Jan Swasthya Abhiyan

(Peoples Health Movement – India)

Health for All - Now! **Health is a Basic Human Right!**

Comments by Jan Swasthya Abhiyan on the Niti Aayog's scheme to link new and existing private medical colleges with functional district hospitals and the related 'Concession Agreement Guiding Principles for Setting up Medical Colleges through PPP'

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Summary

The proposal, as detailed out in the document on Niti Aayog's website, entails providing "exclusive right, license and authority to augment, operate and maintain the District Hospital and provide Healthcare Services and design, finance, procure, construct, operate and maintain the Medical College (the "Concession")" for a minimum of sixty years as per terms and conditions set in the model agreement.

There is only a very brief justification provided for introducing this scheme: "India has a dire shortage of qualified doctors. It is practically not possible for the Central/State Government to bridge the gaps in the medical education with their limited resources and finances. This necessitates formulating a Public Private Partnership ("PPP") model by combining the strengths of public and private sectors. Accordingly, a Scheme to link new and/or existing Private Medical Colleges with functional District Hospitals through PPP would augment medical seats and also rationalise the costs of medical education."

Both these premises are questionable (detailed below), and further there is no reason to believe that the proposed scheme will address these issues. On the other hand the situation could be worsened by this scheme. JSA's contention, based on a close reading of the scheme, and the draft concession agreement, is that this scheme is drawn up as an avenue for corporate investment and profits in health care and this includes investment by global capital. There is also a further implicit aim to re-shape the health sector as a sector that runs along the lines of corporate industry, with profit maximization rather than health outcomes as its goal. The whole proposal is violative of the spirit of universal health care. It also violates the government's own National Health Policy of 2017- which promises free drugs and diagnostics and free care for all in the public hospitals, and prioritizes building up of public hospitals and engagement, and secondarily with not for profits for fulfilling all secondary and tertiary health care needs.

It does seem that pressed by financial crisis due to huge additional expenditures on defense and national security on one hand and the economic slowdown on the other, the government is looking at public hospitals and public health services as a source of revenue rather than as the fulfillment of commitments of a welfare state. And further in a period of economic slow-down it is re-creating the public hospital as a site for capital investment for both Indian and foreign capital. In doing so it is removing the district hospital from the ambit of the primary healthcare approach and making it part of a corporate monopoly industry.

Comments:

1. The first premise in the introductory note is that there is a dire shortage of doctors, which is itself not true. Moreover, no differentiation is made in this rationale on the availability of general physicians, specialists or super-specialists. There is no doubt a dire shortage of doctors in many states, but there is also a surplus in many other states. Some states should in fact be calling for a freeze in expansion of private medical colleges. At no point is there any indication of prioritization of states and regions such PPPs must come into being.

2. The second premise is that the gap cannot be closed by central and state financing alone. Yet there is no reason to believe that what government spends by way of grants, and bank loans would necessarily be less. There are serious doubts whether bank loans to corporate agencies to set up such institutions would "perform" or add to non-performing assets. The proposal clearly anticipates that it could do the latter and has made provisions for both debt re-financing and insolvency management. Here it is pertinent to point to the failures of similar PPPs in many parts of the world including in England[1], Sweden[2] and Lesotho[3]. It is ironic that as the world's biggest experiment in health PPPs in England (Private Finance Initiative) is brought to an abrupt end by the government there due to mounting negative impacts on the public purse and wide scale failure to deliver value for money[4], Niti Aayog is proposing an even riskier model at an even larger scale with no reference to an evidence base on how this would work for the public good or the public exchequer. The cost of Sweden's PPP hospital has doubled in cost to the government and is now known as the 'most expensive hospital in the world'[5]. The PPP hospital in Lesotho was estimated to have cost half the nation's health budget in 2014 and in 2017 cost double the affordability threshold agreed by the government and World Bank[6].

3. The introductory note also states that the proposal is based on "international best practices, and similar PPP arrangements that are operative in the States of Gujarat and Karnataka". The basis of "international best practices" is without any evidence, as most of the evidence is of failures of such PPPs globally, as seen in the examples

[1] https://lowdownnhs.info/explainers/50-failures-in-nhs-outsourcing-2013-2019/
[2] https://phmovement.org/wp-content/uploads/2018/07/B5.pdf
[3] https://www-cdn.oxfam.org/s3fs-public/file_attachments/bn-dangerous-diversion-lesotho-health-ppp-070414-en_0.pdf
[4] https://www.theguardian.com/uk-news/2018/oct/29/hammond-abolishes-pfi-contracts-for-new-infrastructure-projects
[5] https://eurodad.org/files/pdf/1546956-history-repppeated-how-public-private-partnerships-are-failing-.pdf
[6] https://eurodad.org/files/pdf/1546956-history-repppeated-how-public-private-partnerships-are-failing-.pdf

given in the above point. Moreover, in India we are unable to locate any experience in Karnataka that it could be based on. The closest one- in Raichur was a dismal failure on which internal government assessments are available. This proposal is very similar to the "Gujarat Adani Institute of Medical Sciences" model in Bhuj, Gujarat. This model had a high government investment and the Adani's also brought in a Rs 100 crore investment- but after 10 years it still has a cumulative deficit- which the government may or may not be covering. And this is after it has been charging Rs 3 lakh per medical student and Rs 8 lakhs for an NRI student. Moreover, for Adani which has a Rs. 24,000 crore investment in that district of Gujarat, this was well within its CSR obligations. Even when within Gujarat the scheme was sought to be expanded to six districts (Tapi, Dahod, Panchamahals, Banaskantha, Bharuch and Amreli) there have been no takers for this. The scheme is therefore likely to be attractive only to the largest corporate powers and that too with high government investment. It could also be for attracting foreign investors.

4. One of the clauses of concern is Article 43.3 that states that in case of disputes, agreement it would be referred it to arbitration along the lines of International Arbitration Processes. This is of concern as the usual provision in such agreements is to state which High Court would be the scene of regulation. We are therefore concerned as to a) whether foreign investment is being actively sought and b) whether it will get aligned now or later with multi-lateral treaties like the RCEP which would make it obligatory for government to push this approach across all districts.

5. We are extremely concerned that this PPP re-invents the public hospital and the medical college as a corporate activity measured by its revenue generation. The agreement says that the "concessionaire" or agency awarded the contract would be given a grant in the form of equity support (Article 27). At many places the agreement is clear that it is dealing only with entities that are of corporate character- having shareholders that raise equity and that has a board of directors. Since it is such a corporate agency, the shares can be traded on the market and even ownership can change, subject to government being informed and/or approvals for major changes. After a period of some years the Private partner would be sharing the profits/dividends that accrue from the revenue generated by the hospital. The exact formula of computing the proportion of revenue to be shared is complex and its implications are of great concern.

6. The government proposes to handover the hospitals at an extremely low fee with additional grant in the form of equity. The "concessionaire" has to pay rupees one crore (though in section 28.1 it erroneously mentions rupees one) with an annual increase of only 5% for the first seven years and subject to a gross ceiling of 50% of Gross Revenue. For the subsequent years one 1% of the revenue would be shared with the authority. These rates are extremely low and allows "concessionaire" to show lower revenue earnings in its balance sheet and pay even less. There is no mention at any point of health outcomes that can be expected in the revenue sharing agreement. It is clear that no such performance indicators are expected. The agreement (Article 5.1; xvii) indicates that the services made available should be as per Schedule P. But Schedule P is currently blank. The proposed payment mechanism also allows the agencies to maximize earnings by rejecting the most difficult cases which are costlier to treat and also deny treatment to free patients or regulated patients and only cater to low cost, secured cases for people who are willing to pay higher fees. Thus payment

system would accentuate some of the typical problems of crème skimming that the private sector is so typically characterised by. It also creates possibilities of exclusion of most needy and deprived section of patients for whom the last resort is to seek treatment at the district hospital.

7. One of the most problematic clauses in the model agreement is that the patients shall be categorized into 'Free Patients' and all others (22.1.2). The division of patients into two categories based on the ability to pay goes against both national policy as well as international commitment of the country towards universal health care. To be a 'free patient' one would need a specific authorization certificate from a district health authority (22.2). Such "means testing" before the provision of free services (as proposed in this agreement) has been shown in the literature from all over the world to reduce access to deserving persons.

As per the agreement the 'Free patients' can be provided free consultation, free drugs and diagnostics, but even they would have a Rs 10 registration charge (29.1.2). All other patients would be charged at "market competitive rates" and in fact the hospital "shall be entitled to demand, charge collect, retain, appropriate Hospital Charges, based on market competitive rates" (29.3). However there is some obfuscation around the charges for OPD, since in some paras it states that hospital charges will be as per Schedule S (29.1.1 and 29.3), while in another it states that out-patient care is free (23.4.1). Clearly as many clauses show, the model has user fees, and that too at 'competitive market rates' as the core and further hopes to generate substantial revenue from such user fees.

8. Further all in-patient beds are to be categorized into "Regulated Beds" and "Market Beds" (23.7.1). If there are 900 beds, 480 would be market beds and 420 would be regulated beds. These market beds would be provided on market competitive rates. The 'regulated beds' are implicitly for patients who are covered by PM-JAY or other insurance. So though it is stated as 'free' care, the payment for these patients would mostly come from government itself. Therefore any impression given in this model agreement that the private entity would be providing completely free services to a proportion of patients in lieu of the concessional treatment is false. Further there is a clear emphasis that these free beds will allow patients required for teaching/training purposes to be admitted.

9. The agreement hands over the land and all assets of the district hospital to the concessionaire for sixty years (3.2). At the end of 60 years there is a provision for extension. On the medical college even this return to government after 60 years is not stated and clearly the intention seems to be that the medical college can keep the land and assets in perpetuity. The lease agreement for the site of the medical college would be for 99 years at a highly subsidized lease rent of "8% of the circle rate of the land" (10.1). Further, if it wants, it can buy land and build its own medical college hospital and keep that too. It is possible that there may already be an existing medical college hospital which will be linked to a district hospital. Indication of the possibility for an existing private medical college to be part of this scheme has been made in the introductory note on stakeholder consultation. This model agreement also makes provision for affiliation with private Nursing Institutions for which the private entity will be entitled to collect revenue (26.3). It is incomprehensible how the proposal to hand over public facilities and public land to private entities for sixty years, i.e. for a

whole generation is being made. This means that for the whole generation, people will be at mercy of this 'revenue generating' model.

10. The government doctors can be given on deputation to the private management to serve in the district hospital as well as in some teaching functions (5.16.2). The private entity will reimburse the staff costs to government, other than medical expenses (5.16.3). But, as per clause 5.16.5, if they join the medical college as its regular staff, they can be relieved from government services. The lack of faculty is a crisis that most private medical colleges face and therefore this seems to be a rather convenient approach for private medical colleges to attract, test and retain the best of public hospital staff, at terms that suit them best. This is a win-win situation for the private medical college and a loss for the public sector.

11. There is some provision for three of the many public health functions of the district hospital. But none of these are convincing. They are as follows:
1) Forensic and medico-legal functions (5.18): The agreement just states that this would be the responsibility of the concessionaire. But most of these would be private owners and it remains to be seen whether their opinion has legal standing, and whether they have the required lack of conflict of interests that the public officer is expected to have.
2) Medical Emergency Response (18.8 and 18.9): There is just a contention that they should be required to help during disasters and other emergencies. There is an added clause that the government can appoint an officer to command the hospital in such an eventuality- but these are completely untested statements.
3) National Healthcare Programmes (23.10): There is another bland statement that they would play a role in all national health programs. But there are many programs that require constant interaction and guidance between district hospital staff and primary care providers, and many functions which require substantial time of district hospital doctors and specialists. How is the 'revenue generating' entity expected to provide such support?

12. Article 29.1 states that the agency will be "entitled to determine and recover charges from the use of any Ancillary Facilities, which the Concessionaire can provide to third parties on commercial, sub-license basis" for the following services (listed in 3.1.3):
(a) vehicle parking;
(b) cafeteria;
(c) boarding and lodging facilities for the Free Patients, Patients and their attendants;
(d) [pharmacy];
(e) [any other commercial facilities]; and
(e) other facilities that may be approved and/or notified, in writing, by the Authority from time to time during the Concession Period.
These facilities are critical support for patients and their families. But the private entity will be able to determine and charge costs for use of these Ancilliary services (29.5). Therefore even a 'Free patient' would be at the mercy of commercial enterprises for their accommodation etc. and this model agreement gives complete freedom for "any commercial facilities" to be introduced within the campus. The provision of free or subsidized drugs has also been kept vague (23.5) and upto the discretion of the Concessionaire, with a similar vagueness in the provision of free diagnostic services (23.6). These provisions will result in high out of pocket

expenditure to the patients and increase incidences of catastrophic health expenditure. The Niti Aayog seems to be unaware of the government's claims towards ensuring financial protection to patients and instead it finds acceptable to promote the charging of "market competitive rates" to patients coming to a district hospital!

13. It is concerning that in the section on 'use of information' (5.14) there is no mention of ownership and privacy of patient data, the protocol for the use of such data in research, the protection of such data from being sold to commercial entities or even used by the Concessionaire for its own commercial interests.

14. With regards to infrastructure and facilities to be provided (23.1.2) and doctors to be ensured (23.4.2) for provision of healthcare services by the concessionaire, the use of the word 'adequate' is too vague a concept in medicine and health care. This kind of vagueness prevents pinning any accountability on the Concessionaire.

15. The management board has no public representatives and is clearly reflective only of equity/shareholder interests- with government itself being a minority share-holder. There is no attempt at community engagement of any sort.

The really big problem is the Niti Aayog's complete failure to understand that the district hospital is the apex of primary health care approach- and not a surrogate of the medical college. It is charged with the health of the population of the district- not only of those who seek care in the hospital (like sick newborns who die at home). The entire system of revenue generation would be loaded against such relationships. The more the in-patients, the more the district hospital and medical college "succeeds". But in the approach that is required, what is known as the primary health care approach, the actual incidence of patients requiring secondary and tertiary care procedures should go down. Clearly no one has explained to the Niti Aayog the difference between primary level care (which may or may not involve the district hospital) and primary health care approach- where the district hospital has a central role.

The private medical colleges are also not geared towards providing the right kind of doctors- for medical seats are also seen as revenue generating and sharing activities. Student fees are seen as one of the main sources of revenue- and other than the inadequate safeguards available under the existing acts, there is nothing to ensure that we would be producing the sort of human resource that is required, and where it is required.

The Niti Aayog has completely failed to recognize the reasons why user fees are not seen as a desirable and why market based mechanisms of service delivery is rejected across the world. The only exception is the USA, and even there it is contested. But it is only to this discredited model that we are being pushed. The proposal is all about ensuring the right of the agency to charge "market competitive rates" than about financial protection.

Tax based public financing of healthcare as a goal of health policy is for all practical purposes abandoned with this proposal. Instead we are entering an era of the transfer of public assets to private hands for private profits, with government earning a share of such profits. This is a dangerous and ideologically driven proposal with no

rationale or evidence base to support it. This proposal is against the recommendation of every national expert committee or policy statement or policy committee that has ever been constituted, though it is in line with a few international consultancy/expert proposals and recommendations. This in itself is a matter of great concern.