Chapter 7
Summary of Findings and Discussion

Introduction:

In chapter 1 we set out the context of this study and an introductory review of literature that explained the choice of this theme and then put down the objectives and broad methodological approach we were taking to answering our research questions. Then in chapter 2 we presented a detailed study on the origins and evolution of the term strategic purchasing, both in academic discourse and as a policy direction and reviewed how this concept was interpreted and implemented across many nations. In chapter 3 we examined the experience of Chhattisgarh with regard to using PPP contracts as a form of strategic purchasing and in chapter 4 we examined the making and evolution of policy and the process of implementation with respect to PHFIs as a form of strategic purchasing. In the next two chapters (chapter 5 and 6) we presented our findings with regard to the effectiveness of PFHIs in achieving their stated objectives and the general objectives of strategic purchasing in Chhattisgarh and compare it with the experience with PFHI with four other states of India.

In this chapter, based on these findings and the analysis of each of these strategies, we re-examine the meaning of strategic purchasing, the various forms its implementation has taken, the experience gained and the lessons learnt, and used this to comment on the implications this has for the theories that underlie strategic purchasing and for policies that rely on strategic purchasing to structure the health systems. We conclude with the limitations of the study and identify some key areas for further work.

Multiple Meanings of Strategic Purchasing:

As introduced in Chapter 1, SP as discussed in this study is about buying services side of healthcare i.e. services like ambulatory visits and hospitalization. Further as discussed in Chapter 1, this study sees 'purchasing' as the situation when rather than providing the service directly, a health actor asks another party to provide the services in exchange for a payment (Perrot 2006). When institutions purchase services on behalf of individuals, from various kinds of providers, a 'purchase strategy' comes into play, with the first important decision being whether to provide directly or to buy from another party (WHO 2000; Perrot 2006). The above question is similar to the debate on 'making or buying', applied to healthcare services (Mills et al. 2001; Preker et al. 2000). The above formulation departs from WHO's definition of purchasing. WHO sees purchasing as a health financing function for allocating pooled funds

to providers (WHO 2010). The current study finds the above definition to be too broad to allow a meaningful analysis of SP. By this definition, input-financing by government by paying salaries to its own staff is also 'purchasing', though a passive form. That is inconsistent with the shift from input to output based financing, a central feature of SP as proposed by WHO (WHO, 2000).

Though SP has been defined by WHO, the study of origin and evolution of SP undertaken in Chapter 2 finds that SP carries multiple meanings in literature and in practice. The meaning of the term changes with the different purposes that are ascribed to it under various understandings.

SP has been seen as necessary to keep the cost of UHC affordable (Xu et al. 2015). It has been argued by WHO that just having more money for health will not ensure universal coverage, unless it is spent more efficiently (WHO 2010). The assertion is that "countries cannot spend their way to UHC" (Kutzin et al. 2016). Health systems need to seek greater value for money and SP can help in achieving "more health for the money" (WHO 2010). The above statements indicate the emphasis on efficiency in SP. Quality is another objective of SP (WHO 2010). Some WHO documents do mention 'Equity' but there is critique that they do not adequately indicate how SP will address it. SP has been criticized for being more focused on efficiency and keeping equity secondary to it (Ridde 2018).

Public providers receiving fixed budgets from government has been seen as 'passive purchasing', because it causes inefficiencies due to its rigidities and inability to respond to external incentives. Another form of passive purchasing is when open-ended payments are made to providers without creating incentives to put limits so that providers had to be more efficient (Kutzin et al. 2016, Cashin et al. 2018). It seems that purchasing cannot be called strategic unless it is efficient.

SP has been recommended as a means to promote access to private sector care. SP is meant to create possibility of 'exit' and thus promote choice. SP represents 'new universalism' in provisioning, promoted by WHO (WHO 1999). According to this approach, public or private ownership of facilities does not matter and the more efficient providers could be contracted to get the job done (WHO, 1999). This approach was meant to allow the use of a large number of private providers that exist especially in LMICs (WHO 1999, Lagomarsino et al. 2009). Under 'new universalism' government role was transformed from provisioning to 'stewardship' - mainly regulating and funding, but also setting priorities. Purchasing from private sector was visualized as contributing to social solidarity provided governments paid the bill (WHO 1999). The debate shifted from who should pay to who should provide (Deber, 2007). SP has been seen as 'solidarity' based approach, rather than 'market based' approach (WHO 1999, McIntyre 2007). In this understanding, a move from market to a quasi-market is seen as desirable and adequate.

'Quasi-markets' has been described as the form of public service delivery that retains state funding for the service, but with users having the choice of independent providers operating in a competitive market (Le Grand 2011).

According to Economics of Organisation (EO) theories, competition is needed to avoid market failure. But it is not easy to find competition in healthcare due to several reasons including spatial monopolies (Busse et al. 2007). PPS is the mechanism to have competition under quasi-markets and competition in turn is expected to deliver efficiency (Lewis 1996). A differing view is that competition is necessary but not sufficient for efficiency. Quasi-markets faced limitations due to limited competition and price regulation was recommended to fulfill the aim of efficiency (Shackley and Healey 1993). The notion of contestability is seen to have a better chance than competition, when entry of new providers is possible. Another challenge pointed out is that the consumer choice and competition clash with equity (Busse et al. 2007). Applying EO theories, SP was seen as a move from hierarchy structure of conventional public sector bureaucracy to the market-structure (Forder et al. 2005). SP sought to address the problems by creating possibilities of 'exit' and thus choice for patients as consumers. It seeks to shape the market by promoting competition, through demand stimulus. In terms of which services to buy, the market structure i.e. buying was suggested for less complex services (Preker et al. 2000). Due to limitations of the market approach to healthcare, some have argued in favour of network structure for healthcare with relational contracting as the 'third way' (Busse et al. 2007, Forder et al. 2005).

Competition is also a rationale for the recommendation to move towards output based payments. This system of output-based remuneration for services rendered in principle can improve efficiency in service delivery through competition (Ensor 2004; Standing 2004). WHO has also recommended a shift from supply side payments to demand side financing (WHO 2000). Supply side provider payment mechanisms, such as line item budgets common in funding of public-sector in LMICs, focus purchasing efforts on inputs and make it impossible for providers to respond flexibly to external incentives. Demand side financing is important for promoting free choice for consumers or "money follows the patient" (WHO 2000). For flexible resource management and risk sharing, contracts are needed and for contracting, PPS is necessary.

SP has also been proposed as means for regulating private sector (Lagomarsino et al. 2009; Ensor and Weinzierl 2007; Siddiqi et al 2006). In LMICs, private sector is large and governments find it difficult to regulate it (Akhtar 2011). In such contexts, contracts are seen as a possible mechanism to achieve

regulation. According to WHO, SP can help in bringing a large number of private providers into a structured public–funded system, thus allowing their regulation through contracts (WHO 1999). According to Cashin et al., contracting private providers through public coverage arrangements can also provide an important avenue for setting rules (Cashin et al. 2017).

SP draws its origin from the New Public Management (NPM) discourse that preceded it. According to one formulation, SP recognizes that its origin lies in NPM but seeks to distance itself from the neoclassical theories on which NPM was based (Forder et al. 200; Mills et al 2001). There is some difference between NPM and SP in the extent of emphasis on buying versus making. Under NPM, the prescription was more explicitly in favour of 'buying' rather than 'making' whereas SP positions itself as willing to buy from either, based on its strategic considerations. SP retains the Purchaser-Provider Split (PPS), a key principle of organization under NPM (Forder et al. 2005). Other very important features of NPM that find continuity in SP include the use of contracts for delivering public services, focus on 'outputs' rather than 'inputs' and the emphasis on measuring and incentivizing performance.

To summarize- the he study of origin and evolution of SP undertaken in Chapter 2 from our review identified the following theoretical premises:

Main Premises:

- Competition and Choice increases efficiency
- Output based payments 'Money follows the patient' make the 'supply' more responsive to 'demand'
- Alignment of Incentives gives desired performance, irrespective of ownership of facilities and the public/private character of providers
- Contractual conditions are effective in regulating provider behaviour

Corollaries:

- Purchaser and Provider need to be kept separate. Each of them need to have adequate autonomy.
- Purchasers need to have 'capacity'
- Capacity is needed in government for stewardship
- Information systems are needed that allow the 'Purchaser' to 'selectively contract' the best amongst the 'providers' and to measure their results and quality. Patient can also get better informed to exercise choice.
- Appropriate payment mechanisms can be designed to align the incentives

The Meanings and Forms of Strategic Purchasing in India

As described in Chapter 2, SP figures as a prominent strategy in the recently unveiled National Health Policy (NHP) of India, 2017. Different sections of NHP articulate different functions of SP. One section of NHP sees SP as a route for improving 'access' by filling critical gaps in services which public provisioning is unable to provide currently. For 'purchasing', it prioritises government owned facilities followed by non-profits and the for-profit private sector is included as the last option. There are other sections in the policy that call for SP for across the board services in urban areas, including for primary care. Another section of the policy sees promotion of private sector as a desired goal and envisages SP as a means to provide stimulus to it (GoI 2017; Sundararaman 2017).

There seemed to be little connect between different purposes ascribed to purchasing in NHP 2017. Is the purpose of purchasing to promote synergy between private and public providers? Or, is it the opposite, of achieving efficiency by creating greater competition between private and public providers? One part of the policy sees involvement of private sector as means and that too as the last resort. And another section sees private sector promotion as an end in itself. The resolution of above contradictory approaches may depend upon which of the formulations of SP in the policy get amplified in implementation (Sundararaman 2017).

As presented in Chapter 3 and Chapter 4, India has experience of implementing purchasing through PPP contracts with private providers for more than two decades now, including contracts involving clinical care as well as auxiliary services (Venkat Raman and Bjorkman 2007). Further, India has implemented a national PFHI programme for a decade now, for purchasing hospital care by empanelling private and public facilities (Karan et al. 2017). Several states in India have implemented PFHI schemes with larger vertical and horizontal coverage (Forgia and Nagpal 2012; Ravi et al. 2017). The current context in India allowed an appropriate opportunity to assess SP in practice.

As described in Chapter 2, PFHI is the largest form of purchasing in India in terms of total funds, range of services and volumes involved. So far, it has been used in India mainly for in-patient hospital-care (Ranjan et al. 2018). Compared to PPPs, PFHI based purchasing in India came further closer to the concept of 'Strategic Purchasing' in terms of being demand-side financing where money follows the patient and in terms of having objectives like aligning incentives and promotion of competition and choice. LMIC governments across the globe are increasingly using the PFHI route (Lagomarsino et al. 2012). Internationally, the attention to PFHI as a form of SP seems to be at a nascent stage (WHO 2017). A few recent studies from other LMICs have looked at PFHI as a form of SP (Munge et al. 2017;

Ogbuador et al. 2018). In India, there is a recent case study of PFHI in Karnataka state as a form of SP but it has not looked at how it played out on ground (Klein et al. 2018). A process evaluation of PFHI in Tamil Nadu has also described the PFHI scheme as a form of SP but it does not analyse it in terms of conceptual components of SP (Karan et al. 2017b). PFHI is thus yet to be studied systematically as SP in India and the current study is perhaps the first attempt to do so.

In India, the current debates on SP are in the context of launch of PMJAY, the enlarged national PFHI programme (Ghosh 2018). PFHI is one of the routes mentioned in the NHP for strategic purchasing. In actual implementation, this part of the policy has dominated. One focus of debates in India is on designing the appropriate service-package, especially pricing of individual procedures (Bhushan 2018). Another debate is 'Insurance' versus so called 'Trust' Model, i.e. whether to use insurance companies as intermediaries in PFHI or not (Nagulapalli and Rokkam 2015). With the roll-out of PMJAY, it has become clear that the form of SP that India has chosen to emphasize in implementation is to increasing access to private care, by improving its affordability through PFHI (Bhushan 2018; GoI 2018). The SP in this case is meant to align incentives and increasing competition and choice.

Strategic Purchasing for Selecting Efficient providers

As described in Chapter 1 and 2, selecting the providers who offer best value for money is an important component of SP. As presented in Chapter 3, the selection for many of the clinical care PPPs in Chhattisgarh was not based on competitive bidding. Other studies in India have pointed out that many PPP contracts selected providers without competitive bidding (Venkat Raman and Bjorkman 2007; Barua 2015). One study recommends that pre-negotiated partnerships with not-for-profit providers were empirically more successful than competitive-bid based contracts (Venkat Raman and Bjorkman 2007).

As described in Chapter 3, the selection for ancillary services was based on competitive bidding, whereas for clinical care services under PPPs, contracts were awarded to for-profit providers without a competitive process. Does it represent the move to 'selective contracting' recommended in the SP approach, selecting the most efficient and high quality provider rather than just focusing on lowest price? The current study found that in Chhattisgarh, the reason stated for non-competitive selection of providers for clinical care was that it was difficult to define parameters to judge quality for selection under PPPs. It was also difficult to find information about providers, other than their size and experience in the concerned activity, which were inadequate to judge quality. Under PFHI, insurance intermediaries were selected through a competitive process but the empanelment of hospitals was not based on any competitive

process. PFHI scheme selected providers based on minimal criteria of infrastructure and HR and it was difficult to include other measures of quality, like the track-record of hospital, outcome measures or patuent-feedback.

NHP 2017 recommends a clear hierarchy in preferring providers under SP – first preference to public sector, then to non-profit and to use private sector as a last resort and that too as a stop-gap measure to fulfill a critical gap. The current study showed that the practice in Chhattisgarh, most of the providers contracted were from for-profit private sector.

Getting private sector to invest has been a stated policy rationale for PPP contracting. In the examples studied, private sector did not put in fresh investment. Many of the contracts involved the upfront investment to be made by government. In examples where private sector was to invest, private sector showed unwillingness by not bidding. In PPPs using existing capacity, the risks were lower and relatively equal for both parties. The risk for the contracted provider was mainly related to delay in payments, as found in other studies (Venkat Raman and Bjorkman 2007).

Selective contracting based on performance has been suggested as a desirable under SP. However, in Europe, most of the countries found it very difficult to implement (Robinson et al. 2005). Selective contracting implies that purchaser will select the provider, thus restricting consumer choice which is another desired element sought under SP. Selective contracting also faced opposition from medical providers as it interferes with their professional freedom (Figueras et al. 2005). As described in Chapter 4 of the current study, PFHI could not use selective contracting due to difficulties in measuring performance in context of Chhattisgarh. The kind of selective contracting carried out under PPPs in Chhattisgarh on the other hand was based on non-transparent criteria and became untenable over the time and had to be replaced with competitive bidding. Thus selective contracting was difficult to implement in Chhattisgarh but for reasons different than in European context.

Strategic Purchasing for Aligning Provider Incentives for Performance

In terms of performance of PPP contracts, the current study suggests that success in delivering a service depended more on the capacity of the contracted-provider and its method of organizing the service. The incentive of profit was there in other contracts as well but, it was not effective in ensuring performance. A recent international review of case studies of PPPs in LMICs has also found that capacity of the providers

was a key factor and private providers often faced challenges similar to public providers, like shortage of human resources and delays in flow of funds (Rao et al. 2018).

In case of PFHI, it was expected to perform in terms of increasing access and to care with financial protection. As the quantitative analysis in Chapters 5 and 6 shows, PFHI schemes examined across five states in India did not perform well on both of above counts. Utilisation of hospital care did not increase with enrolment under PFHI, even in states where utilisation was poor to start with. Financial protection was even more fundamental to the purpose of PFHI (Devadasan et al. 2013). As described in Chapter 5 and 6 of the current study, the Out of Pocket expenditure for hospitalization did not reduce with coverage under PFHI. The incidence of Catastrophic Health Expenditure also did not come down with insurance. This defeated the basic purpose of the PFHI. Such findings about PFHI in India are not uncommon (Prinja et al. 2017). As the review of literature in earlier chapters showed, most of the evaluations of PFHI in India, from its early days to now, have reported that it could not achieve financial protection. An exception has been a study in Karnataka which showed significant reduction in OOPE and mortality due to PFHI (Sood et al. 2014). The study was carried out in early stages of PFHI in Karnataka and used Ordinary Least Squares (OLS) to analyse OOPE. The study did not take endogeneity into account and that could be the reason for different results. Some studies have suggested some corrective measures in operational features of PFHI (Karan et al. 2017; Prinja et al. 2017). Many recent studies have cautioned against relying on PFHI (Ranjan et al. 2018; Ghosh and Gupta 2017; Nandi et al. 2017). Another recent study looking at comparison of three different states in India (Gujarat, Uttar Pradesh and Haryana) has used a primary survey and it showed that the PFHI was ineffective in improving financial protection (Prinja et al. 2019).

An important finding of the current study was regarding the widespread 'impermissible copayments' being charged by providers from patients under PFHI. This phenomenon has been termed 'double-billing' by Rent and Ghosh (2016). Earlier, Devadasan et al have described the practice of 'double-billing' in their study of PFHI in Gujarat, another state in India –

> "On the supply side, the organisers need to prevent providers from collecting money from both the patient as well as the insurance company. The fact that nearly 60% of insured patients had to spend about 10% of their annual incomed on hospital expenses, despite being enrolled, is problematic. Enrolment in the scheme and utilisation of the RSBY card are merely intermediate steps in a process of having cashless benefits that protects the families from OOP payments. If this objective is not met, then the entire purpose of the scheme is jeopardised. However, Insurance company has no incentive to monitor or reduce OOP payments. Hospitals that force

> RSBY patients to buy medicines and pay hospital bills are paid twice: first by the patient, second by the insurance company. Patients are often not in a position to negotiate as they are vulnerable at the time of admission. Hospitals are indulging in this fraudulent activity." (Devadasan et al. 2013)

In PFHI literature, the above malpractice has also been referred to as 'extra billing' or 'balance billing (Forgia and Nagpal 2012). The current study suggests that terming this behaviour as 'double-billing' may be more accurate as the provider takes money from patient as well as the insurer for the same activity. It is a fraudulent activity where one service is billed twice. It can also be called 'impermissible copayment' because PFHIs in India promised completely 'cashless' benefit and the contracts with hospitals prohibited any charges to be taken from patients.

In the approach taken by Gertler and Solon, the above practice of charging the insured patient has been seen as 'price discrimination' (Gertler and Solon, 2000). In this practice, the provider appropriates the insurance-benefit by charging more from the insured patients. They suggested that governments in LMICs were unlikely to be able to impose 'price-control' on private providers, even under PFHI. The current study found the practice to be common under PFHI in Chhattisgarh, as the providers used 'double-billing'. Monitoring them was difficult and so was taking any action against the wrong-doers.

A recent study on opportunistic behavior in PFHIs of India has cautioned that provisioning dominated by private hospitals may be dangerous because they have a material interest to engage in corruption in collusion with government authorities (Maurya and Ramesh 2018). Another recent study on health insurance in India has pointed out the lack of fair play and the gaps in its regulatory framework (Malhotra et al. 2018). Other studies of PFHI in India have also cautioned against relying on private sector due to inability of governments to regulate it (Bandyopadhyay and Sen 2018; Sen et al. 2018).

Some LMICs, especially from Latin America have reported relatively successful PFHIs or contracting with private providers, without a significant problem of illegal charging under the scheme (Preker et al. 2013). This could be related to better regulation or ability to impose adherence to contracts. Klasa et al in their review of Europe found that SP in Slovakia could not succeed due to widespread corruption (Klasa et al. 2017). The above findings in Slovakia suggest that SP has been unable to solve issues of corruption or act as alternative to corrupt systems and instead posed that it cannot be expected to succeed under endemic corruption. Overall, recent global literature on PFHI and contracting does not indicate evidence

of success in LMICs in using PFHIs or contracting for either improving efficiency or quality of care or providing effective financial protection.

Monitoring performance and rewarding good performance is a key component in SP (Figueras et al. 2005). One of the advantages PPS promised to offer was to provide the purchaser lever of monitoring (Savas 1998). Monitoring of compliance with the incentive structure set under SP has been recognized as of critical importance as a practical issue under SP (Deber 2002).As described in Chapters 3 and 4, most of the clinical care PPPs as well as PFHI in Chhattisgarh did not have well-defined performance or monitoring indicators. Studies from developed countries have shown similar gaps in monitoring, in their practice of purchasing (Donaldson and Currie 2000).

Studies have indicated that ancillary services offered better chances for successful monitoring (Donaldson and Currie 2000). In the current study, contracting for ancillary services had better measures of performance owing to simpler and more measurable nature of services. Provisions of performance based rewards and punishment were also limited to ancillary services. Third party monitoring was used for ancillary services mainly. But even then, there were cases of opportunistic behavior by providers where they over-claimed volume. The government found it very difficult to verify the claims. The contracted-providers realized that refuting their claims will be costly and difficult. They bargained for higher prices knowing that it will be difficult for government to shut down services or to organize fresh bidding. The fact that the performance could be better defined for ancillary services did not solve the challenge and cost involved in monitoring it. This helps us appreciate the well known difficulties of defining performance for clinical care and measuring and monitoring it. And this is one reason why success with contracting clinical care is much less than with ancillary services. Monitoring is essential but difficult and costly (Deber 2002). The experience was consistent with transaction cost theory that recognizes significant costs involved in monitoring (Preker et al. 2000).

As described in Chapters 3 and 4, the quality of services was further difficult to monitor. Even the quality of inputs like human resources was difficult to control. Private providers tried to hire less number of staff or less qualified staff than agreed in the contract. Many contractors paid the staff poorly or took excessive work from them. In some cases it resulted in strikes, which were used by contractors to bargain for higher prices. Other studies have pointed out the poor labour conditions under which staff had to work in many PPPs (Nagulapalli and Rokkam 2015).

The conventional monitoring mechanisms in government were not used in case of PPPs. It reduced the involvement of district officials of health department as monitoring was seen as state directorate's role because the contract was with state directorate. A study of PPP on rural MMUs in Chhattisgarh has

pointed out the same problem (PHRN and JSA, 2017a). This did not help, as even basic functionality of the services did not get monitored regularly.

As described in Chapter 3, contracts were renewed for most of the PPPs without much scrutiny. Contracts were not seen as powerful tools of controlling the provider behavior. The PFHI in Chhattisgarh also had a similar practice. As described in Chapter 4, the difficulty was in proving wrong-doing by the providers. In literature, contracts are seen as important mechanisms for regulation of providers, particularly in LMICs (Ensor and Weinzierl 2007, Palmer 2000, Siddiqi et al. 2006, Lagomarsino et al. 2009).Contracts are expected to safeguard the purchaser against opportunistic behavior (Hart, O. 2003). Under SP approach too, contracts are important to steer the provider behavior in desired direction. However, the current study found that contracts in Chhattisgarh context were incapable of regulating provider behavior. Governments are known to face disproportionate share of risks in Indian PPPs, including of opportunistic behavior by private contractors (Barua 2015). The only exception in our study where contracting added value was where payments were for less frequent and very specific tertiary care services with very minimal moral hazard and where 'gaming' was further reduced by gate-keeping through public sector, viz the Child Heart Surgery Scheme. Thus apart from complexity of tasks, the scale increases costs of monitoring, while reducing its chances of being effective. Monitoring was necessary but more difficult under purchasing. Also, regulation in prices charged by private sector could not be achieved through the mechanism of contracting.

The role of 'stewardship' under SP belongs to government and its capacity can be a key ingredient (WHO 2010). Severe shortcomings in regulation contributed to failure of SP. Government failed to devise alternatives to control the financial malpractices by providers. A few recent studies on SP in LMICs have attributed failures of SP to limited capacity of governments (Munge et al. 2017). On the other hand, there are LMICs like Thailand that have contracted private sector to some extent but are able to regulate its behavior. The difference may be due to less dependence on private sector in such health-systems or other factors that allow better state capacity or limit the power of private sector. The failure of many LMIC governments to impose rules on private providers, including through contracts, requires further examination. Hunter et al in their review of Europe found that the 'stewardship' arm of SP was least developed. Also, the question remains that "how will the governments steer when they are unable to row?" (Hunter et al. 2005). Smith et al while recommending purchasing as a policy option for health-systems, also stated that regulatory frameworks are necessary for any form of purchasing to function (Smith et al. 2005).

Findings in the current study are similar. Private providers had disproportionately high power, including bargaining power due to dependence of the scheme on them. Contracts thus remained ineffective in regulating provider behavior. Mills et al had observed about the nature of private sector in context of healthcare in India that it has poor professional ethos and government regulation was poor (Mills et al. 2001). The current study also showed that increased vertical cover, i.e. the annual sum assured per family did not reduce OOPE because of the ability of providers to indulge in price-discrimination. The incentive was stronger for private sector to over-charge and it could not be aligned with the goal of financial-protection. The states known for their greater capacity for governance also found the same problem.

The power of providers got reflected in their dominant influence over decision-making of the purchaser. It represented a case of 'Provider Capture' as described in literature (Forder et al. 2005). The private providers are able to practice 'price discrimination' when they enjoy disproportionate power with respect to the consumers insured under PFHI (Gertler and Solon 2000). In case of PFHI in Chhattisgarh, providers were not only able to charge extra, they could greatly influence what services got purchased by government and at what prices, to what extent contracts got enforced. Inter-Organisation Relations (IOR), relying on the Social Exchange Theory and Resource Dependency Theory, focuses of other important dimensions of SP – of coordinating relationships and adaptation. IOR approach emphasizes co-creation of value through collaboration and trust. IOR approach suggests that SP would work best when power is divided equally between purchaser, providers and patients (Sanderson et al. 2019). Trust gets undermined if one set of the actors is too powerful. In the context of current study, providers were too powerful and that seemed to be a cause of poor performance of SP.

Strategic Purchasing to fill 'Critical Gaps' in Coverage

One essential component in SP pertains to deciding the services that should be bought. Should purchasing be limited to 'critical gaps' i.e. services that are much needed but not available from public sector? Other studies have recommended private sector contracting when it offers clear advantages in solving a critical gap in public provisioning that the available public sector or non-profit sector cannot provide (Venkat Raman and Bjorkman 2007). Certain parts of NHP 2017 emphasise that focus of purchasing should be to close 'critical gaps' as a stop gap arrangement till the public sector capacity gets built up. This view puts the role of purchasing as making synergistic use of private sector capacity. In the current study, most of the PPPs on tertiary care seem to be in response to 'critical gaps' as the public sector lacked the capacity to provide most of the tertiary care services. The PPPs on primary or secondary care often were not based on 'critical gap' logic. Many of such PPPs that got shelved sought to substitute existing public provisioning with private provisioning, assuming that the existing services were not adequately functional

and contracting could improve their functioning. A criticism of the diagnostics PPP was that there was a big overlap between existing services and PPP was replacing them instead of supplementing (Nandi 2018). This was also true for outsourcing of PHCs.

Our case study of contracting for cataract surgeries brings out the difference between supplementation and substitution. Earlier, Cataract Surgeries contracted under NHM utilized existing capacity of Non-profit NGO hospitals, reimbursing them at a marginal price, while the existing capacity of the public sector was maintained. This is in contrast to purchasing of cataract surgeries under the PFHI, which due to perverse incentive created due to higher pricing, caused a shap reduction in public provisioning and earlier PPPs, leading to idle capacities in these sectors and a shift of the surgeries to private providers at much higher costs. The PPPs for setting up new hospitals allowed charging of unspecified market rates were even more problematic where hardly any price regulation was applied.

As described in Chapter 3, there were PPP contracts in Chhattisgarh which were meant to improve coverage of primary care for under-served populations in rural and remote areas, e.g. the contracts on outsourcing of rural MMUs and remote PHCs. Rural MMUs contracting had to be terminated due to poor performance. PHC outsourcing could not take off because no private providers were willing. Private providers were unable to attract HR for remote areas in Chhattisgarh. A similar constraint has been found internationally (Rao et al. 2018). SP was constrained by the fact that - in geographies where the public sector capacity was poor, the private sector capacity was also very weak. Profit motive did not act in ways that would promote movement of private sector to remote areas. The potential solution was from non-profit NGOs which were available in some vulnerable areas. This was consistent with the recommendation of NHP 2017 to prioritise non-profit NGOs. The contracting procedures in Chhattisgarh however were less suited for NGO participation and were designed for inviting the for-profit sector.

In the states studied here, population coverage achieved in enrollment under PFHI had gaps even when the design was aimed to make it universal. The gaps in enrollment have been pointed out by other studies in India and targeting has been found to be a key cause (Ghosh and Gupta 2017). Further inequity is in terms of availability of services, where rural population has fewer facilities to utilize care as pointed out in other studies (Devadasan et al. 2013). In the current study, purchasing services under PFHI did not add to remote population coverage.

Purchased services under PFHI did not add to coverage of critical gaps in tertiary care services. The services actually provided and utilized under PFHI remained in a narrow range. Effectively, PFHI bought what the private providers were willing to sell, rather than what the population needed. Investments did

not flow to remote areas or 'critical gap services' despite 'demand' being created there through PFHI enrollment. The stimulus to demand provided through PFHI, could not get the supply to respond.

As analysed in Chapter 4, the service-mix purchased under PFHI in Chhattisgarh did not correspond well to the population health needs. 'Population health needs' has been seen as one of the most desirable individual components in SP (Klasa et al. 2017). It is also one of the least practiced components of SP. A review of ten countries of Europe found that – "no studied country has successfully managed to assess both current and future population health needs and synchronize these needs with its purchasing decisions". (Klasa et al. 2017). The review also found that the epidemiological and population coverage priorities articulated in national health policies did not get reflected in service-mix purchased in these countries (Klasa et al. 2017). A similar concern has been raised by other researchers (Mckee and Brand 2005). Our study of current efforts of Global Health Institutions to promote SP in LMIC contexts suggests that relatively less attention has been paid to 'population health needs' and instead the focus has remained mainly on payment mechanisms. World Bank has not emphasized 'population health' in its literature on SP (Preker et al. 2007). This component also seems to be inadequately integrated with the concept of SP in theoretical terms too (Mckee and Brand 2005, Hunter et al. 2005).

There is an expectation expressed that SP should help in improving geographical equity in services by influencing distribution of providers in disadvantaged areas (LSHTM 2014). However, most of the normative literature on SP, from global health institutions like World Bank and WHO, seems to have ignored this point. The focus is on contracting providers who offer the best value for money in terms of prices and quality.

The pattern of inequitable distribution of services between geographies in India has been seen as exacerbation of 'inverse care law' under PFHI (Nandi et al. 218). It also represented a resource transfer from the vulnerable areas to urban population as resources earmarked for the remote areas and tribal communities were put into the insurance premium for the population here, but they could not get services in return and most of the claims came in from urban areas. Creating combined risk pools covering entire population has been seen as a measure for equity (WHO 1999). Through such pooling, SP has been seen as means to increase funds and promote equity by cross-subsidising the poor (McIntyre 2007). But in case of PFHI practice in Chhattisgarh, combined pools through PFHI route achieved the opposite. Funds meant for tribal population were used for PFHI, resulting in effective resource transfer from the more vulnerable to subsidize the relatively better-off urban population. There can be a conflict between the goals of equity and efficiency that has been recognized in the World Health Report 2010 and a balance is

recommended (WHO 2010). The current study found that in the examples of SP examined here, neither efficiency nor equity could be achieved.

The experience from purchasing in Chhattisgarh suggests that the approach should be to see SP as the means to fill gaps in public provisioning. It also sees it as a stop-gap arrangement till the public services get strengthened (GoI 2017). It sees the overall healthcare delivery to be based on public provisioning with some space for purchasing when required (Sundararaman 2017). This approach to provider synergy that works in practice seems to be the opposite of competition based approach, recommended in much of the literature on SP.

Strategic Purchasing for enhancing Competition and Choice

NPM emphasized that purchasing should aim to enhance competition and choice in healthcare. By this view the services which are available in public sector, should also be subjected to market competition to realize best efficiency (Figueras et al. 2005). In Chhattisgarh's experience, almost none of the PPPs resulted in increase in competition. Most of the PPPs were not designed to increase consumer choice either, except for the PFHI. The PPPs were mainly aimed to make a service available and functional. In some PPPs, payments to providers were based on number of patients to whom services were provided. PPPs for setting up new hospitals, on the other hand, acted as supply side stimulus to private sector.

In case of PFHI in Chhattisgarh, there was a high possibility of competition between numerous private providers empanelled under PFHI in urban areas along with competition between public and private providers as envisaged under SP. The scope for 'contestability' however did not give the desired results. A rationale underlying PFHI was that the poor had no choice but to go to public sector because private sector was not affordable. They could not exercise 'exit'. PFHI was supposed to make private sector affordable and thus create 'choice'. But in actual practice after PFHI came in, private sector continued to be unaffordable. The 'choice' created through purchasing thus got limited.

As discussed in Chapters 4, the overlap in services provided by private and public sector encouraged opportunistic behavior by HR of public sector and caused damage to public sector. Through PFHI route, most of the financing in form of insurance claims went to private sector. It also reduced the availability of funds for strengthening public sector as substantial share of health budgets went towards PFHI. Demand side financing worked poorly for public sector. Incentives to public-sector staff out of the insurance claims failed to encourage the public facilities to make greater use of PFHI. A remarkably similar set of problems has been reported from other LMICs such as Morocco where regulation is weak (Mathauer 2017, Akhnif and Dkhimi 2017).

According to experts from WHO, SP involves making decisions based on information and linking provider-payments to information (Mathauer 2017; Kutzin 2017). There is no SP without information (Kutzin et al. 2016). Role of government in improving access to information has been seen as a way to mitigate information-asymmetry in healthcare purchasing (Musgrove 1998). As described in Chapters 4, 5 and 6 of the current study, governments did carry out awareness campaigns around PFHI but they were not effective in resolving information-asymmetry. Internationally, electronic health information systems have been often portrayed as a potential solution but there seems to be inadequate evidence on how they helped the patients in getting better services. Klasa et al in their review of SP in Europe found that "virtually all countries continue to struggle with implementing a successful electronic health platform" (Klasa et al. 2017)

Our study found that use of the 'voice' mechanism was largely ignored in implementation of SP in Chhattisgarh. No citizen committees or consultations were in place. It was not possible to assess the whether such mechanisms could have been useful but, what is clearly visible is the lack of emphasis on 'voice' in practice of SP in Indian scenario. This is very different from the European SP literature that counts 'citizen empowerment' as an essential component of SP (Figueras et al. 2005; Klasa et al. 2017). As described in Chapter 4, phone helpline was used for grievance redressal and perceived by implementers as a mechanism of 'voice'. The persistent and widespread over-charging by providers indicated that grievance redressal could not be implemented as per design and enough action was not taken against providers. Other studies have reported that mechanisms for 'voice' like citizen-consultations and patients-rights had been initiated in many European countries but they were inadequate. Further, there was a risk that groups already getting the services got more empowered in such initiatives whereas the most marginalized groups got left out (Klasa et al. 2017).

Implications for Policy:

After reviewing implementation of SP in ten countries of Europe, Klasa et al made the following recommendation recently:

> "Countries with inherited purchasing systems should not place bets on strategic purchasing and countries without purchasing should not prioritize its introduction relative to other policy tools" (Klasa et al. 2017)

SP has been assessed as un-implementable and serving mainly as attractive political rhetoric (Klasa et al. 2017). Their contention was that when SP could not be implemented well in developed countries of Europe, it was unlikely that other countries would be able to a better job of its implementation. The current study found that to be the case for India.

Thailand's health-system has been celebrated as a successful case of UHC through SP (Tangcharoensathien et al. 2014). Thailand purchases most of the services from public sector and it is not meant to increase competition or choice (Tangcharoensathien et al. 2018, Kumar and Birn 2018). In this approach to SP as implementing flexible forms of financing to public facilities, has been portrayed as SP. Costa Rica is a similar example (McIntyre et al. 2013). The review done as a part of the current study raises the question on what can be legitimately be termed as 'strategic purchasing' or even 'purchasing'.

In the last two decades, global institutions led by World Bank and WHO have focused their efforts of promoting SP in LMICs by including it prominently in their agenda-setting (Mathauer et al.2017, Meessen 2017, WHO and others 2016). In the international context, UHC has emerged as the dominant global policy discourse (Tichenor and Sridhar, 2017). SP has been aggressively promoted as the policy option countries should take if they are to make progress towards UHC (Preker and Langenbrunner eds. 2005, Preker et al. eds. 2007, Loevinsohn 2008, WHO 2010, WHO 2017b). Influential global non-state donors are also promoting SP in LMICs (Langenbrunner 2017). There has been an expansion in SP in LMICs, using modes like 'contracting' and PFHI. Evidence of performance of purchasing has been poor, unclear or at best mixed – not just in LMICs but also HICs. As described in Chapter 2, most of the HICs have retained a large share of public sector in provisioning whereas private sector provisioning has expanded in LMICs. As discussed in Chapter 2 of the current study, a global consensus seems to being imagined around SP without adequate evidence and scrutiny of concept and its application.

The ongoing debates on SP have got limited to a few issues like design of Payment Mechanisms (Fee for service, Capitation, DRG etc.) and their appropriate mix to achieve the right balance in incentives (Mathaeur 2016, WHO, 2017b). Some have advised caution in limiting SP to payment mechanisms, quality tools or provider competition (Williams 2007, Busse 2007). Yet, there is tendency to see SP as a techno-managerial issue that does not require institutional change (Mathaeur 2016). The current study finds that the debate surrounding purchasing in India is even more limited, usually restricted to whether pricing of services is attractive enough for private sector or whether to use an insurance intermediary.

Some studies of SP have emerged from LMICs. They have reiterated the importance of Purchaser-Provider Split and attribute poor success in SP policies to continued political interference in purchasing decisions (Ogbuador et al. 2018). There is a prominence given to importance of capacity of government to handle contracting i.e. in stewardship (Munge et al. 2017).

When purchasing has not worked, it has been called 'passive' (Etiaba et al. 2018). This seems like a circular logic, where 'strategic' purchasing by definition can never fail, because whenever it fails, it is being termed as 'passive purchasing'. The conceptual ambiguity introduced by the adjective 'strategic', in the concept of SP has been pointed out (Klasa et al. 2017). There is also a critique that the term SP itself is loaded and it conveys an emphasis on ethos of consumerism (Williams 2007).

It has been suggested in literature that the issue of purchasing in healthcare should be examined empirically (Le Grand 2011). The findings of our study indicate serious failings of SP in the context it was studied. Was it due to poor implementation? Or was it due to issues with the theoretical premises underlying the approach of SP? In empirical terms, the primary survey done in Chhattisgarh as part of this study, showed severe limitations of PFHI, even for urban areas where the PFHI had best chances of success due to better availability of empanelled providers. Our study examined PFHI based purchasing in four more states in India and they showed similar pattern in failing to achieve the main goal, of financial protection. It included states with better governance, technical capacity, experience of contracting and a proven track record in providing public services including primary healthcare. The widespread ineffectiveness of PFHI based purchasing indicated a need to examine the underlying assumptions. The study attempted to list the main theoretical premises of SP and found that in practice they played out very differently on the ground. Most of the theoretical premises of SP listed in this study were found to be of very limited validity when examined in practice.

In India's mixed health system, 62% of the health expenditure is being borne by individuals or families, in form of OOPE (NHSRC 2017). In the current study, private sector utilisation was a key determinant of size of OOPE and a predictor of incurring Catastrophic Health Expenditure in all five states and it did not change with PFHI enrolment. No cost-saving was found with PFHI-based purchasing, due to persistently high OOPE. The size of OOPE and incidence of catastrophic expenditure was several times lower for utilisation in public sector, irrespective of PFHI. The implication for policy is that increasing the share of public provisioning in care can give better results but effective ways need to be found to strengthen and expand public-provisioning of clinical care services.

The public hospitals are likely to have less incentive to cheat patients or to engage in other fraudulent activities under PFHI (Maurya and Ramesh 2018). In the current study, public sector was found to have

relatively better presence in remote areas compared to private sector and the same has been reported by others (Nandi et al. 2018). Public sector was found to be preferred by the more vulnerable population in the current study as well as many others (Ranjan et al. 2018, Nandi et al. 2017). Increasing the share of public provisioning could be a strategy likely to reduce OOPE, improve efficiency and equity. Mohanty and Kastor found that while the catastrophic-expenditure incidence for maternal care in public sector came down sharply between 2004 and 2014, it remained high in private sector. They recommended strengthening of public sector and regulation of private sector (Mohanty and Kastor 2018). In the current study of PFHI in Chhattisgarh too, maternal conditions represented a water-tight case where even when covered comprehensively under PFHI, CHE incidence in private hospitals was three to four times of public sector. The states covered in this study used substantial resources on PFHI, between 10 to 20% of their health budgets. In order to strengthen public provisioning, redeploying some of these resources could be an option.

NPM kind of reforms have been justified by pointing out the poor responsiveness of public sector and widespread corruption in it. But these same authors caution that NPM reforms are unsuitable for LMICs because of high likelihood of opportunistic behaviour by private sector there. The professional ethos of private sector in LMICs including India was thought be poor. This was coupled with the poor ability of patients to act as well-informed customers. The ability of government to regulate private sector was also judged to be poor (Mills et al. 2001). The current study started with the assumption that there could be problems in direct provisioning by government as well as in purchasing. Its findings indicated that the purchasing from private sector was more problematic than direct public provisioning in the Indian context. The public sector showed some advantage in terms of being more accessible to the vulnerable populations in remote rural areas. There was OOPE involved in utilizing public sector too but it was several times less than in private sector. Similar pattern has been reported by other studies on PFHI in India (Ranjan et al. 2018; Nandi et al. 2017).

According to Economics of Organisation (EO) theories, market-structure offers strong incentives. But, there can be conditions when incentives under market governance structure lead to opportunistic behaviour. Double-billing in PFHI represented opportunistic behaviour by providers. It is a form of transaction cost. The extent of double-billing practiced meant that transaction costs of opportunistic behavior were very high. According to EO theories, Hierarchy governance structure offered advantages when reducing transaction costs is priority. Hierarchy (though weak on incentives) can have advantages in a context where powerful providers dominated and the system was deficient in control mechanisms and regulation. Hierarchy also offers advantage when societal objective is equity in access and providing according to ‘need’ (Allen 2013).

The current study found that aligning the incentives through purchasing contracts was most difficult. Others have pointed out this difficulty in achieving alignment of incentives, even in the first-world situations. In a review done for World Bank in 2004, Deber et al concluded that it was highly difficult to align the incentives of investor owned private hospitals with public-health goals. They suggested contracting with not-for profit sector (Deber et al. 2004). India's National Health Policy advises a similar prioritization of partnering with the not-for profit sector, but the advice seems to be ignored in implementation.

The market structure performed poorly even though the kind of healthcare examined here – episode based clinical care can be considered as closer to being private goods. The element of monitoring was found to be necessary to ensure compliance of contractual conditions. A market structure for healthcare private goods with challenges of monitoring powerful providers gave poor results.

Another driver for NPM kind of reforms in 1990s was the concerns of international institutions about cost and equity in healthcare of LMICs. There was a concern that government allocation of funds favoured the rich (Mills et al. 2001; Gwatkin 2005). The current study found that public sector was more accessible for the most vulnerable in Indian context, compared to the services purchased from private sector. According to a recent study, World Bank is seen as highly suited to playing a big role in pushing UHC agenda especially due to its experience and relationship with finance ministries in LMICs, but runs the risk of promoting privatization (Tichenor and Sridhar 2017). The current study found that the international institutions like World Bank and WHO promoted SP as desired policy for LMICs when the evidence of success of such reforms seemed to be limited. The role of international financial and health institutions in promoting SP on LMIC agenda requires further exploration.

Involvement of private sector in provisioning under publicly funded healthcare has been widely suggested for LMICs (Preker et al. 2007, WHO 1999, Lagomarsino et al. 2009). There have also been reports of some positive experiences with PPPs in some LMICs where the context was more suitable for their success (Loevinsohn 2008). But the above recommendation seems to be of doubtful use in other LMIC contexts where the capacity to regulate an opportunistic private sector is poor. Many studies have pointed out the problems LMICs face in regulation, especially of private providers (Gupta and Chowdhury 2014; Kumarnayake 2000; Shiekh et al. 2015).

In many High Income Countries (HICs), public sector continues to play the dominant role in provisioning. As described in Chapter 2, nearly 95% of the total hospital-beds in Europe were in public sector in 2013 (WHO Regional Office for Europe 2018). It has been attributed to the strong moral infrastructure of solidarity in such societies (Maarse, 2008). WHO acknowledged the role of 'classical

universalism' in building successful health systems while advocating 'new universalism' in 1999. 'New universalism' was an attempt to redefine solidarity, where public funding was essential but public provisioning was not. This recommendation was aimed more at LMICs. Some of best known successful health systems in LMICs involve a dominant role of public sector in provisioning, e.g. Thailand, Srilanka, Malaysia and Costa Rica (Kumar and Birn 2018; Cashin et al.2017).

At the same time, different health-systems have different starting points and India has many disadvantages in that regard. In the current study, around half of the hospital-beds in Chhattisgarh were in private sector. This contradiction in many LMICs, a poor ability to regulate and a large private sector presence, poses challenges that need further careful exploration. There is still inadequate information on the best way to implement SP in LMIC situations (McIntyre et al. 2013). Further research has been suggested to compare models based on funding public facilities with flexibility like Thailand with the models relying on private sector, like PFHI in India (McIntyre et al. 2013).

Limitations: The study has not looked at quality of care which is an important element but was beyond the scope of this study (WHO 2010, Propper 2018). The current study did not investigate the likelihood of provider induced demand under PFHIs and the danger of un-necessary procedures being carried out by hospitals, known to contribute to OOPE and inefficiency (Meng 2012; Wagstaff and Lindelow 2008). The study uses Catastrophic Health Expenditure as a measure of financial protection, which though widely used is known to have some limitations (Giedion et al. 2013).

Suggested Areas for Future Research: Based on the review of literature that was part of the current study and the findings of this study, some areas for future research are suggested as follows:

There have been a large number of PPP contracts attempted in India over the last two decades. However the body of empirical literature on PPPs seems to be modest. Even documentation of the many efforts, that is available not only to the public but even to policy makers does not exist or is very incomplete. More studies of PPP contracts are needed in other states, on the lines attempted for Chhattisgarh in this study. There could be different experiences in other states.

More study on the policy process, including the role of international financial and health institutions in promoting 'SP' on LMIC agenda is required to understand how these programmes expand and their ability to learn and correct from past experience. PFHI programmes are increasingly popular with state and central governments in India and it is coupled with overwhelming evidence of their failure in preventing OOPE. The contradiction between the popular appeal of PFHI and their inability to curtail OOPE requires exploration. SP for ambulatory or primary care is another area requiring attention in India.

Further research has been suggested to address the challenges of regulation in LMIC contexts despite a large private sector presence and the potential of regulation to provide affordable care. McIntyre et al. had suggested research to compare models of SP based on funding public facilities with flexibility like Thailand, with the models relying on provisioning through private sector, like PFHI in India (McIntyre et al. 2013). This remains one relevant question for LMICs globally and for India.

As discussed in the limitations of this study, more studies are needed on how quality dimension has been addressed through Strategic Purchasing. We came across a concern about 'un-necessary care' under PFHI based purchasing and it may be a significant issue that requires more research. Further studies are needed in India on competition between providers and its effect on costs, quality and rational care. More studies are needed on perspectives of patients, providers and policy-maker on such policies.

Conclusion:

There have been few studies of SP in India and the current study was aimed to examine this new area, highly relevant to current policy discourse in India and other LMICs. It is also perhaps the first attempt to assess PPP contracts and PFHI as forms of SP in India. This study is an addition to the small body of emerging literature on SP from LMICs. It has been well recognized that there is a dearth of methods for assessing the implications of health financing strategies for health system goals (McIntyre et al.2013). The current study attempts a mix of methods to understand this complex phenomenon in Indian context

'SP' carries different meanings in different policy contexts. In Indian context, it plays out very differently from the intended design. Desired outcomes of improved access, efficiency, financial protection could not be achieved by attempts to align incentives through PPP contracts or Publicly Funded Insurance schemes.

This study suggests that there is a choice to be made between 'SP' as a stop-gap arrangement or as the essential desired path for health systems in LMICs. It proposes that 'SP' can be useful under some conditions. It suggests that 'SP' can be employed judiciously for meeting 'critical gaps' in public sector capacity. The purchasing from private sector can work when the partner selected has the desired capacity, and has better methods of organizing the delivery of service, and that the scheme is done on a scale that allows adequate gate-keeping by public sector.

Under an 'SP' approach that treated health as a market commodity, it was very difficult to align the incentives with public health goals. This reliance on market forces coupled with weak regulation resulted

in severe forms of opportunistic behavior by providers. Nor did supply increase in areas with new demand.-side financing. Market behavior was found to be not dependent on only supply and demand. Further demand stimulus in such a context does not alter market behavior in the direction desired.

The opposite of market principles is the principle of 'Solidarity' (Hart, 1990). Organising provisioning around principle of 'Solidarity' may be a better option if 'equity' is the societal objective. Such systems require high levels of trust and one needs much work to understand the conditions under which such levels of trust and solidarity can flourish. Solidarity based approach has been suggested to be more suitable to context of LMICsthan trying to contract private sector (Mills et al, 2001). Solidarity promotes healthcare provisioning as means of supporting each other, the healthy supporting the sick and the wealthier supporting the poor.

The study set out to ask the question whether SP can improve performance of health system in India. The answer this study indicates is that the progress towards the goals of UHC is likely to remain elusive under a 'strategic purchasing' approach that perceives healthcare as a market commodity and where all the focus of reform is on financing, with the implicit assumption that if demand and market failures are addressed the problems of access and provisioning would also get addressed. As Indian health system moves from a largely patient-funded system to a public-funded one, it is necessary to also consider the principles on which provisioning isorganised. Provisioning based on principles of solidarity can serve the goals better than trying to mitigate the market-failures.