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The political economy of public private partnership in healthcare

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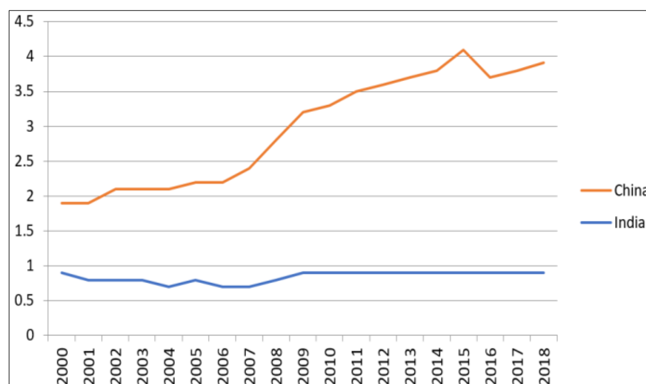
Abstract
United Nations defines Partnerships as voluntary and collaborative *relationships* between various parties working together to achieve a common purpose. However, definitions like these tend to be mechanical, reduce the complexities involved in such collaborations and the context in which such partnerships and collaborations happen. Focusing mainly on the logistics and typology, these operative definitions downplay the role of power networks that exist and define a partnership. Despite the scale and significance of the phenomenon, there is relatively limited conceptualization and in-depth empirical investigation regarding the nature of Public Private Partnerships (PPP) in healthcare. Often advocated for their ability to provide high-quality services at significantly lower cost; they have also been criticized for fostering private financing for public services. This paper is an attempt to understand the political economic processes that have led to global rise of PPPs and understand how neoliberal policies have enabled its burgeoning growth. It will look into the role of global consultancies and multilateral institutions in advocating this shift in the developing countries.

Keywords: political economy, public private, healthcare

Introduction

Indian health-care system is a mix of public and private services; however, the dominance of the private service providers is palpable. As per the NSSO report of the 71st round, private health care services account for as high as 79% of the overall utilization of services in the rural areas. This dependency on the private sector for utilizing health services, takes a huge toll on the financial stability of poor households in India, often leading to catastrophic health expenditures. A chronic underinvestment in health by the government is the most important reason for the lack of availability and access to public healthcare services, subsequently leading to very high out of pocket expenditure. Figure 1 represents how the government's health expenditure has remained more or less stagnated in the last 15 years. In comparison, the neighbouring country China, has consistently been increasing government's expenditure towards health leading to a more strengthened health system and much improved health indicators.



Source: Global health observatory, WHO [1].

Fig 1: Government health expenditure as % of GDP

Given the overwhelming presence of the private sector in health, various state governments in India have been exploring the option of involving the private sector and creating partnerships with it in order to meet the growing health care needs of the population. Health Policy documents going as far back as the first five-year plan have been stressing on the role of non-state actors in providing healthcare in India. Private sector, including voluntary organization (VOs) were engaged with the government in a few programs, especially family planning and in some cases in maternal and child health. Private sector was also used in increasing community awareness about epidemics and epidemics management in diseases like TB, leprosy and malaria (Duggal, 1988) [4]. However, with the advent of NRHM and the Reproductive Child Health Program (RCH), the role of both for profit as well as not for profit non state actors became even more important as NRHM strategy includes promotion of public-private partnerships for achieving public health goals. RCH II clearly identifies PPP as one of the strategies to meet the health goals. Similarly, the NRHM strategy 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 (GoI, 2005).

PPPs have also been promoted as an important development financing mechanism in support of the Sustainable Development Goals (SDGs). SDG 17 outlines a vision for partnerships between governments, private sector and civil society, and delineates these as 'inclusive partnerships built upon principles and values, a shared vision, and shared goals that place people and the planet at the centre, are needed at the global, regional, national and local level.' It is assumed that collaboration with the private sector in the form of Public-Private Partnership would improve equity, efficiency, accountability, quality and accessibility of the entire health system. Advocates argue that the public and private sectors

can potentially gain from one another in the form of resources, technology, knowledge and skills, management practices, cost efficiency and even a make-over of their respective images (ADB, 2000) [2].

Neoliberal directions of public health: the global political economy of PPPs

The 'The Roaring Twenties' witnessed immense economic growth for America and its allies. However, the bubble finally burst leading to closure of banks and industries, loss of jobs, reduction in wages, mass hunger and illness [2]. The 'New Deal' to save the economy relied on the Keynesian principles of economy advocating greater public investment to stimulate demand. The coming decades saw the strengthening of Keynesian economics in other high-income countries, led by the rise of welfare state in Britain. Public health was one of the biggest beneficiaries of the Keynesian policies as public investments in social sectors improved the living conditions of people. Virtues of social medicine were advocated by prominent voices from public health as well as the civil society. In his seminal book titled "Condition of the Working Class in England", Engels presented a macabre account of the living and condition of workers in England.

The Chadwick Report of 1942 and the Sanitary movements that followed in Britain offered tangible proof of success for the social medicine approach. However, the success was short-lived and the economic recession of the 1970s and the following reforms redirected resources away from social sectors. The decade of 1970's is arguably the most eventful decade in of the 20th century for public health; it was a decade of Alma Atta and the formation of a global consensus that health for all will be achieved by ensuring universal primary healthcare. It was also the decade of the oil crisis, the decline of Keynesian policies and of the welfare state; it was the same decade when the free-market experiment was started after the assassination of Salvador Allende in Chile (Klein, 2007) [12]. The decade was also a witness to the bolstering of the free market economic philosophy championed by Thatcher in Britain and Regan in America. The philosophy was built on the ideas of Milton Friedman and the Chicago school and is popularly known as Neoliberalism. A stream of economic thought which considers the state and its organs as obstacles to economic and social development (Navarro, 1988) [19]. It advocates limited state intervention even in social sectors proposing that market forces if allowed to work independently will cure the chronic problems of inequality, hunger and disease. However, the claims of the neoliberal doctrine are yet to materialize, according to David Harvey;

> "Theory of political economic practices that proposes that human well-being can best be advanced by liberating individual entrepreneurial freedoms and skills within an institutional framework characterized by strong private property rights, free markets, and free trade. Furthermore, if markets do not exist (in areas such as land, water, education, health care, social security, or environmental pollution) then they must be created, by state action if necessary, but beyond these tasks the state should not venture. State interventions in markets (once created) must be kept to a bare minimum" (Harvey, 2005) [6].

The belief that neoliberalism facilitates accumulation of wealth to a few is not even contested by its proponents, however, they argue that the wealth eventually trickles down to the poorest of the population. Neoliberal economic policies give power to global corporations through its economic policies that favour reduction of government spending on public services and withdrawal of state regulations on health, labour and environmental practices (Holloway & Parmigiani, 2014).

One of the major milestones in the globalization of the neoliberal ideas was the implementation of the structural adjustment policies in developing and least developed countries from and after the 1980s. Structural Adjustment Programs are a package of conditions the World Bank and the International Monetary Fund (IMF) attach to loans to debtor countries with the objective of helping these countries pay off earlier loans by restructuring national economies. To qualify for the loans, countries have to submit to the economic recipe prescribed by the WB and IMF. Typically, the components of SAPs are promotion or introduction of free-market policies, reductions in import restrictions, advancement of exports, privatization of public industries, relaxation of State controls, credit restrictions, wage controls, cutbacks to the public sector - particularly health care and education. In 1990, nearly one third of the World Bank's $22 billion budget went to SAPs that begun in the early 1980s. In an in-depth analysis of the socio-cultural context of such programmes, Kanji and others argue, 'SAPs serve to exacerbate inequalities and threaten to reverse the social gains of the majority achieved through the struggle for independence, in the interest of the indigenous capitalist class' (Kanji *et al*., 1991) [10].

The public private partnership model of health has been endorsed by several global agencies associated with public health. International aid agencies and foundations (USAID, 2002) [27] mostly fund available literature advocating the need for PPPs. They are symptomatic of the ceding of authority of the state to the private sector since the fall of the welfare states. There is no clear agreement on what does and what does not constitute a PPP. The European commission defines it as "the transfer to the private sector of investment projects that traditionally have been executed or financed by the public sector" (European Commission in IMF, 2004) [9]. The PPP model has long been used in different countries for carrying various development projects, but their advent in the field of public health is not an old phenomenon. The Public private ventures in world health have essentially been brought and nurtured by philanthropists, two in particular; the Rockefeller Foundation and the Bill and Melinda Gates Foundation (WHO, 2004). The International AIDS Vaccine Initiative (IAVI) was the first product development PPP that was created after concerted efforts of the Rockefeller Foundation from 1994-1996 (Ibid).

One filling the gap left by the other, private bringing their intellectual superiority, business efficiency and management principles and the public providing the resources or the provisions to utilize that expertise (Reich, 2002). But, this benign and beneficial side of PPPs are yet to be demonstrated. Health activists and researchers have criticized partnerships for diverting resources from public actions and distorting public agendas in ways that favor private companies. Any partnership essentially means equitable sharing of objectives, efforts and benefits, essentially an equitable sharing of power. However, the role of the government in a PPP raises serious doubts about the balance of power (Ibid). Nevertheless, the most obvious incongruity lies in the objectives of the government and the private entities, government's objective is to ensure social justice (at least ideally)

and the private company's objective is to make money. In addition, most often-social justice does not contribute to accumulation of profits for a few. In addition, governments have to be regulators as well as partners, which is a very tight rope to walk. How does one facilitate and regulate at the same time?

Public health scholars have also argued that the private sector firms approach local governments in low-income countries with the message of power sharing, but once the process is in motion the interests of the community are often overwhelmed by those of the most powerful member of the partnership-the private sector firms (Miraftab, 2004) [17]. One of the most apparent disadvantages of the public private partnership model is the obfuscation in roles and responsibilities of different actors in the global health arena. UN agencies, governments, multinational corporations, philanthropic foundations and NGOs are all called 'partners'. The fact that these actors have different and possibly conflicting mandates, goals and roles has been lost in the present context (Richter, 2004) [24].

Public private partnerships: conceptual and normative architecture

Even though the term 'Partnership' is widely used to express some form of a collaboration between entities, there is hardly any agreement on 'how to define a partnership'. The Task force on public private partnerships, constituted by the GOI, defines 'Partnership' as,

> "a collaborative effort and reciprocal relationship between two parties with clear terms and conditions to achieve mutually understood and agreed upon objectives following certain mechanisms" (GOI, 2009) [21].

Venkat Raman and Bjorkman have sifted through various definitions to deduce three broad themes that are overarching in a partnership: mutual benefit, commitment to agreed objectives and sense of equality between the partners.

However, the nature of partnerships has changed and the PPPs that exist today would cease to be called partnerships if they are to be judged on these parameters. The most basic conflict lies in what each partner desires from a partnership. While for the private and non-state entities, it is the pursuit of profit, for the state, it is welfare and providing healthcare to its people.

It is also argued that PPPs have the capacity to deliver high-quality services to consumers and the government at significantly lower cost, which would be impossible for public investment and government provision to provide (IMF, 2004) [9]. It is interesting to note that the people in need for health services are referred to as consumers, signifying the ideological moorings of the PPP model itself. It is a neoliberal model that commodifies health and brings in private businesses to trade freely in health, with no respect towards the social justice and equity aspect of health. Although on the face of it, the public private partnership model looks to combine the benefits of the state provisions as well as market dynamics.

According to IMF there is a lack of fiscal and accounting standards for PPPs, essentially meaning that it will be very difficult for public agencies to fix accountability in case of a PPP (IMF, 2004) [9]. Profiteering of the private has often impinged on the public benefit, it is the balance of power in the partnership that decides the impact they would have on public health. In reality, Private sector firms approach local governments in low-income countries with the message of power sharing, but once the process is in motion the interests of the community are often overwhelmed by those of the most powerful member of the partnership-the private sector firms (Miraftab 2004) [17]. One of the most apparent disadvantages of the public private partnership model is the obfuscation in roles and responsibilities of different actors in the global health arena. UN agencies, governments, multinational corporations, philanthropic foundations and NGOs are all called 'partners'. The fact that these actors have different and possibly conflicting mandates, goals and roles has been lost in the present context (Richter, 2004) [24].

Despite the scale and significance of the phenomenon, there is relatively limited conceptualization and in-depth empirical investigation. Their advocates argue that by promoting increased diversity of provision and contestability, such 'partnerships' secure better-quality infrastructure and services at 'optimal' cost and risk allocation (Kwak *et al*., 2009) [13]. Critiques of PPP also argue that PPPs are part of a shift towards 'welfare pluralism', representing a trend towards private financing and provision which fosters access for multinational companies to markets in public services (Birch & Siemiatycki, 2006). The criticisms of PPPs, however, have not dented the ways large international organisations view their potential. Within the health sector, the introduction of PPPs sits at a nexus of concerns with unleashing large amounts of private money to solve particular kinds of health problems (ignoring others), building a focus on personal responsibility for poor health, and a wider movement looking at health systems and the ways in which they help build provision of health and right. The World Health Organisation has reinforced the importance of taking broader social determinants of health approach, which includes looking at gender issues, arguing this must sit alongside the need for money to advance goals. The implication of this for some of the critical engagements with PPPs, forms of development assistance and approaches to the SDG agenda need analytic attention.

Although conceptually a public-private partnership (PPP) can be defined relatively simply, as "a long-term contract between a private party and a government agency, for providing a public asset or service, in which the private party bears significant risk and management responsibility" (World Bank, 2012), there is variation in practice based on the separation of ownership and risk-bearing between the public and private sector actors. Additionally, it is suggested that working with private sector companies may allow public sector organizations to access idiosyncratic resources and capabilities in seeking to realize more innovative responses and, for instance, improved health services quality (Kivleniece and Quelin, 2012) [11].

Some authors argue that public sector organizations often assume sub-ordinate roles in PPPs which may trap them into post-contractual 'lock-in situations' considering the length of these contracts (Lonsdale, 2005) [16]. Grout (1997) [17] notes that when private companies are mainly remunerated for successful delivery of services, their incentive structure focuses on cost minimization and not on service enhancing activities.

The network of relationships in a 'typical' PPP includes technical and financial advisers, funders and investors, government departments and users of public assets and services (Ramiah and Reich, 2006) [23] and it is widely asserted in the literature that these PPP networks differ from other inter-organizational

relationships and hence a different skillset is needed for managing them (Noble and Jones, 2006) [20]. Somewhat ironically, given that their avowed purpose is to access the additional capabilities of the private partners, several research studies note the problematic impact of asymmetric skills between public and private actors (Akintoye *et al*., 2003) [15]. While public actors were found to have limited abilities to engage in strategic planning with private actors, private actors have been criticized for their purely commercially driven outlook of public-private partnerships.

Public Health scholars have often raised the concern that in their eagerness to address market failures and pursue international public goods PPPs are often structured so that the public sector absorbs the lion's share of the risks and costs, while the private sector absorbs a disproportionate share of the profit (Stansfield *et al*, 2002) [25]. PPP comes across as a first step towards privatisation of the entire subcentre, PHC, CHC and district hospital system. PPPs in health have already seen the costs of institutional births and the number of caesarean sections rise for many households.

Evolution of public-private partnership in India

In the 1980s, with an economic crisis facing India, there was a substantial increase in the utilisation of medical services in the private sector, with explicitly governmental support. The 1983 National Health Policy for the first time proposed to expand healthcare provision through the private sector. The Sixth Plan (1980-85) also suggested utilisation of the private sector. In 1986, the hospital sector was recognised as an industry, which meant that financing was available from public financial institutions. Customs duties on high technology medical equipment were reduced. What ensued was a rapid, unregulated, expansion of commercial medical services not only at the primary but also at the secondary and tertiary levels. Until this time the private sector was largely characterised by individual doctors or small groups of providers practising in nursing homes. These providers could not afford the capital cost for cutting edge technologies, which were found in government-run tertiary care centres (mostly medical college hospitals) or in the better endowed charitable trust hospitals. Under this scenario, at least in theory, specialised medical care was made available to all regardless of their socioeconomic position.

Privatisation coincided with huge developments in medical technology. At the same time, governmental outlays for health were stagnant and even declined. Over the years, the government had reduced its expenditure on health and it had fallen from 3.30% in the mid-1950s to 1.80% by the beginning of 1980. Public sector hospitals had insufficient funds to keep pace with technological advances. Private hospital enterprises like the AHG (followed by others like Max, Fortis and Wockhardt), entered the space. All have employed the strategy of lobbying the government for concessions, promising free or subsidised treatment for a percentage of patients – a promise unkept. For example, the twelfth report of the Public Accounts Committee 2004-2005 (Fourteenth Lok Sabha) which deals with allotment of land in Delhi at concessional rates to hospitals, observes, “Ultimately, what was started with a grand idea of benefiting the poor turned out to be a hunting ground for the rich in the garb of public charitable institutions.” Simultaneously, government hospitals have seen an obvious decline in infrastructure, qualified personnel, and patronage of most sections of society–except perhaps the poorest. According to the National Sample Survey 60th round, more than 70% of expenditure on healthcare in India is met out of pocket.

PPPs in national health programs in India

The world bank supports public private partnerships in 76 countries with the underlying rationale that PPPs can help improve service delivery and the provision of basic infrastructure, including for the poor (World Bank 2005) [28].

Developing countries like India have witnessed a rise in the number of market forces participating in public provisioning. However, the rise in not backed by evidence for the social and political benefits of increased participation of market forces. Rather, their rise backed by neoliberal economic policies is often due to the lack of a perceived alternative and/or the powerful pressure on governments by international lending agencies.

Perusal of the policy papers of such institutions, especially the World Bank corroborates this claim. In a discussion paper brought out by the Health, Nutrition, and Population (HNP) group of the World Bank’s Human Development Network, four key policy recommendations were made:

Policy Recommendation 1: The Government Should Strengthen Its Public-Private Partnership Capacity

Policy Recommendation 2: States Should Contract Out the PHCs

Policy Recommendation 3: Devise a Strategy for Improving the Performance of Informal Providers

Policy Recommendation 4: Promote Sustainable and Affordable Health Insurance

As far as the government’s policy on PPPs in healthcare is concerned, there seems to be an incongruity or a shift in government’s position. The task force on PPPs emphasized the role of PPPs at the primary level of care in India in providing basic healthcare to all citizens. It recommended that the secondary and tertiary level care should be kept out of the PPP framework (GOI Task Force). However, the national health policy 2017 takes a polar opposite position stating that:

“…free primary care provision by the public sector, supplemented by strategic purchase of secondary care hospitalization and tertiary care services from both public and from non-government sector to fill critical gaps would be the main strategy of assuring healthcare services.”

However, the invasion of PPPs can be seen across the three levels of care in India. While in states like Andhra Pradesh and Gujarat secondary and tertiary level care has been either contracted out or being run in partnership with private hospitals, in Uttar Pradesh, the state government has contracted out the primary, secondary and district level centres in four districts to private players.

The 1960s and 70s witnessed a rapid expansion of the public sector in the developing countries including India. In contrast during the 1980s and the 1990s there was a widespread attempt to limit states involvement in the economy and privatization was the key agenda (Hemming and Unnithan, 1996) [7]. However, the decade of and after 2000s saw a decline in the pro privatization

narrative and a rise of the partnership agenda. This turn towards privatization and subsequently towards a partnership of the private with the government has happened with a larger economic, social and political structure of neoliberalism. An ideology led by a group of economists and philosophers who met at Mont Pelerin under the guidance of Friedrich Von Hayek advocated for the role of the market in ensuring individual liberty (Mirowski *et al*, 2015) [18]. Milton Friedman later adopted and improved upon these ideas in 'Capitalism and Freedom' (1962) and 'Free to Choose' (1980). 'Free to choose' was also adapted as a ten-part television series advocating free markets. Essentially neoliberalism has developed as a stream of economic thought which considers the state and its organs as obstacles to economic and social development. However, Evidence that market-oriented health services are more efficient than public health care systems, however, is not even to be found in countries such as the United States, with its already highly market-oriented health care system. Partnerships are voluntary and collaborative *relationships* between various parties, both State and non-State, in which all participants agree to work together to achieve a common purpose or undertake a specific task and to share risks, responsibilities, resources, competencies and benefits (UN, 2003). However, definitions like these tend to be mechanical, reduce the complexities involved in such collaborations and the context in which such partnerships and collaborations happen. Focusing mainly on the logistics and typology, these operative definitions downplay the role of power networks that exist and define a partnership (Miraftab, 2004) [17]. Conceptually there exists a lot of ambiguity or to be more precise a lot of overlapping when one attempts to define what is 'public' and what is 'private'. As the nature of the state-market relationship has evolved over the years taking it current neoliberal form, the nature of 'public', 'private' and the interconnectedness between the two has also adapted accordingly. The big push for PPPs came from the OECD countries, advocated by change agents like management consultants and multilateral banks through the NPM route. State agencies contemplating institutional change or strengthening systems often enlist the services of management and accountancy consultants, who have been instrumental in the inclusion of new management techniques from the private into the public sector. They have played an important role in packaging, selling and implementing NPM techniques.

Even though the template for PPPs in infrastructure development in the earlier days and subsequently in health services was exported from OECD countries, the way they were conceptualized, negotiated, formed and implemented have varied tremendously in different countries (Larbi, 1999) [14]. A key difference in the public-private partnership approach in India today and earlier such initiatives around the world is that those were implemented in times of economic crisis when state funding for the health sector needed to be reduced. India, on the other hand, has experienced unprecedented economic growth post liberalization and hence the rationale of lack of funds as one of the determinants of introducing PPPs doesn't really fit in the Indian context (Das, 2007).

Discussion

Public private partnerships in health raise very important ethical questions on the role of the private sector in public health. Where does the ultimate responsibility of ensuring health and well-being lie? Can corporations be awarded rights similar to individuals, and if such rights are accorded to them then how will accountability and responsibility be fixed? How will social justice and profit accumulation co-exist? What role the state would play; of a regulator, provider or facilitator of services? These questions have no clear answers, but the positive change claimed to be brought by PPPs is yet to be demonstrated with evidence. Public Health scholars have often raised the concern that in their eagerness to address market failures and pursue international public goods PPPs are often structured so that the public sector absorbs the lion's share of the risks and costs, while the private sector absorbs a disproportionate share of the profit. The Indian health policy and planning documents have praised the PPP model, but the model adopted is riddled with contradictions.

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