Remunicipalization of a Public-Private Partnership: Lessons in Health Policy from Chhattisgarh, India

Deepika Joshi

Jan Swasthya Abhiyan, Chhattisgarh
People's Health Movement Global
deepikajoshi2008@gmail.com

Sulakshana Nandi

Public Health Researcher
sulakshana.nandi@gmail.com

Abstract

The last few decades in India have seen a policy push towards Public-Private Partnerships (PPPs) and they continue to remain a key feature of health sector reforms in India. The emergence of PPPs in healthcare relates to the country's move towards commercialization of healthcare, influenced by both national processes and the international political economy. In this paper, we provide a historical overview of health policy making on PPPs; discuss the evidence on PPPs nationally and internationally in terms of their impact on people and health systems; and through a case study of remunicipalization of a public-private partnership from the Chhattisgarh state of India provide insights on alternative pathways. Data collection methods for the case study include semi-structured interviews of key functionaries involved in the process of remunicipalization and patients who had received services from the hospital along with secondary data and newspaper reports. The study shows that alternative paths are possible for governments wanting to provide quality, free and dignified health services within the public sector. Strengthening government health systems and bringing in outsourced and privatized institutions and services into government ownership are a key policy step towards health equity and universal healthcare.

Keywords: public private partnerships, remunicipalization, health systems strengthening, health equity, PPP

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Remunicipalización de una asociación público-privada: lecciones de política sanitaria de Chhattisgarh, India

Resumen

En las últimas décadas en la India se ha producido un impulso político hacia las asociaciones público-privadas (APP) y éstas siguen siendo una característica clave de las reformas del sector de la salud en la India. El surgimiento de las APP en el sector de la salud se relaciona con el movimiento del país hacia la comercialización de la atención médica, influenciado tanto por los procesos nacionales como por la economía política internacional. En este artículo, proporcionamos una descripción histórica de la formulación de políticas de salud en materia de APP; discutir la evidencia sobre las APP a nivel nacional e internacional en términos de su impacto en las personas y los sistemas de salud; y a través de un estudio de caso de remunicipalización de una asociación público-privada del estado de Chhattisgarh en la India, se ofrecen ideas sobre caminos alternativos. Los métodos de recolección de datos para el estudio de caso incluyen entrevistas semiestructuradas a funcionarios clave involucrados en el proceso de remunicipalización y pacientes que habían recibido servicios del hospital junto con datos secundarios e informes periodísticos. El estudio muestra que son posibles caminos alternativos para los gobiernos que quieran brindar servicios de salud de calidad, gratuitos y dignos dentro del sector público. Fortalecer los sistemas de salud gubernamentales y hacer que las instituciones y servicios subcontratados y privatizados pasen a ser propiedad del gobierno son un paso político clave hacia la equidad sanitaria y la atención sanitaria universal.

Palabras clave: asociaciones público-privadas, remunicipalización, fortalecimiento de los sistemas de salud, equidad en salud, APP

公私合作伙伴关系的再市政化：印度恰蒂斯加尔邦卫生政策的经验

摘要

过去几十年，印度政策推动了公私合作伙伴关系(PPP)，并且这种关系仍然是印度卫生部门改革的一个关键特征。PPP在医疗保健领域的出现与该国医疗保健商业化的进程有关，受到国家进程和国际政治经济的影响。本文中，我们对关于

PPP的卫生决策进行了历史概述；探讨了国内和国际上关于PPP对人民和卫生系统影响的证据；并通过印度恰蒂斯加尔邦公私合作伙伴关系再市政化的案例研究，提供了有关替代性途径的见解。案例研究的数据收集方法包括：对参与再市政化过程的关键官员和接受过医院服务的患者进行半结构化访谈，以及次级数据和报纸报道。研究表明，对于希望在公共部门内提供优质、免费和有尊严的医疗服务的政府来说，替代性途径是可能的。加强政府卫生系统并将外包和私有化的机构和服务纳入政府所有，是实现健康公平和全民医疗保健的关键政策步骤。

关键词：公私合作伙伴关系，再市政化，加强卫生系统，卫生公平，PPP

Introduction

The last few decades in India have seen a policy push towards Public-Private Partnerships (PPPs), and they continue to remain a key feature of health sector reforms in the country (Baru 2003; Baru and Nundy 2008; Singh 2020; Sarwal et al. 2021; Prasad 2022). The emergence of PPPs in healthcare relates to the country's move towards commercialization of healthcare, influenced both by national processes and by international political economy (Baru 2003, Nandi et al. 2020). In this paper, we provide a historical overview of health policy making on PPPs, discuss the evidence on PPPs nationally and internationally in terms of their impact on people and health systems, and through a case study of remunicipalization of a PPP provide insights on alternative pathways in health policy for improving health services. In the current Indian context, where the policy push in healthcare is showing trends toward PPPs and away from public provisioning of health services (Nandi 2020; Nandi and Joshi 2021; Sarwal et al. 2021), this study aims to demonstrate the potential of the public sector in ensuring efficiency and equity in healthcare services.

Historical overview

Despite the Indian state's socialist leanings post-independence, the national focus remained on industrial growth while social sectors like health and education were given low priority (Sen and Drèze 2002; Duggal 2001; Amrith 2011). Historically speaking, investments in health in India in terms of budgets have been lower than in almost any other country (Sen and Drèze 2002). At the time of Independence, the Bhore committee of 1946 had comprehensively dealt with the state of poor and inadequate health infrastructure making comprehensive recommendations but this was only partially adopted (Duggal 2001). The

form of public healthcare provisioning that the 1950s and 1960s and later years saw, focused on the eradication of diseases such as malaria, smallpox, and Tuberculosis in a "techno centric approach" through vertical programmes,[1] done mostly through the aid of international agencies (Duggal 2021). It was in the decade following 1983 (the first National Health Policy was formulated in 1983) that the expansion of primary healthcare through Primary Health Centres (PHCs) and Sub Health Centres (SHC) took place (one PHC per 30,000 population and one SHC per 5,000 population). However, even though public infrastructure was created, it remained insufficiently resourced, parallelly leading to privatization and private sector expansion in the health sector in this period (Duggal 2001; MoHFW 2002). It is important to note that the growth of the private sector is related to the underfunding of the public sector, and both sectors are not discreet (Baru and Nundy 2008).

Scholars have noted that in the decade of 1980 onwards, the Indian economy saw a marked "shift towards greater commercialization and the opening of the health sector to more private sector investment" due to various events, including the 1991 liberalization reforms (Jeffery 2018). Before the 1980s, partnerships primarily involved non-profit organizations and focused mainly on National Health Programs, particularly the Family Welfare Program (Nundy 2021). However, in the mid-1980s, the concept of PPPs broadened to include other National Health Programs such as disease control and Reproductive and Child Healthcare programs, facilitated by external funding from institutions like the World Bank (Baru and Nundy 2008). Baru and Nundy (2008) make a distinction between the PPPs of the 1990s and the ones prior to it wherein the "former conceptualizes both partners as equal and is arbitrated through a formal memorandum of understanding (MOU) while in the latter the role of non-state players was peripheral to the programme" (Baru and Nundy 2008). The rationale behind collaborating with the for-profit private sector was often justified by the argument that the public sector was not meeting its objectives. However, this reasoning overlooked the fact that states often lacked adequate funding for healthcare and lacked an appropriate regulatory framework for the private sector to effectively deliver social services (Jeffery 2018; Nandi et al. 2021). While discussing the national picture, it is important to highlight the variations within the Indian states. For example, a state like Kerala with Left-leaning politics, and a focus on state involvement and strong local health governance, or Tamil Nadu with a history of progressive movements, have done significantly better compared to other states in public provisioning of healthcare and health governance (Amrith 2011; Balabanova 2013).

PPPs and influence of ideologies and international processes

The PPPs have been defined as "a more or less permanent cooperation between public and

private actors, through which the joint products or services are developed and in which the risks, costs and profits are shared" (Montagu and Harding 2012, 15). Scholars have also categorized all forms of interaction between the private sector and the government as PPPs (Raman and Björkman 2008). The neo-liberal ideology and ethos have served as a conceptual and motivating framework for policies of privatization and PPPs (Baru and Nundy 2008). Some features of this ethos are: reduction of government's role in economy; retrenchment of the welfare dimension of the state, such as, privatizing public assets, reducing public expenditure, a market-based approach, and deregulation; and lastly individual responsibility replacing the concepts of public goods and community (Sakellariou and Rotarou 2017). Such ideological apparatus was necessary to bring in policies that gradually or swiftly aided the commercialization of healthcare in different ways.

The election of conservative governments in the 1980s (Thatcher in the UK, Reagan in the U.S., Kohl in Germany) accompanied by events of recessions led to a swift proliferation of this ideology. Following the debt default of developing countries, structural adjustment policies (SAP) were imposed on indebted countries (Baum et al. 2016). The SAPs meant a reduction of public health budgets, opening of markets, reduction in regular and secure recruitment/hirings and so on (Sengupta et al. 2018; Steendam et al. 2019; Pownall 2013; Nandi et al. 2020). As such, it is believed that neo-liberalism pushed for a market economy in public healthcare, education, and social security sectors (Baum et al. 2016). Multilateral organizations were also influenced by the international processes and in these decades came to endorse public-private collaborations in the health sector (Baru and Nundy 2008; Nandi et al. 2020). Although involving the private sector through a PPP is different from outright privatization these PPPs have been seen as a continuation of the process of commercialization of the health sector (Fabre 2019; Baru and Nundy 2017; PHM 2022). The PPPs have taken different forms in recent decades, and implemented widely all over the world, particularly in lower- and middle-income countries (Rao et al. 2018; Fabre 2019; Nandy et al. 2021; Nandi 2023; Sundararaman and Garg 2022; Mukhopadhyay and Sinha 2019). In the recent years PPPs have been globally promoted within the framework of universal health coverage (UHC),[2] with the stated objectives of improving equity, access, financial protection, and coverage of health services (Kumar and Birn 2018; PHM 2022). In India, this is being seen in the rolling out of a Publicly Funded Health Insurance scheme (PHFIs), in the form of Pradhanmantri Jan Arogya Yojana (PMJAY). In this form, empanelled private hospitals are expected to provide health services (currently mostly limited to tertiary level) while the government finances/reimburses them for these services instead of providing/strengthening it in the government sector. Studies evaluating these schemes in India have shown their inability to provide financial protection, occurrence of distress financing and

adverse impact on women and other marginalized communities (Nandi et al. 2022, Bhageerathy et al. 2021; Nandi 2020; Garg et al., 2020; Garg et al., 2023).

Evidence related to PPPs in India and globally

Overall, the academic literature covering PPPs in healthcare is scarce (Fabre 2019; Nundy et al. 2021). A literature review of existing evidence at best suggests that the performance of PPPs has been mixed in terms of its "success." It has been noted that at the beginning a PPP may bridge the immediate gap in an otherwise non-existent or weak system and make services available possibly leading to an increase in initial uptake and utilization of these services (Nundy et al. 2021; Nandi et al. 2021). Evidence shows the adverse impact of PPPs on people's health, particularly on women and indigenous and other marginalized communities, health worker rights, health governance, accountability and transparency, public healthcare system and healthcare costs (Joudyian et al. 2021; Carvalho and Nuno 2022; Nandi et al. 2022; Tizard and Walker 2018; Gideon and Unterhalter 2017; Kotecha 2017; Hall 2015; Enríquez and Blanco 2023). Recent studies have linked privatization and outsourcing of health services and facilities to declining quality of care with negative effects on health outcomes, staffing, and accessibility (Goodair and Reeves 2024). Additionally, experiences in India on implementing PPPs show that often they do not take off or fail in implementation (Nandi et al. 2021; Nandi and Joshi 2018a; Nandi and Joshi 2018b). Rajasulochana and Dayashankar (2020) note that the enthusiasm for PPPs in healthcare has, however, not been accompanied by a willingness to draw lessons from it. They argue that even the basic tenets of design and implementation of the PPP model have not been met, and in their absence, PPPs have become wasteful and burdensome on the public exchequer. Theoretically too, there has always been the danger of the private partner prioritizing profit or revenue maximization at the cost of issues of equity and poverty (Roy 2017; Mitchell n.d.).

Different rationale are being provided to introduce PPPs. These include presenting the private sector as more efficient than the public sector, and competition as a solution for overcoming market failure, reducing costs, and enhancing efficiency. This view portrays the government as lacking the capacity to provide services, regulate, and procure, among other factors (Sundararaman and Garg 2022). Another rationale given for PPPs is the scarcity of state resources available with the state (Baru and Nundy 2017; Carvalho and Nuno 2022) and in that framework partnerships with the private sector are viewed as a solution, a source of greater investments, and a way of filling gaps in delivery of clinical and/or nonclinical services (Baru and Nundy 2017). However, this argument does not stand any longer as under the UHC framework,[3] a policy of purchaser-provider split and "strategic purchasing"[4] is advocated, which effectively means private provisioning of health services but with pub-

lic funds (Nundy et al. 2021; PHM 2022; Sundararaman and Garg 2022; Nandi et al. 2020; Kumar and Birn 2018; Sinha 2022). At the same time, evidence from many "low resource" countries or regions, such as Thailand and Sri Lanka, suggests that better health and social outcomes can be achieved (often better than others at a similar level of income) through political will and socially progressive policies reflected in public provisioning of health services (Balabanova 2013; Tangcharoensathien et al. 2018; Kumar and Birn 2018). Even in India, states such as Kerela and Tamil Nadu have done significantly better in terms of public sector healthcare provisioning, which was also reflected during the Covid-19 pandemic (Balabanova 2013; Adithyan and Sundararaman 2021).

Remunicipalization of Advanced Cardiac Institute (ACI) in Chhattisgarh, India

The following case study is about remunicipalization of a tertiary hospital, Advanced Cardiac Institute (ACI), which was initially built as a PPP in Chhattisgarh state of India. (Re)municipalization is understood as the creation of a new public service—municipalization— or reversals from a period of private management—remunicipalization (Kishimoto et al. 2020). Through documenting and analyzing the remunicipalization process of ACI, we aim to illustrate the alternative policy pathways to PPPs, their strengths, advantages for people, and the public healthcare system over PPPs. The case study (Joshi and Nandi 2021) was undertaken as part of the larger research project on municipalization and de-privatization. The case was identified as an instance of remunicipalization. The study aimed to understand the impact/effect of the remunicipalization on the provision of health services and draw lessons (if any) in health policy from it. Data collection methods included semi-structured interviews of key functionaries involved in the process of remunicipalization and patients using the services (Table 1). Additionally, review of hospital data, government documents, and media articles was undertaken. The researchers manually analyzed the qualitative data, guided by the study objectives and emerging themes. Informed consent was obtained from all respondents in the study.

Table 1: Respondents (health officials) and their designations

Interview Respondents	Position
Resp. 1	HoD, Cardiology Department, ACI
Resp. 2	Medical Social Worker
Resp. 3	Ex-Dean, Bheem Rao Ambedkar Medical College Hospital
Resp. 4	HoD, Cardiothoracic and Vascular Surgery (CTVS) department, ACI
Resp. 5	Physician Assistant

Background

In 2000, soon after Chhattisgarh was carved out from Madhya Pradesh, the government of the newly formed state was under political pressure to show visible expansion of health services (Garg 2019). There was a rising demand from the upper classes for tertiary care services, and thus started the first wave of PPPs in the state during which PPPs for critical cardiac care and gastroenterology were introduced (Garg 2019). In this background, in 2002, a "state-of-the-art Heart Command Center" (henceforth called Escorts HCC) was set up in partnership with the Escorts Heart Institute and Research Centre (EHIRC),[5] which was selected through a non-competitive process on the basis of their reputation as a nationally renowned corporate group focused on tertiary cardiac care (Datta 2020; Garg 2019).

The EHIRC was to "manage and operate" the Escorts HCC, according to the Agreement (MoU or Memorandum of Understanding) between EHIRC Ltd and the Chhattisgarh State Government for establishing Heart Command Centre (HCC) on 29 August 2002 (copy of the MoU obtained by Authors). It was set up in Raipur, the capital city, adjacent to Dr B.R. Ambedkar Memorial Hospital (popularly known as *Mekahara*), the biggest government medical college and hospital in Chhattisgarh and an end referral point for people of the state.

The State Government provided all initial capital costs, including land for the hospital, all medical equipment, basic and supporting infrastructure, and facilities. The Escorts HCC on its part, was to recruit all the required medical and non-medical staff and take responsibility for procuring medicines, surgical materials, and other consumables. Other running costs such as electricity, water supply, waste management, etc. too were to be paid by the Escorts HCC on a cost basis. The contract was for a five-year term, and it was renewed twice between the period 2002 and 2017.

The contract conditions were as follows, according to the MoU:

- Escorts HCC was to have full freedom to carry on the operations and management of the HCC including without limitation, fixation of schedule/tariffs, without any interference by, or reference, to the state government.
- Escorts HCC was to make 15 percent of beds available for patients below the poverty line referred by the state government (however, medicine, disposables, and consumables may have to be paid by the patient or the state).
- Escorts HCC was to give a 15 percent discount for employees of state government for services but excluding medicines, consumables, etc.
- EHIRC was entitled to bill and collect, in EHIRC's name and own account, fees for services rendered and medicines, food and other materials supplied to patients. All profits and losses from the management and operations of Heart Command Centre were assigned to the account of EHIRC.

These conditions meant that the hospital was free to charge as much money as they wanted, and the concessions were defined only as a proportion of unspecified market rates (Garg 2019). There was no provision for agreeing upon the rates of treatment jointly. Additionally, the Escorts HCC was also supposed to provide access to students of Pt. Jawahar Lal Nehru Memorial Medical College, Raipur (which is linked to Dr. BRAM Hospital) and state government employees for educational and training purposes.

In 2017, amid reports of underperformance and non-fulfillment of the contract (Dutta 2020), the Chhattisgarh government decided to not renew the contract with Escorts HCC for a third time and instead to provide and improve these services through the Government run Cardiology Unit (GCU) and later the Advanced Cardiac Institute (ACI).[6]

The specific reasons for non-renewal of the contract as understood from the study respondents were as follows:

Failure of the PPP to provide cardiac services to the poor: The Escorts HCC had failed to provide free treatment for patients who are poor and unable to afford its high treatment rates. The only obligation that the Escorts HCC had was to reserve 15 percent beds for poor patients but even that went unused as there were no caps on the cost of care. Since all services were charged and very expensive, it was largely the rich patients who could access these services (Resp. 1; Resp. 3; Patient 4; Garg 2019).

Failure of the PPP to provide training to medical students: Escorts HCC did not provide any facilities for training to the students enrolled in the Medical College despite the clause in the MoU signed. It was also expected that they would train government doctors and specialists who could take over the functions in a few years, but there was no capacity building of local doctors and other health personnel (Shrivastava 2021; Shrivastava 2017e; Resp. 1).

Failure to provide integrated services: The Escorts HCC functioned as an independent private hospital, with no integration with the government medical college and hospital next door (for cross-referrals and other coordination). A door between the two hospitals was supposed to facilitate the movement of patients and hospital staff, but it always remained closed (both metaphorically and physically).

Failure to provide tertiary level cardiac services even to those who could afford it: The Escorts HCC was seen as a failure both by the government and the elites who were supposed to benefit from it. They failed to provide the range and number of services that were expected as they could not recruit or retain highly-skilled surgeons, and their doctors began conducting surgeries in other private hospitals in the city (Garg 2019).

Capacities built within the government system to provide cardiac services: Realizing the need to develop its own capacities, the state government had started setting up an in-house Government Cardiology Unit (GCU) within Dr.

BRAM Hospital from 2009 onwards. Until 2014, the GCU undertook angiography-related procedures, which was expanded with the setting up of a Cath lab facility, adding a 40-bed intensive coronary care unit (whereas the privately-run Escorts HCC had 8 beds in ICCU), hiring and training of staff and other facilities (Shrivastava, 2017b). Initially, Cardiologists from Delhi would come to Raipur once or twice a month and do basic cardiac procedures and also train the hospital staff. In 2010, a paid study leave was provided to one of the hospital faculty for three years for Doctor of Medicine (DM) training in Cardiology at the Postgraduate Institute of Medical Education and Research, Chandigarh (PGIMER). This hospital faculty joined back in Dr. BRAM Hospital after the training and currently heads the cardiology department at ACI. Subsequently, three junior nursing staff and a senior nursing staff were sent to PGIMER, Chandigarh, for two weeks to be trained and received distinction as Cardiac Trained Nurses. They came back and further trained other nursing staff, thus resulting in horizontal skill spread (Shrivastava 2021; Resp. 3).

Government run Cardiology Unit (GCU) was performing much better than the Escorts HCC PPP and was demanding a separate unit, budget head, and more finances: A comparison of Escorts HCC with the existing government-run cardiology unit in 2017 shows that the GCU was doing much better than Escorts HCC in terms of types of facilities available, affordability, and equity (Shrivastava 2017d). Being located within a larger tertiary hospital helped the GCU to provide more comprehensive specialist and ancillary services (Refer to Table 2).

Prior to 2017, the government doctors and administration had been asking for a separate Cardiology department within which the GCU could function (Resp. 1; Shrivastava 2017b; Shrivastava 2017c). A one-time budget proposal of Rs 130 crore was submitted for the financial year 2017–18 (*of which Rs 21 crore was sanctioned*: Resp 1) so that full dedicated cardiology services could be initiated, and these were to be housed under the name Advanced Cardiac Institute (ACI). This proposal was sent after the government had decided not to renew the MoU with Escorts. As a respondent explained: "the prior sanctioned budget (21 crore approved out of 130 crore proposed) was very crucial in the transition process from Escorts HCC to ACI and made the transition process smooth" (Resp. 3).

Process of remunicipalization

Once the state government took the decision not to renew the MoU of Escorts HCC it was handed over to the government medical college (Pt. JN Medical College) and hospital (Dr. BRAM Hospital). The strengthening of cardiology services in the GCU within the government set-up helped the Dean and doctors in building a case that even if the MoU with the Escorts HCC was not renewed the government would be able to take it over and operate it effectively (Shrivastava 2017c). The argument for remunicipalization was also made under the pub-

Table 2: Comparison of Escorts HCC and GCU in 2017

Parameter		**Escorts Fortis run HCC**	**Dr BRAM Hospital Government Cardiology Unit**
Human Resource	Cardiologists	One	Two
	Cardiac Surgeon	One	Two
	Cath Lab Technician	One	One
Number of Beds	**Total Beds**	40 Beds	-
	ICCU	Eight	40 ICCU beds
Complex Cardiac Interventions done (Number of cases)	Paravalvular Leak Device Closure	NIL	One
	Coarctation of Aorta Stenting	NIL	Two
	Bilateral Renal Artery Stenting	-	One
	Ruptured Sinus of Valsalva Aneurysm	NIL	Two
	Neonatal Cardiac Interventions	-	One
Equipment	Cardiac Catheterization Laboratory	Initially very inferior portable Cardiac Catheterization Laboratory which was upgraded to a mediocre-level machine	State of the art - excellent quality Cardiac Catheterization Laboratory
	Echocardiography machine	Low to medium quality echocardiography machine	Most advanced Echocardiography machine
Ancillary Services availability	Blood Bank, In house pathology, Pediatric, Nephrology Services etc.	Lacked entirely	All services are in house and functioning optimally

Source: Shrivastava (2017d)

lic goods logic wherein services like healthcare are supposed to be provided by the state, away from the market logic (Shrivastava 2021). Thus, with the agreement of the state government and doctors and administrators of Dr. BRAM Hospital and Pt. JN Medical College, the process of handing over Escorts HCC PPP to government ownership proceeded (Resp. 3).

The transition process that ensued was time-consuming and cumbersome (Resp. 3). The new government team who were to be responsible for the ACI faced several challenges. The first challenge was making the necessary equipment and infrastructure available and functional, as the Fortis Escorts group had taken away all the equipment (Angiography unit, ICU set up, and Heart-Lung machine, etc.) despite requests made to them to leave them. They were unable to build more floors above the existing building, as the ceiling turned out to be a false ceiling (Resp. 3). Replacing the equipment and recruiting staff took time. Whenever required, staff from Dr. BRAM Hospital was deployed (Resp 3). The ACI was still "underfunded and poor compared to Escorts [HCC]" (Resp 3).

Despite all these challenges, the GCU shifted to a bigger premise (with the exception of catheterization lab) in 2017 where the Escorts HCC PPP was functioning previously and came to be known as ACI. At the time the case study was written, the ACI had two departments—Cardiology and cardiothoracic and vascular surgery (CTVS). The patients come to the main Dr. BRAM Hospital, pay user charges for Cardiology department/ CTVS department, and head to the ACI department in the adjacent building.

The Escorts HCC was purposely re-named as the "Advanced Cardiac Institute" (ACI) and not named after a politician or popular leader (which is usually the practice) so as not to seem partisan to any particular political party or ideology (Resp. 1). It was thought that this would ensure the sustainability of the name and the government's commitment even in the event of any future change in government. The timeline of the remunicipalization is illustrated in Figure 1.

Impact of remunicipalization on the Availability, affordability, and accessibility of cardiac services

"In Escorts HCC patients would come in cars, now in ACI people come in two-wheelers": The most significant and common observation across all interviews (hospital staff, patients, administration) was the change in the profile/ socio-economic background of patients coming to the hospital after being remunicipalized.

> Escorts was running it like a private hospital. Rich people can fly to Kokila Ben [hospital in Mumbai] or AIIMS [hospital in Delhi] for operation. The clientele shifted after the handover. Till it was Escorts [HCC] people in car would come as patients. After being taken over [by government] people come in two wheelers and from all over state (Resp. 3).

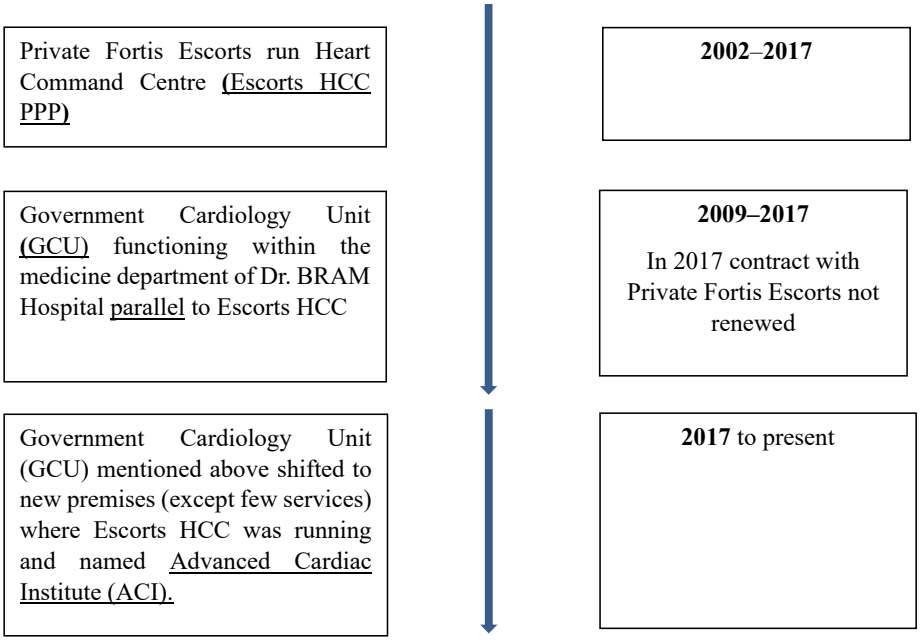

Figure 1: Timeline of Remunicipalization

This is illustrated by the following case study: Reema (name changed) had a hole in her heart and was brought to the GCU (when the cardiology unit was running under the medicine department and was not yet ACI) during 2014–15. Her father worked as a cook in a hotel in Bilaspur district, which is two hours away from Raipur. He shared that they had already spent a lot of money on private hospitals (nearly Rs. 1.5 lakh) for their daughter's treatment. He then came to Raipur to get his daughter's treatment in a reputed charitable hospital through open-heart surgery. However, later they learnt through an advertisement in the newspaper that their daughter's treatment could be done at the GCU through "button treatment" (possibly a less invasive procedure) rather than an open heart. Therefore, they chose to take their daughter to GCU. The procedure was successful and Reema's father was very satisfied with the procedure even after all these years.

Free and affordable cardiac services: The Escorts HCC used to charge patients exorbitant and unregulated market prices. They were supposed to provide a 15 percent discount to government officials and had a 15 percent quota for people belonging to lower socio-economic categories. They were also to implement existing government schemes providing reimbursement or publicly-funded health insurance. However, other than some procedures on children suffering from heart defects under the Chief Minister's Child Heart Scheme (Mukhyamantri Bal Hrudaya Yojana) (we came across three or four such patients), they didn't implement

either the quota or other government schemes properly.

The ACI on the other hand provides services free of cost to patients belonging to lower socio-economic categories as identified by the government. For those who do not fall into this category, the services remain free, though they are required to buy those consumables that cost beyond Rs. 50,000, such as stents. Additionally, ACI implements the state's universal publicly- funded health insurance scheme[7] which covers the costs of treatment for both the poor and non-poor. However, in using such schemes patients sometimes face delays in approvals. The maximum amount reimbursed by government to the hospital for one of the procedures till now is Rs. 1,900,000. Respondent 6 (aged 70 years) was very satisfied with his treatment as he couldn't have been able to afford this amount of money for his procedure otherwise. However, he did complain that it took two months to get his 19 lakhs sanctioned. Therefore, the delays in processing/approving the support amount to patients is a gap that needs to be filled.

Most beneficiary respondents in the study belonged to poor and lower-middle or middle-class backgrounds and had highly benefitted from the free-of-cost service that they received. For instance, Jagannath (name changed, aged 76 years old) is a retired private school teacher in Mahasamund district. He started developing chest pains in 2015. He went to the district hospital and then consulted a doctor in Mekahara, Raipur. The doctor advised him to visit GCU (which was not yet renamed ACI). A stent for Rs 1.5 lakh was needed for his angiography which was provided by the hospital itself. He opined: "A poor patient considers many things about money, resources, time before going for such procedures and it is a great relief especially for poor patients as many services are available in ACI itself."

Strengthening of referrals and integrated services: One of the biggest failures of the Escorts HCC was the lack of coordination with the adjoining government hospital. The MoU between EHIRC and the government had stated that both would coordinate regarding referrals, particularly of patients below poverty line. However, this never happened and Escorts HCC continued to function as a stand-alone entity. After the ACI became functional, coordination between it and the main hospital was streamlined. Regular and emergency patients in Dr. BRAM Hospital are referred to ACI when required (Resp 1). The two hospitals complement each other, providing services to the patient as required. The door between the two hospitals (mentioned above) now stays open facilitating communication and movement between the two hospitals.

Expansion of quality cardiac care services: The expansion of cardiac services within the government system started with the setting up of the GCU prior to 2017, as discussed in the section above. Shifting to a separate premise in 2017 as ACI, with additional finances and individual budget head helped to expand the services further. In August

2020, a Cathlab machine was installed in ACI further improving the standard of care (Resp. 5). In addition to Cardiology, the department of CTVS became operational, with a dedicated operation theatre and post-operative ward (Shrivastava 2017e). The establishment of the CTVS department led to thoracic, lung surgery, and vascular surgeries, which were happening for the first time in the state (in either the public or the private sector). These procedures which are otherwise very costly, are provided free of cost in ACI. The ACI has also maintained good standards and uses the best quality equipment, which may not even be available in private hospitals. For instance, the valves used in Mitral Valve Repair (MVR) procedure at the ACI are very expensive in the private sector, which then ends up using substandard quality valves for the sake of cost cutting. This clearly contradicts the popular narrative about how the private sector has better quality and more advanced services (Resp. 4). "Such availability of complex procedures in a government facility for zero or nominal charges is not common in a public system and largely benefits the poor who would otherwise not afford these procedures" (Resp. 4).

Increase in outpatients seeking care: In terms of the number of outpatients, there has been a steady increase since the handover, from Dec 2017 to 2019 (Figure 2). The reduction in numbers in 2020 and onwards can be attributed to COVID-19 pandemic and suspension/ restriction of health services during that period.

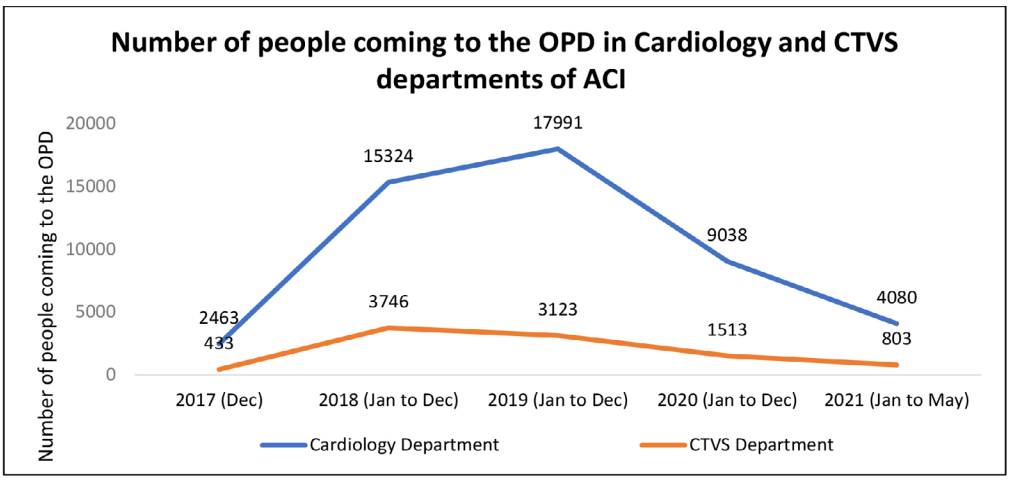

Figure 2: Outpatient department (OPD) numbers in Cardiology and CTVS department of ACI

Source: ACI OPD data collated by authors

Increase in number of Cardiac Procedures, including complex procedures: The yearly procedures done in GCU/ACI has increased steadily since 2013 (Figure 3). In 2020 and 2019, there was a decrease in procedures due to the Covid-19 pandemic and also because there was no machine to operate (Resp. 1).

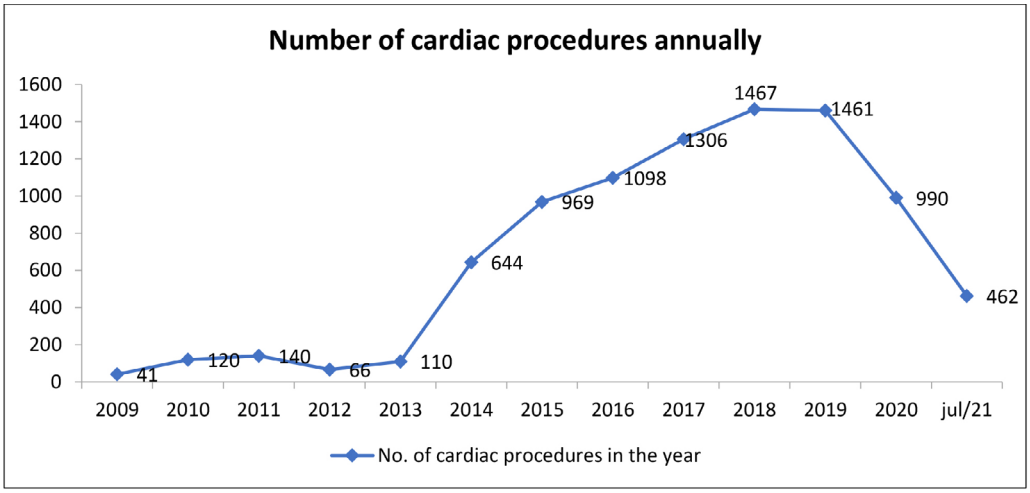

Figure 3: Cardiac procedures in ACI over the years

Source: Shrivastava 2017a

Strengthening capacities within the public sector through health workforce training and research: The process of setting up a cardiac care unit within the government system simultaneously built capacities of government doctors and nurses in providing these services and undertaking other functions such as procurement, budgeting, etc. The institute has sanctioned 36 posts for human resources recently including cardiac anesthetists, two associate professors of cardiology, and one general physician (*Dainik Bhaskar* 2021).

The ACI plans to expand its initiatives by offering courses and training sessions for cardiologists and cardiac care nurses in each district of the state. It plans to establish advanced training programs like Doctor of Medicine (DM), Master of Chirugiae (MCh), Cath lab, Technician, and Perfusionist courses and introduce sub-specialties such as Electrophysiology and Pediatric Cardiology. Furthermore, the ACI plans to provide consultation services and protocol guidance through teleconferencing (Shrivastava, 2017d; Resp. 1). Since its establishment, ACI has also worked to improve its research output, publishing in international and national journals and two chapters in a textbook on cardiology (Shrivastava 2017e).

Better equity and working conditions for health workforce: Under the MoU, Escorts Fortis was to hire all medical and para-medical staff who were to be their employees or consultants. The staff recruitment being done by a private entity was not expected to follow the reservations meant for the historically marginalized social categories as defined in the Indian Constitution for affirmative action and social justice. Government on the other hand is compelled to follow the affirmative action norms and implement other social security benefits that come with a regular government job and which are more equitable. Using PPPs or other outsourcing arrange-

ments to bypass pro-labour and social justice norms has been documented in other contexts too (Nandi et al. 2021).

Along with all these achievements, the ACI has been facing challenges recently in terms of a shortage of staff, especially of nursing and para-medical staff and finances and delays in procurement and supply of equipment and consumables, which is affecting its performance and slowing down the further expansion of services (Resp. 1, Resp. 3, and Resp. 4).

Discussion

In summary, the two models (Escorts HCC PPP and the remunicipalized ACI) functioned differently in terms of their costs to the patients. While ACI largely provides services without cost, the PPP unit had very high costs to the patient. This is also the reason for most patients from higher economic strata visiting and taking services from the PPP unit as opposed to the publicly owned unit which is visited by poorer patients due to its no-cost or subsidized services. The publicly owned unit also worked to provide a vast range of cardiac services compared to the limited cardiac services offered by the PPP unit. While the publicly owned unit could seamlessly integrate and leverage existing public health system services, while also contributing through training and capacity building, this integration and contribution was not observed with the PPP unit. Lastly, the PPP unit was not bound to follow affirmative health action for socially oppressed sections in terms of hiring as mandated in the Indian constitution. Many of these services and provisions, which could not be delivered by the PPP unit, were mandated in its MoU with the government.

The differences that emerge in functioning of the public sector (especially a well-functioning one) versus a profit-oriented healthcare model are not new (PHM 2022; Sundararaman and Garg 2022; Nandi et al. 2020; Kumar and Birn 2018; Balabanova 2013; Tangcharoensathien et al. 2018). Global experience shows that PPPs and the privatization of healthcare generally fail to deliver on their promises. Publicly managed services, on the other hand, tend to be more focused on quality, universal access, affordability, and in the achievement of broader social and environmental objectives (Kishimoto et al. 2017). Additionally, public providers are often both more innovative and more efficient than private operators (Kishimoto et al. 2017).

It is important to note that the remunicipalization was *not merely change in technical ownership*. The administrators/doctors who facilitated the remunicipalization process located it within the understanding that health is a public good, to be provided by the government through ensuring adequate budget allocation and other necessary support. The role of the state in health and other key sectors was envisaged as primary and significant (Shrivastava 2021). There was a lot of pride and ownership among the doctors/administrators on being part of this remunicipalization process and steering it.

Such an understanding helped to guide the process and institute to truly serve people's interests as we discussed in the point above. Additionally, the government setup had started building its in-house capacities in cardiac care even before the actual remunicipalization, and that helped strengthen the case for remunicipalization of Escorts HCC. It is important to note that even though a few motivated people within the department were responsible for steering/leading the remunicipalization process, this was done through strengthening the institutional structures involved. Without this and without the support of the larger government machinery and leadership, political and executive, it would not have been possible to bring changes mentioned in the article such as allocation of the new budget, hiring and training of human resources, provision of complex and challenging cardiac procedures, formation of separate cardiology and CTVS departments, etc.

The study shows that *high-end and rare procedures were now made available in government facility free of cost or at nominal cost.* Such high-end services for free are not usually expected in a country like India where the public health system struggles to provide basic health services amidst underfunding and under resourcing. However, some of the best tertiary level hospitals in the country are public ones, such as All India Institute for Medical Sciences, Postgraduate Institutes of Medical Education and Research, and so on. While there is an emphasis that these procedures are "free" in the government facility, ACI ensures that there is no compromise in the quality of services. The quality of equipment used in GCU/ACI is at par or even better than what is available in the private sector, *contradicting the oft-repeated narrative that private sector provides better quality healthcare services*. The study adds to the list of studies and research in recent times that questions these notions entrenched around for long and are finally being challenged by communities and researchers (Nandi et al. 2021; Kishimoto et al. 2017; Oxfam 2014; Averill and Dransfield 2013; Kumar and Birn 2018; Balabanova 2013; Tangcharoensathien et al. 2018; Goodair and Reeves 2024). The experience during the COVID-19 pandemic reinforced this (Freeman et al. 2023).

While this study did not do a cost comparison, being located within an integrated health unit (government medical college and hospital) helps to save costs through streamlining with other services already being provided. For instance, when there were staff shortages for the cardiology unit, staff from the government hospital could be deployed to address the shortfall. Similarly, already existing ancillary services (such as blood bank, diagnostic, pediatric services, etc.) in the government hospital are used by ACI, instead of having to develop their own systems.

As discussed above, the institute has plans to strengthen publicly provided cardiac care services at secondary and primary levels. Chhattisgarh is undergoing an early epidemiological transition (WHO India 2022; Jain 2015) where NCDs are now the leading cause of mortality in the population above

the age of 40 years, with 33.5 percent deaths due to cardiovascular diseases and 11.6 percent due to cancer (ICMR et al. 2017). In this context, such tertiary level services will be very useful for referrals and continuity of care, linked to primary (Health and Wellness Centres) and secondary level (WHO India 2022; Nandi 2022).

The functioning of the ACI in public set up has brought its own challenges of shortage of Human Resources, delays and shortages in procurement and equipment, linked to structural issues of human resources, governance, and finances that need to be resolved (WHO and SHRC 2019).

The decision to remunicipalize Escorts HCC was taken towards the end of the right-wing party's rule which had been in power for 15 years and whose policies otherwise promote commercialized healthcare. The opposition party replaced them in December 2018, which had campaigned with a progressive and socialist-leaning manifesto. They promised universal healthcare with a strong vision for strengthening the public healthcare system (Ghose 2019). Once they came to power, the new political leadership provided sustained support to the ACI, contributing to its expansion and its success.

The failure of the PPP model as illustrated by the case study has been seen commonly in India, including in Chhattisgarh and globally (Eurodad 2022; Kishimoto 2017; Singh 2020; Roy 2011; Nandi 2021; Nandi and Joshi 2018a, 2018b). Moreover, there are examples available within Chhattisgarh itself, of providing health services in some of the most "remote" and rural districts through strengthening secondary and tertiary government hospitals (WHO 2020). The pandemic has also illustrated the crucial role played by public health systems in every aspect of pandemic management (Marathe et al. 2023; Garg 2020; Sundararaman et al. 2021; Adithyan and Sundararaman 2021).

The study has important lessons for health policy development and health systems strengthening in India, which has since structural adjustment policies (Baru 2003; Jeffery 2018; Sathi 2021) neglected public systems and promoted PPPs. Sustained and increased financing for the public sector is essential for universal healthcare. India has one of the lowest public spending on health at 1.35 percent of its GDP (GoI 2023). Therefore, there is a need for an increase in the health sector budgets by the centre and states, which in turn needs to be used to strengthen public systems and services. Diverting public funds towards PPPs or incentivizing the for-profit private sector to provide health services has led to a lack of equity, access, and financial protection (Nandi 2023; Nandi et al. 2022; Tizard and Walker 2018; Gideon and Unterhalter 2017; Kotecha 2017; Hall 2015; Enríquez and Blanco 2023; Goodair and Reeves 2024).

In the current Indian policy environment, there has been a renewed policy push from the centre and Niti Aayog towards promoting the for-profit private sector in healthcare delivery

(Prasad 2022; Nandi and Joshi 2021; Sarwal et al. 2021). This includes proposals for privatizing district hospitals and linking them to new or existing private medical colleges through "public private partnership" and recommending expansion of private players to operate and build hospitals in tier-2 and tier-3 cities as "attractive investment opportunity" and providing incentives /viability gap funding for the same (Nandi and Joshi 2021; Sarwal et al. 2021). There has been opposition to this from health rights groups (Kakvi 2020; Belagere 2022). As discussed in the paper earlier, this also includes the flagship Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB-PMJAY), considered to be the largest Public Private Partnership (PPP) initiated by the Indian Government and which has been known to fare poorly when it comes to equity (Nandi 2020; Kaur 2019).

Such proposals and trends are concerning for health and health rights of the people of the country especially for the poor, and highlight the commercial determinants of health, as reflected in the policies and processes (Lacy-Nichols et al. 2023). In that context, this study shows that alternative paths are possible for governments wanting to provide quality, free, and dignified services for people within the public sector. The study clearly shows that governments should not and must not hand over crucial and lifesaving health services to for-profit entities and expect it to serve the interest of people, let alone of the poorest. Strengthening government health systems and bringing outsourced and privatized institutions and services into government ownership is a key step towards health equity and universal healthcare.

Limitations of the study: The reasons for the cancellation of the contract are partly based on the perceptions of the study respondents, some of whom were also crucial in leading the remunicipalization process.

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Endnotes

1 Health services (curative and preventive) can be provided using two modes of delivery: horizontal and vertical. By horizontal delivery, services are delivered through publicly financed health systems and are commonly referred as comprehensive primary healthcare (WHO 1978). Vertical delivery of health services implies a selective targeting of specific interventions not fully integrated in health systems (Banerji 1984; Rifkin and Walt 1986). Horizontal programs are the oldest of the two modes of delivery—they were derived from Primary Health Care (PHC), originated as part of the WHO/UNICEF declaration in Alma Ata in 1978 (WHO 1978) (Msuya 2003).

2 Universal health Coverage (UHC) means that all people should have access to the full range of quality health services they need, when and where they need them, without financial hardship (*https://www.who.int/health-topics/universal-health-coverage#tab=tab_1*). It covers the full continuum of essential health services, from health promotion to prevention, treatment, rehabilitation and palliative care. UHC is included in the Sustainable Development Goals (SDGs) as a sub-goal under the SDG 3 and is the main global policy directive of current times.

3 See the previous endnote.

4 Strategic Purchasing – Strategic Purchasing is projected as a key strategy in achieving UHC. Strategic Purchasing (SP) has been advocated as a healthcare financing measure as central to improving health system performance and making progress towards UHC and involves a continuous search for the best ways to maximize health system performance by deciding which interventions should be purchased, how, and from whom (WHO 2000).

5 In 2005, EHIRC was bought over by Fortis Healthcare.

6 We use the acronym Escorts HCC (Heart Command Centre) for the private Escorts run cardiology unit. Parallel to this in the government hospital Dr. Bhim Rao Ambedkar Memorial Hospital (also known as Mekahara), Government run Cardiology Unit (GCU) was running which we call GCU. After the exit of Fortis Escorts, the GCU shifted to the premises where Escorts HCC was running and called Advance Cardiology Unit (ACI).

7 Dr. Khubchand Baghel Swasthya Suraksha Yojana or DKBSSY and the Chief Minister's Special Support Scheme Mukhyamantri Vishesh Sahayta Yojana, previously called Sanjeevani Sahayta Kosh.

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