

EDITORIALS

Effective public-private partnership in healthcare: Apollo as a cautionary tale

GEORGE THOMAS¹, SUNEETA KRISHNAN²

¹St Isabel's Hospital, Oliver Road, Chennai 600 004 INDIA email: george.s.thomas@gmail.com ²Women's Global Health Imperative, RTI International, San Francisco; University of California, Berkeley; 114 Sansome Street, Suite 500, San Francisco, CA 94104 USA email: suneeta.krishnan@gmail.com

Very few in the medical fraternity, if any, would have been surprised by the Delhi High Court panel finding that Apollo Indraprastha Hospital, New Delhi was not honouring its mandate to provide 33% of its beds free of charge to the poor and indigent. In 1986, the Delhi Administration invited proposals to establish a multidisciplinary, super speciality hospital on "a no profit no loss" basis. Two years later, the government leased prime property to the Apollo Hospital Group (AHG) on a token payment of one rupee a year, to set up the Indraprastha Hospital. The hospital is a joint venture with the Delhi government. By the terms of this agreement, the government provided 15 acres of land and Rs 16 crore. In return, the AHG agreed to provide free services to patients occupying at least one third of its 600 beds and to 40 per cent of those seeking outpatient care (1). A landmark public-private partnership (PPP) was thus embarked upon. A review of the terms of agreement clearly indicates that the expectation and agreement were not for the AHG to render "charity" or even to engage in corporate social responsibility. Rather, the Delhi Administration had established a legal obligation for the AHG to provide certain clearly specified services for its citizens in return for a substantial financial subsidy to the company. In practice, the AHG failed to provide any such service.

The media image of Dr Prathap C Reddy, the founder of the AHG, which has been in large part carefully crafted by the Group itself, credits him with having brought modern multidisciplinary super specialty care (henceforth called high tech care) to India for the benefit of patients. Much media coverage has been focussed on the AHG as the pioneer and leader in high tech care in India. More worrying is the fact that policy makers hail the Apollo model as something to be emulated. For example, speaking at the launch of Apollo Reach, the venture by the AHG into small towns and rural areas, the prime minister, Dr Manmohan Singh, said: "Dr Prathap Reddy is a role model for many in the medical fraternity who aspire to emulate his example." (2) Coming from a person who is not only the prime minister, but a noted economist, it may be read as a sign of government intentions for the medical care sector. In this article we argue that commercial, for-profit entities such as the AHG are primarily for the benefit of shareholders and cannot be effective partners in a public-private linkage to provide accessible, equitable care.

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 (3). 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 (3). 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 (3). 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." (4) 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.

Problems of privatisation

The increasing concentration of high tech care in the private sector has also been accompanied by ethically questionable practices such as kickbacks to doctors referring patients for expensive investigations like computerised tomography (CT) scans.

Although government medical colleges have ceased to be the last word in difficult medical problems and are limping on with rudimentary infrastructures, the quality of care provided by private hospitals such as Apollo remains unstudied.

The AHG and others of its ilk ushered in an era dominated by the corporate hospital model, that is, a company whose business is medical care, whose stockholders profit from people's illness. Given the motivations underlying for-profit provision of medical care, we do not believe that it was reasonable for the government to have expected the AHG to meet its obligations (5). Moreover, evidence has been accumulating on the adverse health impacts of medical care privatisation. By the 1990s, it was evident that health disparities were on the rise. The Working Group on Health Care Financing (6) states that paying for medical care is a cause of indebtedness in 3.3% of the population. By the time the National Health Policy of 2002 was drafted, it was apparent that 13 of the 17 goals articulated in the 1983 policy were unmet (7). Yet, remedial action on the part of the government was not forthcoming until very recently. The Qureshi Committee which insisted that the government enforce agreements with private sector providers was formed only in 2006 followed by the current judgment levying a fine on the AHG.

Healthcare delivery in India: the way forward

There is no doubt that the public sector model of medical care as practised in India has not met the expectations of patients. The major reasons for this failure are cogently summarised in the National Health Mission document that provides a framework for implementation (8). They are: poor infrastructure, poor human resource planning, poor financial planning and excessive bureaucratisation.

It is notable that both The National Rural Health Mission (8) and the draft National Health Bill 2009 (9) emphasise PPP for delivery of tertiary medical care. It is clear that utilising non-State abilities in delivery of healthcare can be a powerful tool. The question is how to properly use this tool. The Working Group on Health Financing lauds the success of PPP with SEWA in Gujarat, which has been developed and controlled by the people themselves (6). Other observers have also come to the conclusion that direct participation by the users themselves is a good way to ensure success in a public-private partnership (10). We argue that the AHG's failure to meet its obligations to offer free and subsidised care is inevitable in a society where regulatory frameworks are poorly implemented, and a for-profit entity will do all it can to maximise profit.

Regarding medical care, India is a country of tremendous disparities, where the wealthy have access to the most sophisticated treatment options, the poor die for want of basic ones. On the one hand, treatments that entail a recurring expenditure of over Rs 1 lakh a month are now easily available in all the metropolises. On the other hand, pregnant women still die for lack of access to basic surgical facilities. For the political class, these treatments are often provided free in return for favours granted or to be granted at the cost of the public exchequer, this is an important cause of the impunity with which the AHG has ignored its obligations. This kind of politician-industry nexus is unlikely to change in the near future, which is another argument against PPP of the Apollo kind.

Conclusion

Considerable public action – from government as well as from civil society – is needed to make equitable provision of high tech care a reality in India. First is the need to regulate the expansion of the private sector. The role and nature of subsidies and PPP needs careful scrutiny. As noted by Muraleedharan and Nandaraj, "very clear incentives for businesses to make contributions" are needed in the context of PPP; that said, carefully designed and implemented PPP have – successfully improved access to care, reduced costs, and enhanced effectiveness of service provision (11). Second, substantial improvements in the enforcement of laws and regulations pertaining to the registration, licensing and accreditation of medical care practitioners and various types of medical care institutions are urgently needed. Rational expansion and establishment of medical care facilities is critical – ample data demonstrate the abundance of care providers in urban compared to rural areas. Third, there needs to be far greater attention to the quality of care provision. The drafting of the Indian Public Health Standards, the National Health Bill, the National Rural and Urban Health Missions are steps in the right direction.

A concerted effort is needed to ensure that the challenge of equitable and fair access to medical care is addressed in India (12). The present system of providing the most rudimentary services in the government sector and leaving hightech care largely in the private sector is completely unjust, especially when public funds are used to subsidise private providers, as was done in the case of the AHG. Public-private partnerships can be an effective means of providing rational, affordable and comprehensive care to the entire population, provided that the private partners are chosen with care. Current evidence suggests that the best private partners are the not-for-profit entities like self-help groups. Instead of a misplaced enthusiasm for corporate bodies, the government would do well to heed the advice of its own creation, the National Rural Health Mission, and depend on them to take its stated agenda forward. Or else we will see the same drama played out, only too common in India – public subsidy, private profit.

Acknowledgment: *The authors are grateful to Amar Jesani for comments.*

References

1. Staff reporter. Court directs Apollo to provide free medicines to poor and needy patients. *The Hindu* [Internet]. 2009 Sep 23 [cited 2009 Dec 28]; New Delhi: [about 2p.]. Available from: <http://www.thehindu.com/2009/09/23/stories/2009092354760400.htm>
2. Prime Minister's Office- speeches [Internet]. New Delhi: National Informatics Centre, Government of India. PM launches Apollo Reach Hospitals; 2008 Sep 5 [cited 2009 Dec 28]; [about 2 screens]. Available from: <http://pmindia.nic.in/speech/content.asp?id=710>

3. Lefebvre B. Bringing world class care to India: the rise of corporate hospitals. In: Vaguet A, editor. *Indian Health Landscapes under Globalisation*. New Delhi: Manohar and Centre de Sciences Humaines; 2009.
4. Public accounts committee, Ministry of urban development. Twelfth Report (2004-2005) Allotment of land to private hospitals and dispensaries by Delhi Development Authority. New Delhi [Internet]: Lok Sabha Secretariat, Government of India; 2005 Apr [cited 2009 Dec 28]. 77p. Available from: <http://164.100.24.208/ls/committeeR/PAC/12threp.pdf>
5. Bhat R. Issues in Health. Public-private partnership. *Econ Pol Wkly*. 2000 Dec 30; 35 (52): 4706-16.
6. Ministry of health and family welfare. Report of the working group on health care financing including health insurance for the 11th five year plan [Internet]: Government of India; 2006 Oct [cited 2009 Dec 28]. Available from: http://planningcommission.nic.in/aboutus/committee/wrkgrp11/wg11_rphfw3.pdf
7. Ministry of health and family welfare. Health Activities- National Health Policy 2002 [Internet]: Government of India; [cited 2009 Dec 28]; 36p. Available from: <http://mohfw.nic.in/np2002.htm>
8. Ministry of health and family welfare. National Rural Health Mission- meeting people's health needs in rural areas, frame work for implementation- 2005-2012 [Internet]. Government of India; [cited 2009 Dec 28]; 168p. Available from: <http://www.mohfw.nic.in/NRHM/Documents/NRHM%20-%20Framework%20for%20Implementation.pdf>
9. National Rural Health Mission, Ministry of health and family welfare. The National Health Bill, 2009: working draft for feedback from public (proposed by Ministry of health and family welfare, Government of India) [Internet]. Government of India. [cited 2009]. Available from: http://mohfw.nic.in/nrhm/Draft_Health_Bill/General/Draft_National_Bill.pdf
10. Kumar G. Promoting public- private partnerships in health care. *Econ Pol Wkly*. 2003 Jul 19; 38 (29):3041-4.
11. Muraleedharan VR, Nandraj S. *Private health care sector in India - policy challenges and options for partnership*. In: Yazbeck AS, Peters DH, editors. *Health policy research in South Asia: building capacity for reform*. Washington D.C: The International Bank for Reconstruction and Development and The World Bank; 2003.
12. Joe W, Mishra U S, Navaneetham K. Health inequality in India: evidence from NFHS 3. *Econ Pol Wkly*. 2008 Aug 2; 43 (31): 41m-7

World trade, the poor and swine flu

BEBE LOFF

Department of Human Rights and Bioethics, School of Public Health and Preventive Medicine, Monash University, Alfred Hospital Campus, Melbourne, Victoria 3004 AUSTRALIA email: Bebe.Loff@med.monash.edu.au

In the last edition of this Journal Anant Phadke provided readers with the dreadful story of the death of Rida Sheikh from the H1N1 flu virus (1). Moving from this local and most concerning incident to the international arena reveals further matters worthy of consideration in the context of pandemic influenza. In 2005 the World Health Assembly adopted revised International Health Regulations. The purpose of these Regulations is to prevent the international spread of disease while avoiding unnecessary interference with international traffic and trade (2). According to the Regulations countries are obliged to develop certain minimum public health capacities for the detection, assessment and reporting of infectious disease outbreaks. Member States are urged to support developing countries in this regard. While it is unlikely that Member States will privilege the interests of developing countries, the question of what constitutes "unnecessary interference" with international traffic and trade and how this issue ought to be considered in the context of a threat to "global" public health seems not to have been the subject of conspicuous debate.

Similar issues were of concern to the rulers of the European populus during the 13th and 14th centuries. Their regulatory systems were directed towards limiting the impact of the plague on trade and controlling the rampaging poor once the rich had fled the confines of their cities. Armed militia were employed to put down rebellions of the poor and to stop them from pillaging the property left behind by the rich. Quarantine including house arrest was ordered. Plague victims and their carers could be sent to pest houses, hospitals such as there were, and monasteries. Schools were closed and religious assemblies banned. Goods thought to be contaminated were confiscated and destroyed. Travellers were banned. Cordons sanitaire were established and specified travel routes mandated. Information was exchanged between health authorities.

In early 2009 the H1N1 flu virus was described as the heir to the so-called Spanish Flu that had led to the death of millions at the end of the First World War. That flu virus spread quickly and had been capable of causing death within 24 hours of otherwise healthy young men and women. Governments expressed concern over how this new flu pandemic was to be managed. On April 29, 2009, the *New York Times* reported Dr Michael T Osterholm, director of the Center for Infectious Disease Research and Policy at the University of Minnesota, as saying that closing borders is dangerous because many goods needed in a pandemic are made abroad. After making reference to masks, gowns and gloves, and the raw materials to make drugs, he continued, "Our global just-in-time economy means we are dependent on others." Much of our food is from overseas. "A Kellogg's Nutri-Grain bar has ingredients from nine countries in it." On April 30, 2009 the Kellogg company and its subsidiaries reported a solid first quarter operating profit \$529 million(3).

While most of us could do without Nutri-Grain bars if the choice is between the bar and contracting the H1N1 flu, legitimate questions may be raised about the privileging of the current international trade regime and the extent to which developing states should be supported so that they might have available what is needed during periods of national emergency (and otherwise). In this context it seems industrialised countries would like to have their cake and eat it too, having constructed world trade law so that their domestic producers and manufacturers have unfettered access to international markets but evincing limited