlling an epidemic outbreak?
- Will the employees of the private operator cooperate with the government doctors / employees towards fulfillment of public health functions?

A meeting was held at the state health directorate at Dehradun on the 1st of May, 2013 to brief the CMOs, Medical Superintendents and District Program Managers of different districts of the state regarding the provisions of the PPP model for different CHCs. Towards resolving the aforementioned queries the following clarifications were provided in the meeting:

- The private provider shall be responsible only towards providing uninterrupted clinical

services, while the government doctors shall be responsible for managing the public health functions and the medical superintendent of the CHC shall continue to be the administrative head of the facility.
- The existing government's staff at the CHCs shall have the choice of getting themselves transferred to some other facility in the state or may even choose to work with the private operator.
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Well one cannot wish more that the things were really as simple as that. But that they are not was made amply evident by the numerous queries raised by the district health officials. For example, it was initially mentioned that there would be just two government doctors at the CHC – one medical superintendent and a GDMO who would be responsible for handling the medico-legal cases.

This immediately led to the question – that how can just one GDMO attend to medico-legal cases (MLCs) round the clock for s/he cannot be put on duty for more than 8 hours at a time? So it was decided that there shall be at least three GDMOs apart from the medical superintendent to perform 8 hours shifts each.

The government doctors shall not be primarily responsible for the clinical work, even though the state's Mission Director for NRHM said that no one shall prevent them from performing clinical duties if they wish to do so. However, there are unaddressed issues related to this:

- The MLCs at CHCs are few and far between and the government GDMOs shall have to be on round the clock duty to attend MLCs. With few MLCs and freed from clinical duties, not only will they be grossly underutilized, but may undergo deskilling over a period of time. It is questionable as to whether this would be acceptable to GDMOs and that they would not like to quit the job, leading in turn to the government losing its own manpower potential.
- Secondly, if the government medical officers will perform clinical functions, then will the private operator not like to make up for the lack of availability of doctors on his / her part by the services of government doctors? What shall be the reliability and terms of such a quid pro quo?
- The medical superintendent would be required to exercise overall administrative control in terms of ensuring that the private operator fulfills all of its obligations towards service provision; that there are no undue investigations or overtreatment of patients in order to increase the revenue due to the operator through variable grant.

It would be reasonable to expect that the medical superintendent cannot perform all of these functions unless provided the adequate technical and clerical assistance. There is no clarity over how much staff shall be provided to facilitate such functions.

Additionally, this lends itself to question as to how does an officer exercise supervision over a staff of which s/he is neither the appointing, nor the paying or the disciplinary authority. The staff of the private operator on their part can be expected to know better that their answerability is primarily towards the private operator rather than the government employed supervising officer.

WILL THE DOCTORS COME?

The reigning confusion among the doctors and the staff notwithstanding, there was a general opinion among the doctors and other health workers across the facilities visited that if this PPP would actually result in doctors coming to the facilities then probably this step should be welcome. But their own experience regarding the functioning of the existing PPPs in their districts betrayed a lack of confidence in such a possibility.

There are already mobile medical unites (MMUs) working on PPP basis in every district of the state. The private operators of the MMUs have to make available the services of specialists in internal medicine, pediatrics and a radiologist among others available to the far flung villages of the district through these MMUs. But the availability of the services of these specialists with a measure of consistency to the people in the far flung areas is a dream that is yet to come true.

Doctors at the CHCs in Uttarkashi district told that the operator of MMUs in their block, who has now been awarded the contract of operating their CHC as well, has been managing the MMUs in the block with the help of technicians and pharmacists alone and that such is the level of discontent of the people from their services that just a week before the author's visit to the CHC, in one of the villages people actually stoned the MMU staff.

The CMO in another district told that the MMUs run by the same operator as in the earlier case had been providing the services only for 15 days in a month in the district. The operator was reported to be always ready with excuses like the vans were to be serviced or some equipment was to be repaired. Medical superintendent of a CHC that is slated to go under PPP scheme in the same district volunteered that the MMU operator had till date failed to provide the services of doctors with consistency. He said – "Instead of specialist doctors they brought plain medical graduates, and fresh pass outs at that. When we demanded that the private operator show the degrees of the doctors and deposit a copy of the same, they would say we will get it next time around, and the next time they bring different doctors."

Somehow the district officials seemed helpless before the mechanizations of the private MMU operator and were resigned to things as they are. However, the Mission Director of NRHM (National Rural Health Mission) in the state told in Dehradun that the MMUs are functioning more or less satisfactorily and that the doctors are available at least 80% of the time.

There was another instance of a PPP that was presented to air doubts regarding the ability of the operators to bring in doctors. Very recently surgical outreach camps had been organized in the state where in private health providers were contracted in to bring their surgeons for the camps. The camps were widely publicized by the district health set-ups, only that the surgeons failed to turn up on time resulting in the district health administration losing face before the people.

One of the mechanisms being thought of as a way to get the specialist doctors to the hills is that since each package of the PPP process includes CHCs from the pain as well as the hill areas, may be the operator can rotate doctors between the CHCs located in the plains and those in the hills, such that no doctor is having to stay for long in the hill areas? But what may appear as a logical idea on face of it, may not actually work out that way. Treating patients is not just the physical act of examination, performing procedures or prescribing medicines; it is a team effort and entails a favorable chemistry between members of the team as also between the team and the patients or the communities to be served and this is something that can hardly be served well by rotating team members.

PERFORMING PUBLIC HEALTH FUNCTIONS

Execution of public health functions is a major area of concern that has been thrown up as a result of this PPP proposal. As has already been mentioned earlier, the RFP document does not encumber the private operator to be responsible for either performing any role or promoting government sponsored disease control programs / schemes.

Integrating preventive and curative roles of public health systems seamlessly is a laudable public health principle. However, the health in India is afflicted by a curative-preventive dichotomy which has resulted in distortions in the development of the health services in the country. In as much as a clear demarcation is envisaged in terms of private operator performing clinical functions while the government staff being responsible for public health functions, the PPP proposal shall end up institutionalizing this curative-preventive dichotomy, adding insult to injury.

Though never acknowledged as such, the basic understanding underlying such decisions is that ensuring clinical care is the primary task, while preventive care can be taken care of by ensuring immunization with the help of field workers like the ASHAs (Accredited Social Health Activists who are the peripheral most health workers under NRHM) and the ANMs (Auxiliary Nurse Midwives). Nothing could be a greater travesty of the concept of preventive care that requires a seamless continuum

between clinical treatment and disease prevention and who is better placed than the treating physician to impress upon the patients the need for adequate preventive measures to be taken by them.

But doing so entails conscious efforts in this direction; it ought to emphasize the involvement of clinicians in educating the field level staff and communities regarding the various aspects of disease control and engaging in problem solving vis a vis actual implementation of health programs. All this is negated by the rather simplistic notion that while the doctors of the private provider will take care of clinical needs, the government doctors and staff shall perform the public health functions.

Such a neat division of work is neither desirable nor possible, except at the cost of undermining the public health needs of the people, while the extent to which their clinical needs shall be fulfilled remains circumspect. For example, under the RNTCP (Revised National Tuberculosis Control Program) there is a provision for Senior Tuberculosis Laboratory Supervisor (STLS) to supervise the work of laboratory technicians to ensure the quality of sputum slides. A question that arises is – will the laboratory technician engaged by the private operator lend himself / herself to such kind of supervision, especially as the government disease control programs are not their responsibility?

There are also issues regarding treatment, for example the RNTCP program has well defined treatment protocols to be followed, or may be tomorrow the disease control programs for cardiovascular diseases or diabetes may come up with similar standardized treatment protocols. How will it be ensured that these protocols are adhered to by the doctors engaged by the concessionaire?

Given the way things are planned under PPP proposal even performing routine immunization may run into hiccups if not outright disruption. The cold chain equipment at the CHC is to be maintained by the private operator. The CMO of a district raised the query whether the operator shall in any way be responsible for immunization; and if not then why should management of cold chain equipment be under him? Why should the operator maintain equipment which he is not likely to use or draw revenue from? However, the CMOwas silenced by the rather short answer – this is how things are, you simply take the vaccines required for field immunization sessions. Such apprehensions should give us reason to wait with bated breath for the results to roll out.

At the moment there is a conviction among that state's health bureaucracy that everything shall fall in place as these CHCs are progressively taken over by the private operators. This however is not happening.

THE IMPERATIVE FOR TACKLING THE ROOT CAUSE

To begin with itself we have dealt at some length as to the real reasons for doctors to be reluctant to serve in rural / difficult to serve areas. Having gone through the details of the present proposal for handing over CHCs in the state on PPP basis, the question that still begets answer is – In what way does this PPP model address any of the real reasons for the unwillingness of the doctors to serve in the rural / remote areas of the state?

Perhaps the only response that can come up to this question is that the private operators hope to find doctors to serve in these CHCs by offering good salary packages, that too presuming they find doctors to go to these areas in first place. The chances of this happening anytime soon seem difficult at the moment, especially as the available experience of managing MMUs (mobile medical units); in the state clearly attests to the inability of the private operators to provide doctors in general and specialist doctors in particular with any consistency. One of the private operators – Rajbhara Medicare Private Limited, to whom Package 3 and 4 of PPP proposal has been awarded is already providing MMU services in the state and as already mentioned there have been many complaints against them.

The bidding process for awarding the contracts for all the four packages mentioned in Table 2 was completed in the month of May 2013 and the CHCs were to have been made operational within six months of award of contract. Till now however only 3 CHCs are reported to have been made operational,

of which also two (one at Bazpur in district Udham Singh Nagar and the other at Raipur in district Dehradun) are located in the plain areas of the state while one (at Naugaon in district Uttarkashi) is located in the hills.

The CHC at Bazpur has been in operation on PPP mode since 15th June 2013 and at the moment it is informed that all the required doctors, including the specialists are working at the CHC. However, the details of the functioning of the CHC in terms of the number of procedures being performed, availability of blood bank / storage units, diagnostic investigations, out of pocket expenses to the patients, cost to the government and the issue of rational treatment are not available. The Raipur CHC has been working on PPP mode since 15th of July; however, the operative procedures etc. have started only since about a month back, but in the absence of blood storage facility. Again other operative details are not yet available. The medical superintendent of Naugaon CHC informed that the private operator too over the operation of CHC since 15th of September and has till now managed only two graduate medical doctors and one graduate dental surgeon apart from 3 staff nurses out of the required 6 and other paramedical staff. None of the specialists have joined at the CHC as yet, but it is promised that by and by all will join.

The moot point here is not how many specialist doctors can be made available for how much duration through the PPP mechanism; but whether PPP is the right answer to the need for the state to bolster its capacity to provide primary and secondary level of integrated preventive, promotive, curative and rehabilitative services to the people in the state on an assured long term basis at a cost that is affordable to both the patients and the state?

At the moment there does not seem to be any example from either within the state or from other regions of the country or indeed from anywhere in the world where doing this has been possible in any substantive way for majority of the people through PPP mode. The more successful examples – may it be from the developed OECD countries with notable exceptions of countries like USA, or the developing countries like Cuba, Brazil, Venezuela, Sri Lanka, Costa Rica and Thailand that have made substantive progress in providing Universal Health Care to their populations show that the ability of the state to provide these services has been central to this success. Replicating this in India would mean breaking the elite capture of the medical profession and its nexus with the for profit market provisioning of health care in order to put the larger social motives of health profession on their feet once again.

Health in India is a state subject which gives them the right to design and implement initiatives in health care that are best suited to the interests of the commonest of the common people. Uttrakhand is a new state of India that was created in the year 2000 after separating the hill regions from the state of Uttar Pradesh. While there may have been a number of problems of finding financial and human resources to build the health systems in the new state, Uttrakhand also had the opportunity to start with a clean slate in this regard. There remains a possibility and a pressing need to initiate the following measures which can be helpful in remedying the medical manpower crisis in the state to a large extent if not totally obviating it:

- Till date the state lacks a proper human resource development policy for health sector. At the time of its creation the state did not have even one medical college. Now it has three, of which two are government medical colleges and one is private medical college. There is one more government medical college that is proposed to be started in the state capital Dehradun apart from an All India Institute of Medical Science which is being established under the aegis of the central government. However, the state government has no plan so as to leverage these existing or coming up medical colleges to ensure that they provide a steady stream of doctors to work in the underserved areas of the state.

There is a pressing need for the state to initiate formal policy for preferential admission of students from the hill districts and from socially and economically deprived sections to these medical colleges with full state support for their education in return for strictly imposed fool proof conditionality

of these students serving in the state medical services upon their graduation. But doing this is easier said than done given the fact that the state is finding it difficult to even get faculty and retain them for its medical colleges.

During the many visits to the state and interactions with medical professionals and health bureaucracy in the state the author gathers an impression that the growing private health sector in the state has played a proactive role in sabotaging the growth of government medical institutions. This points to the need for even exercising some proactive curbs on private sector to prevent such practices. However, the state itself has a lackadaisical attitude towards developing its own capacity. In fact Uttrakhand seems to be turning out to be the testing ground for large scale PPPs in the entire development sector.

- To maximize the potential of its own doctors there is a need for the state to look upon them as a valued resource that needs to be developed to serve the needs of the state and its people. However, this vision seems to be entirely deficient in states' health bureaucracy. As per discussions with doctors in different districts there is no thought out transfer policy for doctors to rotate them between the hill and the plain areas. Transfers are in turn handed out as a measure of political patronage or as punishments. This has evidently led to frustration among many doctors, especially those who are posted in the hills. There is a need for the state to develop a proper transfer policy and career progression policy for its doctors.

- Often care of the family and education of their children is an important concern for doctors while serving in the distant locations. These can be addressed to a large extent if the state has provision for building family hostels for health personnel in the bigger towns or district headquarters and a policy for ensuring the admission of the children to good schools while doctors are posted in remote areas. Such doctors can be given special leaves in between to spend time with families in between.

It is not as if these are exceptional measures unknown to the state machinery, but just that there is lack of sincerity to implement these effectively.

- Even though the efficacy of such measurescan at best be said to be partial, the state of Uttrakhand has not even implemented some of the most routine measures that are adopted by other states to encourage their doctors to serve in remote areas like offering substantive financial incentives to graduate and specialist doctors to work in difficult areas. The incentives offered are a pittance and make a laughing stock of government's sincerity of purpose. It ought to be borne in mind that when the government itself has encouraged private sector to become the dominant sector in health care, then it cannot ignore the desire of its doctors to be paid at levels close to those of private doctors if not exactly at par with them.

OTHER PPP MODELS FOR OPERATIONALIZING PUBLIC HEALTH FACILITIES

Among some of the PPP models for managing health facilities that have been much talked about are – running of PHCs (Primary Health Centers) by Karuna Trust in Karnataka, the management of CHC in Sabarkantha district of Gujarat by Shamlaji Hospital and the management of the Rajiv Gandhi Super-specialty hospital at Raichur, Karnataka by the Apollo Group. All of these have followed the Performance Management Contract / Contracting out models where in the entire management and operation of the facility has been handed over to a private party.

However, very few details are available regarding these models in the public realm by which to assess their success. For example a Planning Commission report mentions this about the Karuna Trust model: "Management of Primary Health Centers in Gumballi and Sugganahalli was contracted out by the Government of Karnataka to Karuna Trust in 1996 to serve the tribal community in the hill y areas. 90% of the cost is borne by the Govt. and 10% by the trust. Karuna Trust has full responsibility for providing all personnel at the PHC and the Health Sub-centers within its jurisdiction; maintenance of all the assets at the PHC and addition of any assets if

required at the PHC. There has been redeployment of the Govt. staff in the PHCs, however some do remain in deputation on mutual consent. The agency ensures adequate stocks of essential drugs at all times and supplies them free of cost to the patients. No patient is charged for diagnosis, drugs, treatment or anything else except in accordance with the Government policy. The staff salaries are shared between the Govt. and the Trust."[2]

There is no information on aspects like – what were the public health objectives set for this model? What have been the achievements against these objectives? There are no figures on the increase in the OPD / IPD cases or the number of procedures performed as compared to the baseline. Where from Karuna trust manages its share of 10 percent of the cost, if not by charging the patients? How does the trust manage to get its doctors where the government fails or is it that it manages the PHC with government doctors on deputation? Answers to these questions have and important bearing on the replicability / up-scalability of this model? The devil as they say lies in the detail, and when such details are not forthcoming, the claims of success of these models can at best be said to be presumptive and suited to justify a pre-determined economic agenda. To this extent our paper is the first one to present a micro-economic analysis of a PPP in health in India.

CONCLUDING REMARKS

There is a very famous dictum and a useful one at that – 'the whole is always more than the sum of its parts.' Unfortunately, the understanding of the Uttrakhand state's health bureaucracy regarding the proposal to give CHCs on PPP basis stands in negation of this useful dictum. It betrays an understanding that health outcomes can be made to order; that inherent contradictions in the PPP venture under question shall disappear by themselves or that we can afford to ignore them. Such naiveté can only work to the detriment of people's wellbeing.

The expectation of the state's health bureaucracy that we can put the clinical and the preventive care together as separate parts without interweaving them together and we shall get a seamlessly functioning integrated public health system is, to put it simply, day dreaming. Worse still, this scheme of things has every potential to set different health programs back in time, apart from the government ending up losing its given potential as well in providing primary and secondary level of clinical care to the rural population in the country.

There exists no example of a PPP wherein the private motive of maximizing profit has been reconciled to the more laudable social objective of providing care to the people irrespective of their ability to pay. Rather, the imposition of user charges and the consequent financial gains to be made by the government due to expected increase in footfalls at the CHCs upon functionalizing the PPP scheme is central to the whole scheme. The availability of a huge volume of literature from across the world to show how user charges have proved to the detriment of people's health, especially the poor seems to be of little consequence here.

There has been a rather crude attempt to build in assured profit for the private operators, but also to build a façade of cost benefit. Needless, to say that everyone involved in this shall make gains till the sun shines, but such mechanizations shall ultimately work to the detriment of the financial health of the state and given the talk of financial crunch that is increasingly gaining currency, the financial mechanism of this PPP scheme shall prove to be self-defeating. One can only hope that good counsel prevails on all concerned to put this PPP scheme on hold.

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