ofcourse they do not get cover in their older ages when they need healthcare most and insurance companies don't want them. For those who work social insurance like ESIS must be made compulsory and universal (no income ceiling barriers as currently). This will bring in all the resources needed to double public health spending and will also create a collective voice of class neutral beneficiaries who will demand an efficient working of the system.

● Finally the overall healthcare system in the country needs transformation if we have to move towards a universal healthcare system which is equitable and non-exploitative. Healthcare has to be removed from the market framework and needs to become a public good through a public health legislation. Once this happens a NHS kind of healthcare system can be evolved wherein the private health sector would get socialized and become an integral part of a healthcare system that is driven by public mandate.

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Fractured approach towards the critical public health sector

Tejal Barai – Jaitly

The recent, move by the Bombay Municipal Corporation (BMC) to bring on board private players to manage intensive care units (ICU) at civic hospitals in Mumbai is amongst the more recent public private partnerships (PPP) announced (Singh, 2018). The government will be giving around Rs. 25 crores over a period of two years to manage about 200 ICU beds. The cost of an ICU bed in the public sector for patients needing it is Rs. 200 per day. Through the PPP, the government will give about 10 times this cost to a private agency and how this ensures care for the poor is not clear. While the patient will continue to pay the original cost, clearly, such a move diverts funds away from the public sector towards the private. These are dangerous trends right in the face of clear and clinching evidence against PPPs in the health sector as in case of public health insurance schemes including Rajiv Gandhi Jeevandayee Yojana (RGJAY, now called the Mahatma Jyotiba Phule Jan Arogya Yojana) in Maharashtra and Seven Hills Hospitals (Wagle and Nehal, 2017; Godbole, 2018).

Is the public sector redundant?

Proponents of PPPs have commonly used the argument that the public sector is redundant, which is clearly not true. Public facilities continue to remain relevant and a sizeable population in the country still accesses the public sector in both rural and urban areas. According to the NSSO 71st Round, relatively high percentage of treatment at public hospitals was noted in the rural areas of Assam (84%), followed by Odisha (76%), Rajasthan (44%) and Tamil Nadu (42%). It was also high in the urban areas of Odisha (54%), followed by Assam (44%) and Kerala (31%) (NSSO, 2014).

It has also been argued that with insurance coverage through PPPs, services will be more accessible to the poor and people in rural areas and they are more likely to therefore opt for private sector services. The next section presents evidence against this.

Do Public Private Partnerships increase access?

Through continued government patronage, promotion and subsidies, the Indian private health care industry has expanded phenomenally and is now valued at $40 billion and is projected to grow to $ 280 billion by 2020 (GoI, 2017). Notwithstanding this achievement, it has failed miserably on several counts. Charitable hospitals have violated the legally mandated commitments to the poor that they were obligated to give in return for the free land and subsidies that they have received from the government (Kurian, 2013). Secondly, the private healthcare sector has managed to escape regulatory mechanisms that would make it accountable. Despite this entire context, PPPs continue to be promoted.

In a study by the Centre for Enquiry into Health and Allied Themes (Wagle and Shah, 2017) on the RGJAY in Maharashtra, revealed that the private sector was using the scheme to increase profits by selective promotion of procedures which were quick exits and therefore more profitable for them. Despite the schemes enrolment of the private sector, there was continued high accessing of the public sector; turning the theory upside down that insurance coverage would result in people turning away from the public sector and preferring the private sector. In Mumbai, for instance, there are more private hospitals empanelled under the scheme (19 public hospitals and 32 private hospitals under the scheme in Mumbai). Most of the pre - authorizations under the scheme were raised in Mumbai (37%); and more than half of these were actually in the public sector. There is also evidence that enrolling the private sector has not necessarily increased access to health services. Merely 12% of the total empanelled hospitals belonged to the 12 least urbanized districts of Maharashtra put together. In several districts it was found that even though the private sector dominates the proportion of empanelled hospitals, it has not been utilized. In Chandrapur, for instance, there were 9 empanelled hospitals under the scheme of which 8 were in the private sector and yet more than 90% preauthorizations from Chandrapur were outside the district. Also in terms of increasing access to rural and marginalized groups, lack of private sector presence in itself is an indicator of the fact that such a PPP would fail to increase access. Nandurbar , has more than 65% ST population, has only one empanelled hospital, which is a public hospital, and

no private empanelled hospital. Moreover, medical oncology is unavailable across 12 districts, intervention radiology across 17 districts and radiation oncology across 16 districts through the private sector under the RGJAY. There are also other critical issues that plague the scheme including continued high out of pocket expenses, whereas the scheme was envisaged as cashless. There was also evidence of poor quality of care and poor responsiveness towards a grievance.

The public health sector continues to be relevant and evidence indicates that it can be equipped to perform. Findings of a pilot study in Tamil Nadu revealed that post the strengthening the primary health care there was an increase in the utilization of the sub centers for outpatient services, reduction in the outpatient share of the private hospitals in the area as well as reduction in out of pocket expenditures (Muraleedharan, et al, 2018).

PPPs come at a high cost - worsening access for the poor and further jeopardizing the public sector marked by the movement of funds away from it. Critically, the government needs to reflect on its role in promoting these PPPs; as it continues to do so despite the fact that public private partnerships have led to the exclusion of population as against universal access.

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Public Private Partnership / P3s in Health Sector in India

Bijoya Roy

Introduction

Public Private Partnerships (P3s) in health sector in India has become popular and private sector is being increasingly seen as an alternative in meeting the provisioning and infrastructure gaps. Clearly a greater role of the private sector by mean of contracting out of services and in infrastructure development is being envisaged. Today the role of state is being restructured as a regulator and transferring of the management of the public entities.

At the international level, Sustainable Goal Development 17 (2015) places greater emphasis on partnerships to achieve the SDGs. In India third National Health Policy 2017 reiterates the need to involve private sector in achieving public health goals through contracting out, selective purchasing of services and private financing in meeting the infrastructure gaps. Increasingly, the expansion of P3s is justified on declining and scarcity of public financing for healthcare services (both infrastructure and workforce), more than 70 percent of the population accessing private sector both in the rural and urban sites and 'the private sector provides a complementary means to expand health services, products, and infrastructure'. Lastly, but not the least private sector realizes that public sector can provide links for their expansion in the underserved areas or to the marginalized communities. Overall, now there is a political climate favouring private investment, market expansion and P3s in the health sector.

P3s for Services and Infrastructure Gaps

Contracting-out and PPP of clinical and ancillary services that began as 'an innovation' by the end of 1990s within the public sector healthcare services is now in the process of further change. A second generation of complex P3 projects is emerging with the private sector participating in raising of capital, design, construction of public infrastructure, long-term management and delivery of services.

In 2017 NITI Ayog proposed P3 model based on Model Concessionaire Agreement to deliver services related to Non-communicable diseases at the district level, even though it was not later followed up. These are much complex long-term concession PPP models. It was not the first of its kind. There have been repeated attempts earlier as well to get into these kinds of ventures. In Uttar Pradesh in 2010 and 2016 the state government had invited bids based on Management Operation and Maintenance model for district level and below health services and Operate Maintenance Transfer model for primary health care respectively. Both of them are long-term concession model. Despite