Successes and Failures of Public Private Partnership (PPP) Initiatives in Bihar

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Abstract: *Evidence suggests that a significant proportion of people in India, seek health care from the private sector. However formal channels for tapping the private sector potential in a big way by the States like Bihar, has been absent till recent past. With the advent of the National Rural Health Mission (NRHM), there has been change in the strategy. Pro-people public private partnership has been identified as an area of concerted action in it. The paper enumerates the various PPP initiatives started by the Department of Health, during 2005-2009, the initial four years of NRHM in Bihar and tries to find out the reasons behind success and failure of such initiatives. The learning gathered from the successes and failures in Bihar has wider implications in terms of its applicability to the third world countries, apart from other high focus states in India.*

Evidence suggests that a significant proportion of people in India, seek health care from the private sector. The reasons are many. People's faith in public system has eroded over time. High absenteeism, low quality of clinical care, low satisfaction levels with the care and rampant corruption has led to mistrust of the public system and rapid growth of private sector (Hammer 2007). Inadequate managerial capacity to utilize the huge infrastructure of the public health care system has compounded the problem. Apparently prompted by the desire to increase access for more people, some of the State governments have recently favoured an increasing participation of the private sector in running the existing public health facilities' (Purohit, 2001).

Some of the states in India have been partnering with private parties for providing health care both for clinical and non-clinical for two decades. However, formal channels for large scale tapping of the private sector potential through PPP in states like Bihar have been absent until recent past. With the advent of RCH and the National Rural Health Mission (NRHM), there has been change in the strategy. The NRHM strategy includes promotion of public-private partnerships for gaining managerial efficiency and ensuring achievement of public health goals activities (Bhat 2007).

This paper proposes to list and examine some of the public private partnerships started by the Government of Bihar (GoB) mainly in the primary health care level (few in secondary and tertiary) during the first four years of NRHM (2005-09). The first part of the paper sets the context by discussing the factors and conditions that led to numerous experiments in PPP by the state, the second part discusses some of such PPP projects and the third part discusses the issues involved with the PPP initiatives, followed by recommendations to improve the situation.

This research was designed to capture perceptions of various stakeholders on PPP initiatives and its working in Bihar. Primary data for the paper has been collected by conducting semi-structured interviews with key respondents including government officials, programme managers, state based NGO representatives, private parties who were part of PPP, PRI members and beneficiaries. In total 26 key respondents, across 6 districts of Bihar were interviewed. The government officials and the programme managers were interviewed in their offices in the state capital and district headquarters where as NGO representatives, representatives of private parties, and the beneficiaries were interviewed in the health facilities i.e. district hospitals, CHCs and PHCs where services through PPP were being utilized. Key respondents were initially chosen judgmentally and later through snowballing. Beneficiaries were chosen at random at the facilities visited. Discussions with various stakeholders including people's representatives and beneficiaries helped in understanding the situation better and in the validation of information collected. The secondary data is based on review of various plan documents, including the National Programme Implementation Plan, the State Programme Implementation plans, government reports, and tender documents/advertisements, Terms of Reference (TOR) of projects, information obtained from State Health Management Information System (HMIS) and grey literature. Lack of journal articles on Bihar and specifically on PPP was a major challenge which was overcome by reviewing articles on PPP in other states of India.

I

in India, as in most other developing countries, private providers including voluntary organizations play a significant role along with the public providers in health care. The flourishing private sector is primarily because of a failing in the public sector. The Public spending on health in India is amongst the lowest in the world (about 1% of GDP), whereas its proportion of private spending on health is one of the highest. The cost of services in the private sector makes it unaffordable for the poor and the underprivileged. Despite higher costs in the private sector, there is growing lack of trust in the public system. Critical shortage of health personnel, inadequate incentives, poor working conditions, absenteeism, long wait, inconvenient clinic hours, poor outreach, time of service, insensitivity to local needs, inadequate planning, management, and monitoring of service/facilities appear to be the main reasons for low utilization. (Planning Commission of India 2007).

The government in its various policy documents reiterated the fact that 'a national effort to reach out to households cannot be sustained by government alone.' A partnership of non-government voluntary organizations, the private corporate sector, government and the community needs to be put in place (MoHFW, 2000). The Ministry of Health and Family welfare engaged in a few PPPs prior to RCH but it took up PPPs more actively in RCH-II (2005-10). One of the result indicators set for RCH II was to have at least 15 states to start engaging in such PPP initiatives in 2006 (MoHFW, 2005a). The NRHM strategy also includes promotion of public-private partnerships for achieving public health goals and pro-

people public private partnership has been identified as an area of concerted action (MoHFW 2005b). The NRHM guidelines sent to states and its flexible financing encouraged even weaker states like Bihar to experiment with PPP.

National Rural Health Mission brought an influx of funds which was unprecedented. The funds available through the treasury route have a huge salary component. Its second largest component is for construction of health facilities, but RCH-II funds came with restrictions on new constructions and administrative cost. Administrative cost including salaries of programme mangers was to be restricted to 6%. This left a large sum meant for programmes unutilized as most of the EAG states/High focus states did not have the capacity to utilize the funds. Bihar could only utilize Rs. 1.52 Crores in 2005-06 (MoHFW 2009).

"Bihar lacked human resources and technical capacity. The partnerships with private agencies and NGOs seemed a good way to implement multiple activities ranging from district level planning to running of mobile medical units and to also increase the expenditure", said a government official

Thus public private partnership though untested on a large scale in poorer states like Bihar, became prime strategy.

There was pressure from the political quarters of the newly elected government in the state too, to perform and provide primary health services to all. The newly elected Chief-minister reviewed the health programmes regularly (GOB, 2007). The CM also met the general public through his "Janata durbar (People's court)" where health was a prominent topic. (The Hindustan Times, 2008) Being always an underperforming state in health the department was under pressure to improve service delivery and experiment with new strategies. This served as the starting point of PPP initiatives. Though private corporate investments and partnerships in health in Bihar were almost non- existent, some good non- profit organizations and some private agencies were ready to take up the challenge.

II

"One of the earliest state governments to start public-private partnerships since the NRHM was announced was Bihar. In some areas this was introduced to provide pathology and diagnostic services, operate ambulances services in the state and run additional primary health centers (APHC)" (Das, 2007). Other areas where the private sector was engaged were outsourcing of hospital maintenance services, running of state and district data centers, contracting private specialists, sterilization services, 102 ambulances-Emergency Medical Services (EMS), 1911- doctor on call, preparation of district action plans, running of Mobile Medical Units (MMU). Table-1 gives details of some the PPP initiatives started by the state government in the first four years of NRHM (April 2005 –March 2009).

Most of the PPP started in Bihar were basically contracting. Contracting with private providers for health services delivery is often perceived as a possible mechanism for governments to "withdraw" or be selective in their commitment to health-care provision and

a way to improve efficiency of health-care provision by introducing market mechanisms. (Lönnroth et al., 2006). Most PPPs in Bihar were in non-core support services like cleaning, laundry, diet etc. a few were in clinical support services like pathology and radiology services. A couple of the contracting arrangements were for clinical services like sterilization services and running of APHC and Urban Health Centers (UHC).

Private public partnership can be defined in multiple ways. 'The key criterion in a partnership is collaboration among multiple organizations in which risks and benefits are shared in pursuit of shared goal…the core elements of a viable partnership are beneficence (joint gains), autonomy (of each partner), joint-ness (Shared decision –making and accountability) and equity (fair returns in proportion to investment and effort)' (Venkat Raman and Björkman,2009).

The MOUs examined for the purpose of this study show a shared objective, joint gains for government as well as the private/NGO provider. Though there are some elements of autonomy (e.g. decision to take up a particular facility, HR etc) , shared decision-making (provision for joint decision in case of problems) and equity in terms of fair returns in MoUs (private party gets reimbursement for all patients referred by government doctor, can charge outsiders at the market rate and in lieu the government facility gets pathology /radiology services without incurring any capital cost), the extent to which these are practiced remains doubtful and need to be researched.

Government of Bihar enumerated the objectives of PPP as strengthening the existing health system by improving the management of health within the government infrastructure, improving quality, accessibility, availability, acceptability and efficiency, exchange of skills and expertise between the public and private sector, mobilization of additional resources and widening the range of services and number of service providers(GoB,2008). The outsourcing of cleaning, laundry, maintenance of premises and generator etc. improved the management of health facilities. Doctors and paramedics were free from day to day management of such support services.

The service delivery through outsourcing/contracting made services available in far off places within the state of Bihar and was hailed as almost a miracle (Outlook, 2008). Pathology and radiology services were very popular. As per State Health Society in a period of three years 151 x-ray units and 407 pathology centers were set up all over the state, all the health facilities (district hospitals, CHCs and PHCs) had outsourced cleaning, maintenance and generators facilities. Approximately 3.5 lakh x-rays and 4 lakh pathological tests were carried out in the period of two years (2006-08) (GoB, 2008). Some of the PRIs and beneficiaries with whom the author interacted during the data collection expressed satisfaction in the fact that at least some basic services were now available to them.

"In past the health facilities rarely stayed open, now we have doctors and testing facility. Things have certainly improved." Said the health manager of the facility adding, "Progress is always relative. You cannot compare Bihar with other developed states like Tamil Nadu and Kerala. You have to see where we started. We started at a point where services were non-

existent, now we have something to show." Studies conducted in other low income countries also show that one of the main outcomes of contracting is expansion of access or service utilization (Cruz et al 2003)

Table1: Major PPP Initiatives in Bihar (2005-2009)

Name of PPP and type of partnership	Type of service/ level/ area	Private partner	Objective of partnership	Duration of contract	Year of initiation
Outsourcing of APHC Contracting out	Clinical & managerial/ primary/rural	NGOs/pvt firms	Provide basic RCH services and general OPD services	3 years contract	2006 And 2008
Generic Drug Store	Support services/primary, secondary and tertiary/ rural as well as urban	Private firms	provide Generic Drugs to patients at reasonable rates	3 years	2008
Sterilization Services	Clinical/primary /rural district headquarters	Janani, later more private providers	sterilization service in 19 districts with focus on Male sterilization	7 months initially, later extended	2007
Diagnostic Pathology services	Clinical Support services/ primary and secondary/rural	Sen Diagnostics and Central diagnostics,	Provide pathology services in rural Bihar,	3 years	2008
Radiology Services	Diagnostic support services/primary, secondary and tertiary	IGE medical Systems, Silvassa	Operate and maintain x-ray and ultrasound facility in government t hospitals (facilities in districts to be connected to medical college in Patna, where Central Reporting System has been established to be developed into tele-radiology (in two years 151 x-ray units established)	10 years	2006
Emergency Service Network for ambulances	Advanced Ambulance services/urban	Ziqitza Health Care Limited,	setting up Emergency Service Network in Patna having advanced and basic life saving ambulance services	10 years	2009
Dental clinics	Clinical	Individual Dentists/firms	Establish dental units in government hospitals	5 Years	2008
Urban Health Centres	Clinical services/ primary/urban slums	NGOs and private firms	OPD and RCH services	5years	2008
Ultramodern Diagnostic centre	Advanced diagnostic pathology and radiology services /Tertiary medical college hospitals/urban	Doyen Diagnostic and research foundation, Kolkata and Soft line Media Ltd	Set up and operationalize modern Diagnostic Centres through Public Private Partnership (PPP) in select Government Medical College Hospitals of the State. And Regional diagnostic centre in 9 regions	10 years	2008

Source: Programme Implementation Plan (SPIP), Bihar 2008.

Most of the PPP initiatives listed in Table 1 make an attempt to serve the BPL patients. The services of pathology and radiology, when referred by the government doctor are free. There is no user fee for APHC or UHC services. Sterilization services are free of cost and the beneficiary is paid the compensation as per the GoI norms. The generic drug store has to sell the 188 drugs (as per list given by GoB) at 50 per cent of the MRP printed on the generic drugs. The advanced diagnostic centers and the dental clinics charge rates which are below the existing market rates. However further research is needed to assess the impact of PPPs on public health services and whether PPPs are really bringing equity in health access.

The attempts made under RCH and NRHM to increase access was supported by flexibility in planning and execution embedded in its framework and also encouraged innovative ways to improve service delivery. The structure of the State Health Society (SHS) created to implement NRHM facilitated faster decision making. The government system required a decision to pass through minimum 6-7 levels, where as in Society structure it was hardly 2-3. These factors led to planning of many projects within a short span of time, and majority of them were executed through PPP. Technical specifications or medical issues were discussed with heads of departments of medical colleges. As the Principal Secretary headed all the departments including health and family welfare, Medical education as well as the State Health Society (as CEO) support across the departments on medico-technical issues were easily available.

However the SHS had limited technical capacity in managing PPP or contracting as the programme officers had no prior experience. Moreover no support was taken from professionals /technical bodies having expertise in PPP. MoUs were vetted by the legal experts who safeguarded the interests of the state government but couldn't make the MOU comprehensive or balanced for providers /PSPs.

III

The PPP projects widened the service provider base, and made services available to people in need. However a close scrutiny of issues associated show that for each project that came to implementation stage, there was at least one project which either didn't go beyond its tender advertisement or was scrapped off within a year. 'The ambulance contract ran into trouble right at the outset and had to be suspended. The pathology laboratory started contracting out the work and I have heard complaints from members of patient welfare committees in Bihar that government clinics are now ordering many more investigations than they did before. Yet another story relates to partnerships to run additional primary health centres. Some 30 such clinics were handed over to non-governmental organisations (NGOs) in 2006. I heard complaints that the government did not release money on time, or that funds being given to NGOs was much less than what was being spent in a similar government institution. I learned that these contracts were not renewed this year.'(Das 2007)

Discussions with various stakeholders brought forward multiple reasons. Hasty Planning with no market survey for available services and its cost, inadequate knowledge and

experience in government about planning and executing projects in service delivery through PPP, prevented many projects from taking off. Faulty planning without in- built mechanism of monitoring and assessment led to many controversies.

A major problem with planning was typical "Cookie –cutter approach" where almost all the initiatives were implemented in all the districts, in all the facilities. No distinction was made between the districts which already had the services. No concessions were made for such pre-existing situation. E.g. many hospitals had good pathology or radiology facilities with trained staff operating them but even those facilities were contracted out rendering the trained government staff either idle or engaged in a non-technical work. A more careful planning would have led to better utilization of existing resources within the government system.

Another problem was the way the Private Service Provider (PSP) was decided. The most preferred route of deciding a PSP has been tender. While a good tender process ensures transparency and selects a good PSP, reliance on price as the only criteria, given minimum criteria related to turnover is fulfilled, defeats any attempt to distinguish between a seasoned, high quality standard reputed firm and a novice not understanding the nuances or the know-how of the project.. Tenders were awarded in most cases on the basis of lowest quote or to whosoever agreed to work on the rate given by government. Bihar also faces the problem of not having good PSP willing to work on PPP projects. Due to lack of providers many tenders get cancelled, many end up being given to not so worthy ones. E.g. A computer firm was awarded a contract of health service delivery. Moreover minimum turnover in many cases kept the well meaning small NGOs out of the fray. Quality of services provided by the PSP suffered because of low cost-criteria and negotiations carried out with the finalists of tender-process. Most of the reputed big private parties never bid and many bids were cancelled and were re-advertised because of single bidder.

The projects which crossed the initial hurdles found themselves in the maze of red tape. There were inordinate delays in payments/reimbursements in most cases. Commenting on these issues An NGO partner said:

> *"We were part of one of the schemes which failed. The government is trying to revive it again. The hassles of working with the government are too much. I would not wish to be a part of it anymore. There are inordinate delays in payments, some local officers expect their palms to be greased to make payments, and such a PPP is a drain on my organization's resources. We are happy to work separately."*

Moreover frequent transfers of bureaucrats led to change in the mode of working as the new incumbent came with new ideas. Many changes during the course of the project on hindsight led to disputes between the private party and the public partner as the tender did not include the change in costs or planning as the private party had not included those new things in their planning or cost. Though some of the bureaucrats had excellent vision, those who succeeded them had no clue, leading to untimely demise of many PPP projects and increase in complications in many others.

Commenting on the lack of clear vision among planners, one of the senior officials said that:

"Though most people want something good from the PPP, they are not clear about what good they want. Until you are clear about the good and picture it in detail, how can you get someone to implement it?"

PPP was seen by the resource poor state as a panacea for all ills. On ground level it was transferring all responsibilities to the PSP. The Government's responsibility seemed to end with finalization of TOR and contract. One of the key respondents admitted:

"State lacked the resources needed for proper monitoring of PPP projects. Officers think that there duty ends with the signature on the dotted line of agreement and drawing of TOR, but they fail to understand that it is the beginning. The officials bother about finding out what is going on only when bills are to be paid. There is no handholding which should be an essential part of PPP in such a state. "

Moreover the terms are dictated by government, there is no real partnership. The symbiotic relation which should have been the base of the PPPs was missing. Commenting on the prevailing lack of trust a respondent said:

"Many believe that private parties are only interested in profit and do not hesitate to use unfair means. Most NGOs in Bihar lack the capacity to deliver, existing only on handful of staff. Many exist only as a means of income and not for providing service to public. Hundreds are blacklisted every year by CAPART. There is much distrust which is necessary to overcome for a meaningful PPP"

Another respondent commented:

"The government has to shun its distrust for all the NGOs. NGOs too have to show results by implementing the projects. Only criticizing the government is not going to be of any use. Implementation in a poor state is a huge challenge in itself. A state like Bihar lacks basic systems and amenities; it is difficult to get good private parties to work in the rural areas where there are no roads, no electricity. Skilled Human resource is scarce. We are trying to improve the situation. Government has to provide support to the NGOs."

Discussions with stakeholders brought political reasons too. A stakeholder commented:

"Many projects were started to make the political bosses happy. There were no consolidations or strengthening exercises to make the projects sustainable. It was more like hopping from one case to other at break-neck speed."

An experienced NGO partner said

"There is pressure on the top officials to perform and start new things. The political bosses are happy to inaugurate and get press-coverage. Nobody is concerned about the real results."

Decentralization of decision making powers to local levels was absent in many cases which led to bizarre situations. In one of the district hospitals, hardly 100 kilometres from state

capital, there were three X-ray units in adjacent rooms-one run by the government staff which didn't charge any fee from patients, second run by a charitable trust at subsidized cost and then came the third through PPP because the state government had entered with an MOU with the PSP giving rise to much confusion and controversy. The District Health Society depended on the State to make most decisions. Rogi Kalyan Samities (RKS) at many places existed more on paper as they hardly ever met.

Though many of the facilities had one or many of the outsourced/contracted services, very few private providers opted for the far-flung and hard to reach facilities. For e.g. though tender-bid was floated for all APHCs (approximately1100) of the state only a few of them were taken up 36 in first phase and 40 in second phase. X-ray units and pathology units were also concentrated near the district head quarters and less in the periphery. Though the average number of facilities increased but 'health and development cannot be seen only in terms of averages because differences across regions and within them may be very sharp. Thus the true test of equity and universal access would mean that irrespective of geographic, financial and social differentiation healthcare is accessible to all and this gets reflected in reduced class and geographical differentials of health outcomes' (Duggal 2005)

The situation might seem far from satisfactory but in a big state with 38 districts where development has always remained a problem, everything cannot become perfect overnight. The government as well as the PSP is hopeful, as a representative from a PSP commented:

> *"The situation is difficult but we are not ready to give it up. The guidelines change every few months and we have to comply. But future might be different. It is learning by doing and we will learn from our mistakes. At least a beginning has been made"*

Above observations about PPP is not new and is found to be prevalent in most developing countries and have been widely written about. Partnership between parties who were historically opponents is not an easy task and more so in health sector. There are a number of constraints to building partnerships in health and these include the availability of an adequate number of players in the market, the framing and content of MOUs; the administrative and organizational capacity of the system to define roles and regulate these partnerships; the impact of these partnerships on comprehensiveness and equity (Baru 2008).

In order to address the lack organizational capacity and to provide regulation particularly for infrastructure the state has enacted Bihar State Infrastructure Development Enabling Act, 2006 and the Infrastructure Development Authority (financial, service and technical) regulations 2007. The government declared Infrastructure Development Authority (IDA) to be the nodal agency for all PPP activities. (The Economic Times, 2009) Roles envisaged for IDA are that of a consultant to a department and advisory body for departments on PPP or other projects (GoB, 2007). However infrastructure related PPPs are structurally and functionally different as infrastructure has physical output while those in service related health sector are intangible in nature. IDA framework cannot suit the Health PPPs. Detailed policy guidelines and regulations needs to be made to cater to the peculiarities of PPP in

health sector. HOSMAC (a private agency) has been given contract setting up State Health Resource Centre for providing consultancy services for PPP initiatives of the State and is expected to come up with exhaustive guidelines

(The Telegraph 2010).

Having adequate number of PSPs in the state has always been a problem. Only a handful of NGOs in service sector exist. The private sector is skewed in favour of urban areas, economically better-developed states and within states in districts that are economically more prosperous (Baru, 2005) so the government in the poorer states will have to try harder to woo the prospective PSPs. Developing incentives system to influence the desired geographic distribution of health facilities, and in specified areas, involving qualified providers through contract mechanisms in rural areas to improve the health delivery care system are some of the options (Bhat 2000).

As PPP is no alternative to poor governance and leadership (Ghanashyam 2008), government has to build its capacity. If a government does have the capacity to contract for clinical services, it is likely that it will also have the capacity to deliver those services directly itself. Given the somewhat mixed evidence on the effectiveness of contracting in promoting greater efficiency or higher quality, developing country governments may be well advised to restrict contracting-out to those services where it is clear that they have the capacity to manage contracts and that contracting-out will be beneficial (Bennet and Mills 1998)

The PSPs providing radiology and pathology services collected user charges as fixed by the government. However concerns about the poorest being not able to avail the paid facility led to removal of all the charges for all patients visiting government facilities from this financial year. The Evidence also show that user charges deter those whose health needs are greatest (Creese undated). PSPs will now be paid by the state government. Payment of all the tests being performed in the government facilities is likely to weigh heavy on state. The options for charging those who can afford to pay, to finance those who cannot, should be explored for sustainability of such efforts.

The state should have a Strategy Development Unit within State Health Society with qualified and experienced personnel to plan, and study feasibility of PPP as suggested by the Task Force on PPP for NRHM. (GoI 2008) It also suggests prioritizing of districts so that districts with higher needs could be taken up first. Piloting of a new project to know the practical problems should always be done before scaling it up in all the districts. Monitoring and periodic evaluations of projects should be clearly spelt out during the planning phase. Capacity building of personnel looking after PPP in government needs to be taken up as a priority. The state should also provide required training to the staff employed by the PSP as they too are part of the health service delivery system.

In order to learn from the PPP initiatives and to make it evidence based further research evaluating the impact should be undertaken. It should not only assess the impact on access, but also equity and quality which are often neglected.

PPP is a very useful strategy for achieving public health goals provided the parties involved understand the symbiotic relation and its true spirit. Whether Bihar can make use of this strategy to improve its health service delivery and strengthen its systems remains to be seen. The public is enthusiastic about the recent changes and expects more from the government and PSPs.

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