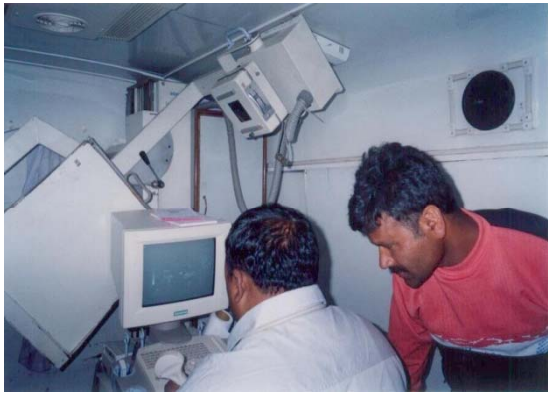
Public Private Partnership in Health

State Institute of Health & Family Welfare

Jaipur

Public Private Partnership

Not all interactions between the private and the public sector is PPP



.....then what is Partnership?

PPP ?

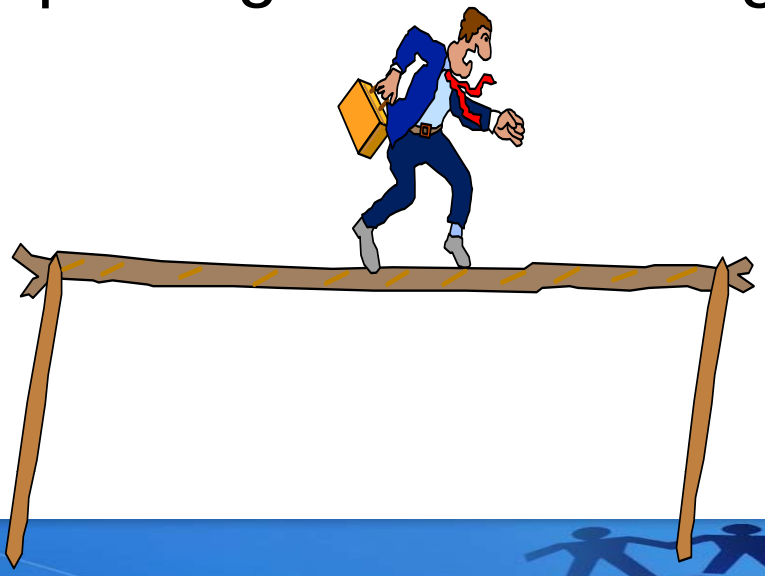
Public-Private Partnerships (PPP) are collaborative efforts, between private and public sectors, with clearly identified partnership structures, shared objectives, and specified performance indicators for delivery of a set of health services (MOHFW,GOI)

Health care: Issues

- Neglected priority-Not a core governance issue
    - Policy-36 yrs
    - No sub-centre till 1971
    - % of GDP –Declining on a regular basis
    - State subject -central dictate
- Human Resource
    - Shortage/ vacancies/ absenteeism
    - Training/ Capacity building
- Low capacity of fund utilization
- Poor management support

Issues in Health financing:

- Reduce out-of-pocket payments
- Increase the accountability towards health care provision
- Risk pooling & Risk sharing.



Health Care: Challenges

- Manpower- Number & Norms
- Rural / Urban differential
- Geographical divide across States
- S-E groups – accessibility/reach
- Gaps between Policy & Action
- **Health sector expenditure**
- Newer Infections

Financing Options for Health

- Public investment
    - Govt. revenue
    - Taxes
    - Debt financing
- Private investment
- Public Private Partnership
    - Public goods
    - Ownership issue
    - User fee
    - Risk transfer

PPP: Why?

- Improve access without substantial investment from public sector.
- Adopt best practices
- Opportunity to increase reach
- Opportunity to regulate the private sector
- Need based Tailored services
- Competition opens Options for poor

Key concerns for PPP

- Availability, Accessibility of Health Care
- Quality of care at affordable cost
- User fee charges- Affordability
- Public-Private Partnership

Attribute	Privatization	PPP
Responsibility	Entrepreneur	Govt.
Ownership	Private sector	Govt.
Nature of services	Decided by private operator	Mutual agreement
Risk & reward	Private sector	Shared between Govt. & Private party

Selection of Service Provider

- Competitive Bidding
- Swiss Challenge Approach
- Competitive Negotiation

Competitive Bidding

Transparent procurement method in which bids from competing contractors, suppliers, or vendors are invited by openly advertising the scope, specifications, and term and conditions of the proposed contract as well as the criteria by which the bids will be evaluated.

- Aims at obtaining goods and services at the lowest prices by stimulating competition, and by preventing favouritism.
- Two types
  - **Open competitive bidding** (also called open bidding), the sealed bids are opened in full view of all who may wish to witness the bid opening

- **Closed competitive bidding** (also called closed bidding), the sealed bids are opened in presence only of authorized personnel.

Competitive Negotiation

- Variant of competitive bidding.
- Government specifies the service objectives and invites proposals through advertisements.
- Government then negotiates and finalizes the contract with the selected bidders.
- Negotiations may be ‘simple’ (direct) or ‘complex’ (indirect).

- Government negotiates through ‘master contractor’/mother NGO, who handles all dealings with sub-contractors/franchisees and monitors the program by collecting information from the beneficiaries.
- Advantages of Master Contracting :
  - Administrative convenience
  - Better control in dealing with less number of service providers.

- ‘Master contract’ not always relevant.
- Negotiation done directly with community/ beneficiaries.
- Less transparent than competitive bidding.
- Decision based on an in-depth study to determine which strategy is the most suitable.

Swiss Challenge Approach

- Refers to suo-motu proposals received from the private participant by government.
- Private sector provides all details regarding its technical, financial and managerial capabilities and its expectations of government support/concessions.

- Government examine proposal and if proposal belongs to the declared policy of priorities, then it may invite competing counter proposals from others with adequate notice.
- If better proposal received, the original proponent is given the opportunity to modify the original proposal.
- Finally, the better of the two is awarded the project/program for execution

Payment Mechanism

- Contractual payments
- Grants-in-aid and
- Right to levy user charges for the asset created/leased-in.

Risk & Revenue Sharing

- Construction/implementation risk, arising from:
  - delay in project clearance;
  - contractor default;
  - environmental damage

- Market risk, arising from:
  - insufficient demand;
  - impractical user levies.

- Finance risk, arising from:
  - inflation;
  - change in interest rates;
  - increase in taxes
  - change in exchange rates.
- Operation and maintenance risk, arising from:
  - termination of contract;
  - technology risk;
  - labor risk.

- Legal risk, arising from:
  - changes in law;
  - changes in title/lease rights;
  - insolvency of developer/service provider;
  - change in security structure.

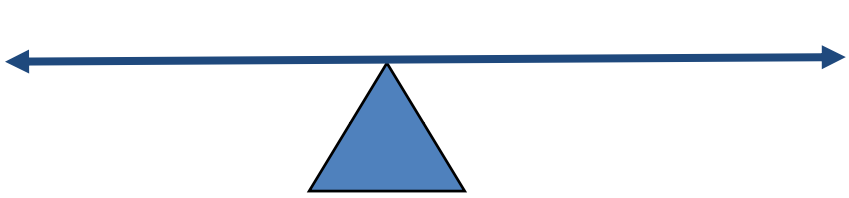
Potential Benefits of PPP

- **Cost-effectiveness-**
- **Higher Productivity-**by linking payments to performance,
- **Accelerated Delivery** – since the contracts generally have incentive and penalty clauses vis-a-vis.
- **Clear Customer Focus** - the shift in focus from service inputs to outputs
- **Enhanced Social Service-**
- **Recovery of User Charges-Innovative**

PPP Messages

- PPPs is about health impact not just resource generation
- Start early in developing partnerships
- Take the time to look for opportunities for PPPs
- Not all projects lend itself to partnerships/alliances
- Some successful country examples exists
- There are tools & resources to help you to develop PPPs

Public-Private Equilibrium



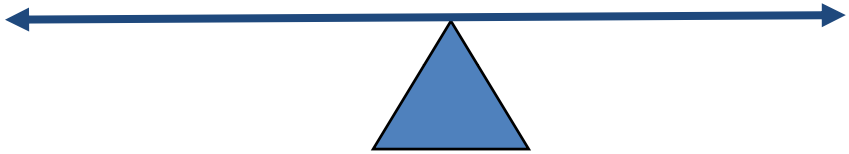
Advantages:

- Improvement in Health is the primary objective
- Economies of Scale
- More Equitable

Advantages:

- Market/Choice and Access
- Efficiency
- Flexibility

Public Sector ⟷ **Private Sector**



Things to watch:

- Efficiency
- Inflexibility/Responsiveness
- Customer satisfaction

Things to watch:

- Primary objective is profit
- Quality of services
- Cost

Objectives

- Improving access to essential services
- Improving the quality of services
- Exchange of expertise
- Mobilize additional resources for activities
- Improve efficiency

- Better Management of Health services
- Increasing scope and scale of services
- Increasing community ownership of programs.
- Ensuring optimal utilization of govt. investment and infrastructure

Basics of PPP

- Problem
- Profile of Partners
- Process of Building a partnership
- Profit – Mutual Benefit
- Phase – start small & build
- Proliferate –Grow, Expand, & Sustain
- Priorities & Preferred group
- Policing – Mechanism of Monitoring & Transparency

- Politics – Governance, Administration, People's audit
- Protection/proof: A security system
- Price: A cost share in terms of money/kind
- Professional Network
- Platform
- Prize: Acknowledgement/recognition

Factors Influencing PPP

- Clarity of Purpose
- Creation of value
- Congruency of Mission, Strategy and Values
- Connection with purpose and people
- Communication between partners
- Continual learning
- Commitment to the partnership

Action Principles for PPP

- Combined action at all stages
  - planning,
  - follow up and
  - termination34
- Complimentary roles
  - expectation of each other are clarified and stabilized
- Creation of a temporary system
  - task force with representatives from both sides
- Continuous Communication

How PPP helps:

Economies of scale

Utilizing existing capacity

Create synergy

Targeting poor

Flexibility in action

Resource mobilization

Technical Up-gradation

Better Services

Better Health

Models of PPP

- Social Franchising
- Branded Clinics
- Contracting
- Social Marketing
- Build, Operate and Transfer
- Joint Venture Companies
- Voucher System
- Donations from individuals

- Involvement of Corporate sector
- Partnership with Professional Associations
- Capacity Building of Private Providers
- Autonomous Institutions
- Mobile Health Vans
- Health Insurance
- Partnerships with Social Clubs and Groups

STRAIGHT Approach to PPP–

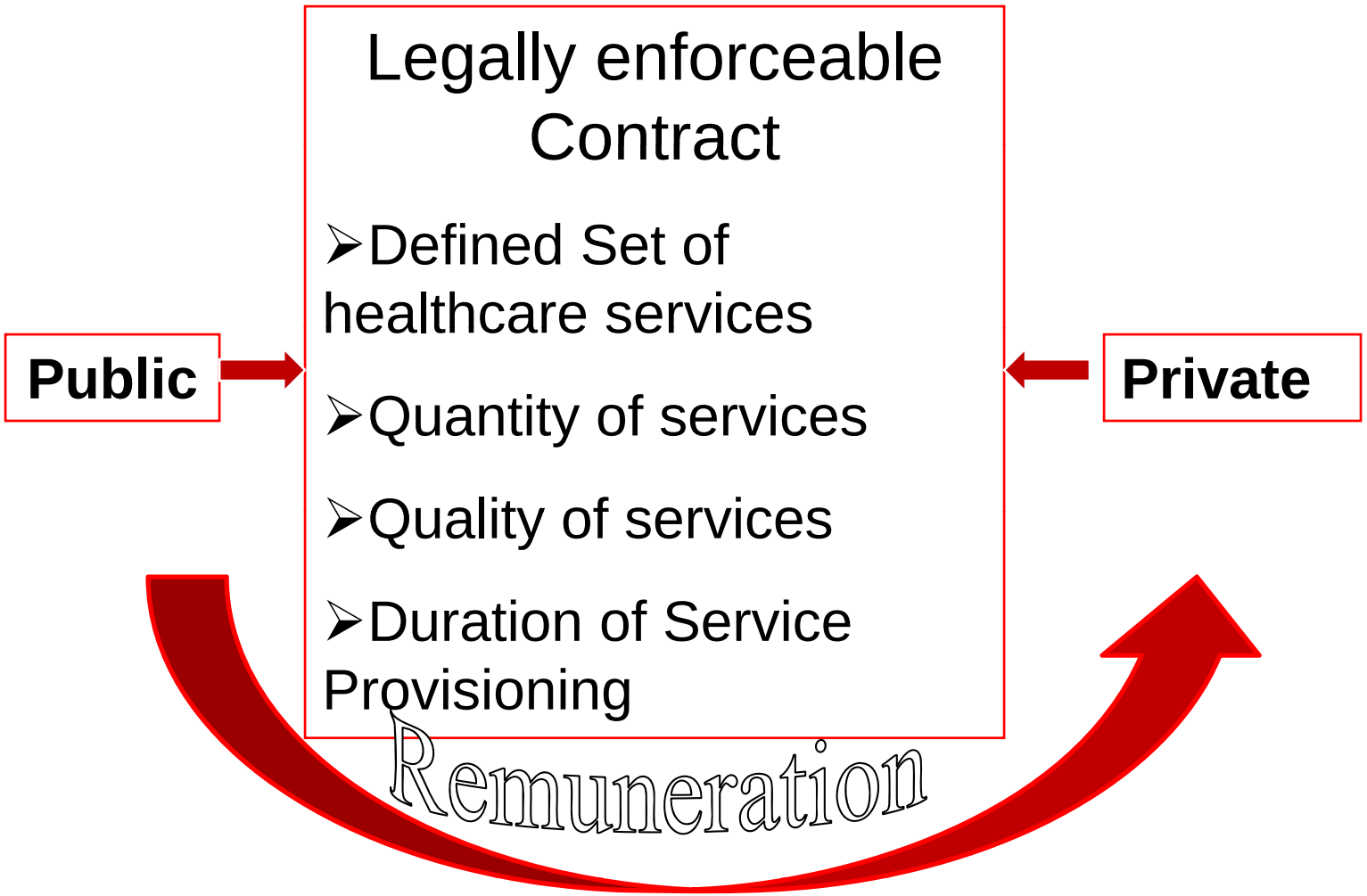
- Identifying the **Scope** of partnership
- Identifying the appropriate **Target** Population
- Selecting the **Right** Partners and Model
- Ensuring **Accountability**
- Ensure active **Involvement** of the Govt.
- **Generate** Support of stakeholders through IEC, advocacy and rapport building
- **Highlight** achievements
- Build **Trust** of all the partners and clients

Some PPP Models in India

Conventional Contracting in	SMS Hospital, Jaipur Bhagajatin Hospital Kolkata	Radiology & Drug store Diet, Cleaning, Laundry, security	**Private Company/ Individual Entrepreneurs**
Contracting out	Karuna Trust, Karnataka Shamlaji Hospital Gujarat Rajiv Gandhi Hospital, Raichur	PHC Mgt. CHC Mgt. Tertiary care hospital	**Charitable NGO** **Charitable NGO** **Private company**
Performance Management Contracts	APUHS Project, Adilabad, AP Chiranjeevi Yojana, Gujarat	RCH Services RCH/MH services	**Charitable NGO** **Private clinics** **Charitable NGO**

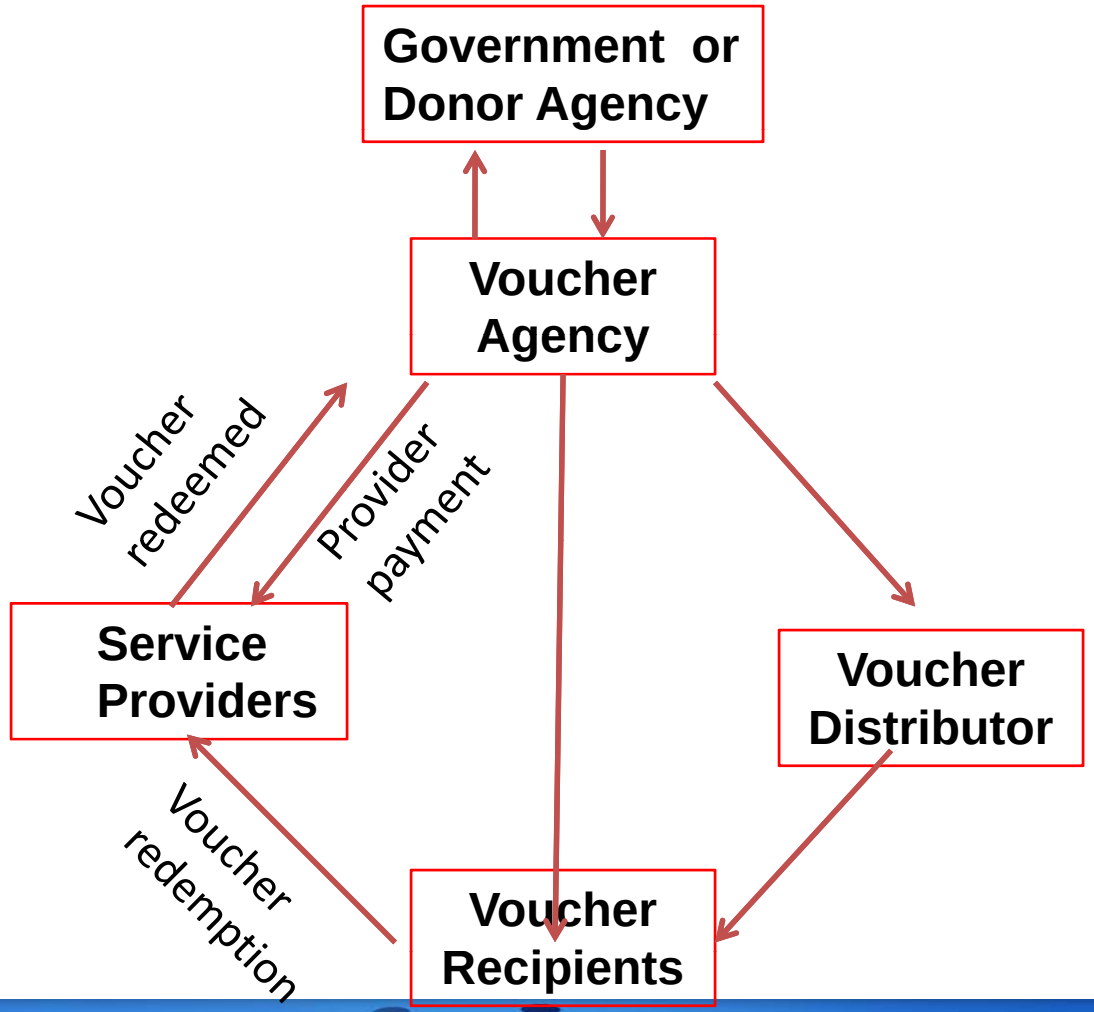
Community/ Health Insurance	Yeshashvini Scheme,Karnataka	Surgical Care	Private Hospitals consortium
Voucher Scheme	Arogya Raksha Scheme, AP SIFPSA, Agra UP SCOVA, Haridwar, UK	Hospitalization Maternity Care/ Institutional Delivery	Private Hospitals/PSU insurance Private Hospitals
Hospital Autonomy	RKS, Bhopal / & Other Places	Patient welfare committee	Public Hospital
Franchising	Merri Tarang; Merri Silver; Merri Gold; Life Spring-HLFPPT/ SIFPSA' Janani, Bihar	M CH / Other curative services	Franchised private entrepreneurs

Contracting –In and Out



Voucher System/ Demand Side Financing

A voucher is a document that can be exchanged for defined goods or services as a token of payment (tied-cash).



Agra Model

Partnerships with Professional Associations

Expert Pool

- IAPSM, IPHA
- FOGSI – Vande Matram scheme
- IMA – Aao Gaon Chalein

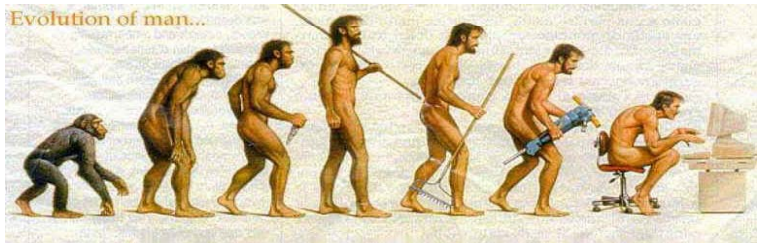
Protocols/ Quality Assurance/ Accreditation

Health Financing in Rajasthan

- Early 1980s
  - Pay clinics
  - Auto finance scheme(1982)
    - Revenue went to State
    - Did not last

Evolution–PPP

- 1994
    - First State to formulate a policy for BOT
- Sector covered under PPP
    - Tourism, Water, Power, Roads, Art & Culture, Health
- Health & PPP
    - 1995-RMRS
    - 1996-LLFS
- Industrial Policy 2003, 2010
- SEZ policy 2003
- Hotel Policy 2006
- Policy for promoting private investment in Health, 2006



Rajasthan Medicare Relief Societies

- NGO-Registered society-Autonomy
- Self-sustainable
- Reducing cost of care –No middle man
- Instrument for cost recovery (user fee)
- Cross subsidy to marginalized
- Promote PPP for capital intensive facilities in Health care

Rajasthan: Success Stories in PPP-

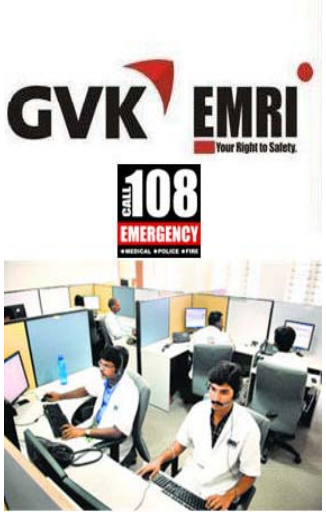
- RMRS
- Linear Accelerator
- MRI and Radio-imaging in Tertiary care Teaching Hospitals
- Geriatric Clinic/ Diabetic centre at Bikaner
- Contracting out of support services
- Urban RCH centers
- Private policy for PHC/ CHC operations
- Policy for promoting Private sector in Health
- MMUs
- 108

PPP : EMRI

- EMRI began operations in Rajasthan with the signing of a 5-year MOU with GoR. in Sep, 2008.
- State provide emergency care with private sector efficiencies.
- The capital cost for purchase and equipping the ambulances ,land & building of the call centre, was provided by the Government of Rajasthan under NRHM funds

Objectives:

- Achieving MDGs
- Improve & increase Access to health care
- Emergencies
- Reduce IMR,MMR & Deaths



- GoR contribute 95% of the operating cost & 100% of the capital cost (of ambulance purchase, fittings, land and building for the state level Call Centre, etc).
- Govt. of Rajasthan's share the cost charged under NRHM.

Rajasthan Medicare Relief Societies

- Autonomy
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- Aimed to encourage alternative sources of health financing through user-fee schemes and in-hospital pharmacies.

- This strategy was first started in a tertiary level hospital, SMS hospital, Jaipur and its success led to its replication in other medical colleges, district hospital and sub-divisional hospitals.

Advantages:

- Revenue generation
- Financial Autonomy
- Improved efficiency in the system
- Cost recovery:

Features:

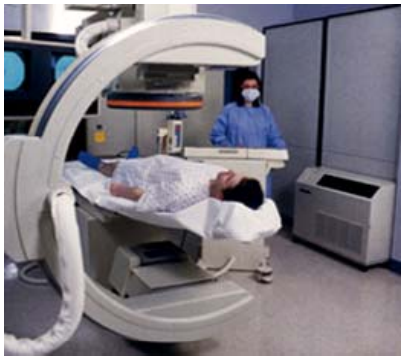
- No Monopoly
- Drugs identified by committee of Sr. Doctors
- Straight from Manufacturer/ C& F
- Lowest price certification by Supplier

- No profit No loss
- Equal opportunity to contractors-Open Tenders
- Contractor –Fixed remuneration + 1% commission

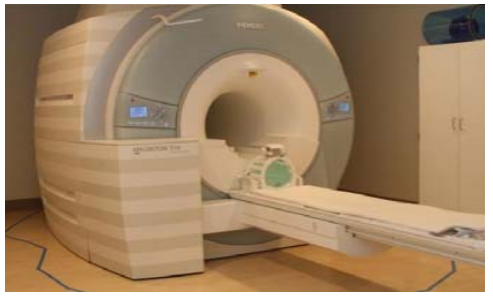
PPP : CT /MRI Machines

- State Government provides space in Medical College Hospital for installing diagnostic equipments.
- Private operator installs & operates the machines, but charges decided by the Government
- 20% BPL patients have to be tested free.

- Installation, Operation and Maintenance of CT-scan and MRI services are contracted out to a private agency.
- The agency is paid a monthly rent by the hospital.
- Proved successful



- Rates of MRI come down from 6000 to 2200 & CT scan from 2300 to 700.
- Private diagnostic centres outside hospitals forced to bring down the rates.
- Machines work for 24 hours & hardly reported damages or breakdowns



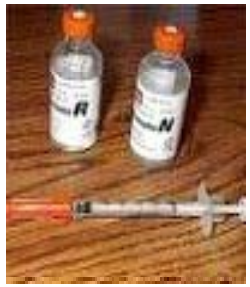
Mid-Day Meal Scheme

- 9.92 lakh children in 8494 schools supplied hot cooked meals prepared under hygienic conditions.

- 27 Mechanised Centralized Kitchens set up by Charitable Trusts and NGOs like Akshaya Patra Foundation, Naandi foundation, QRG Foundation, Adamya Chetna Trust, ISKCON etc.

Diabetic Centre at Bikaner

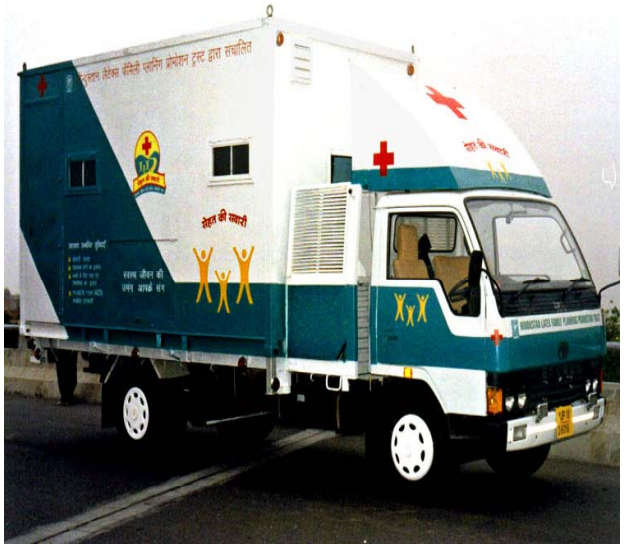
- Building DCRC worth Rs.1 core 50 lakh constructed under "Jan Sahabhagita Yojna".
- Only one research center in Govt. sector-devoted Diabetic
- Well equipped - provide all investigational facilities to patients.



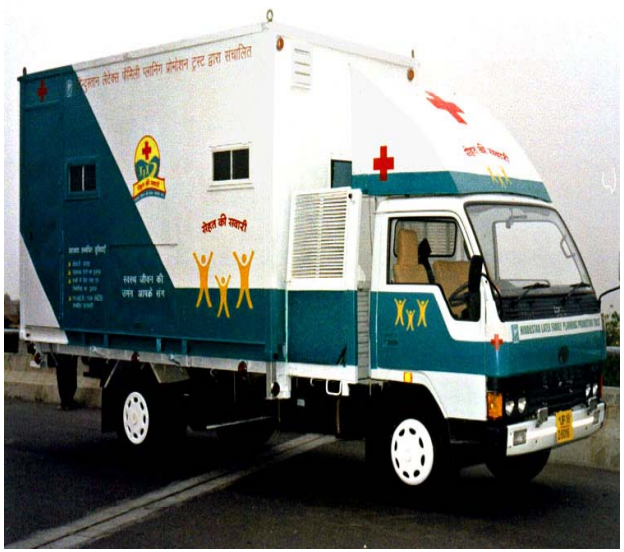
Facilities:

- Regular medical checkup.
- Hematological and biological testing.
- Separate male and female ward.
- Intensive Care Unit.
- Outdoor Patient Department.
- Conference hall and Library for research scholars

Mobile Health Vans



- Already implemented in inaccessible areas
- Comprehensive Health Services
- Fixed Journey Plans
- Public Sector contribution Medical Officers and Medicines
- Private Sector for Purchase and Management of Vans



- These vans are useful in:
  - Provide access to services people living in inaccessible terrain
  - Make services available at central location to reduce travel time and costs of clients

Under NRHM many states have introduced this scheme Rajasthan has entered into an MoU with EMRI, to this effect

?

Are these really Partnerships

Public Private Partnership Appraisal Committee (PPPAC), Rajasthan

- Constituted under the chairmanship of Principal secretary (Finance).
- Members of PPAC:
  - Principal secretary/Secretary of the concerned Administrative Department

- Secretary in charge of Expenditure
- Secretary Plan
- Secretary Law

Functions of PPPAC

- To advise different government department/ agencies in preparing prefeasibility reports by itself or through consultants.
- To recommend preparation of Pre-Feasibility

- Project reports for approval of ECID.
- To recommend development of projects in PPP mode for approval of the ECID
- To recommend final bids of the project for approval of the ECID (Empowered Committee of Infrastructure development)

- Review and develop Model Concession Agreement (MCA) for various sectors.
- Recommend projects for Viability gap Funding (VGF)

- To deliberate and recommended to the Approving Committee any special grants and concessions
- To coordinate the efforts of other department for the furtherance of the objectives of this policy.

- To create and prioritize shelf of projects
- To inspect,visit,review and monitor any PPP project regarding its implementation, execution, operation and management

What should Investor Look Into?

- Policy prescriptions
- Procedural details
- Possibilities
- Provisions at its command
- Presence of Public sector
- Purchasing power
- Phasing
- Proliferation
- Profits

What Public Sector Should Look Into: Key Steering variable

- Preparedness
  - Land Bank
  - Priorities
  - Provisions
- Policy
- Procedures
  - Paper work
  - Time fame

- Policing
  - Regulatory Mechanism
- Performance
- Promotion
  - Accreditation Mechanism

Merits and Demerits of Partnering With the Private Sector

Sub-sector	Merits	Demerits
Informal	Easy Access Client-centric Low cost	Poor quality Difficult to mainstream Poorly educated
Not-for-profit	Better quality Focus on the poor Low cost Community involvement	Low coverage Resource dependency Problem of scale-up Ad hoc interventions
For profit	Efficient deployment of resources High quality (in select disciplines) Huge outreach / coverage Innovative	Short term orientation High Cost Unregulated quality Clustered in cities

Some PPP Models in India

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Performance Management Contracts	APUHS Project, Adilabad, AP Chiranjeevi Yojana, Gujarat	RCH Services RCH/MH services	Charitable NGO Private clinics Charitable NGO

Community/ Health Insurance	Yeshashvini Scheme,Karnataka	Surgical Care	Private Hospitals consortium
Voucher Scheme	Arogya Raksha Scheme, AP SIFPSA, Agra UP SCOVA, Haridwar, UK	Hospitalization Maternity Care/ Institutional Delivery	Private Hospitals/PSU insurance Private Hospitals
Hospital Autonomy	RKS, Bhopal / & Other Places	Patient welfare committee	Public Hospital
Franchising	Merri Tarang; Merri Silver; Merri Gold; Life Spring-HLFPPT/ SIFPSA' Janani, Bihar	M CH / Other curative services	Franchised private entrepreneurs

Yeshasvini Health Scheme in Karnataka

- Health insurance scheme targeted to benefit poor

- Initiated by Narayana Hrudayalaya ,Department of Co-operatives of Government of Karnataka

- Government provide Rs 2.50 of the monthly premium paid by the members which is Rs 10 per month
- The cardholders access free treatment in 160 hospitals for any medical procedure costing upto Rs 2 lakhs.
- FHPL responsible for administering and managing the scheme on a day-to day basis

- Hospitals offer comprehensive
- Trusts monitors and control the whole scheme, formulates policies, appointed TPA and addresses the grievance of the insured members or doctors

Arogya Raksha Scheme in Andhra Pradesh

- Government in collaboration with the New India Assurance Company and with private clinic has initiated this scheme.
- Insurance scheme fully funded by government

- Provides hospitalization benefits and personal accident benefits to BPL
- The government paid premium of Rs.75 per family to the insurance company
- Expected enrollment of 200,000 acceptors in the first year.

- MO issues Arogya raksha certificate to the person who undergoes sterilization
- The person and two of his/her children below the age of five years are covered under the hospitalization benefit and personal accident benefit scheme

- Patient get in-patient treatment upto maximum of Rs 2000 per hospitalization and subject to a limit of Rs 4000 for all treatment taken under a scheme in any one year.
- In case of death due to any accident, the maximum benefit payable under one certificate is Rs 10,000

Telemedicine Initiatives By Narayan Hrudayalaya in Karnataka

- GoK, NH hospital and ISRO initiated a project "Karnataka Integrated Telemedicine and Tele-health Project."
- With connections by satellite, this project functions in CCU of selected district hospitals that are linked with Narayan Hrudayalaya hospital.

Impact of Tele-medicine

- Provide access to areas that are underserved
- Improves access to specialty care and reduces both time and cost for rural and semi urban patients

- Improves quality of health care through timely diagnosis and treatment of patients
- Digital convergence of Medical records, charts, X-rays, Histopathology slides and medical procedures.

Uttaranchal Mobile Hospital and Research Centre (UMHRC)

- Three way Partnership- Technology Information, TIFAC, The Government of Uttaranchal and BISR

- Motive: provide health care and diagnostic facilities to poor
- TIFAC and the State Govt. shares the funds sanctioned to BISR on an equal basis

Emergency Ambulance Services Scheme in Tamil Nadu

- Initiated in Theni District in Tamil Nadu
- Aim- To reduce MMR
- Scheme is part of World bank aided health system development project
- Self supporting scheme through collection charges

- Government support-Vehicles supply
- Seva Nilayam recruits drivers, train the staff, maintain the vehicles, operate the program and report to the government.
- Bears entire operating cost

Urban Slum Health care Project, Andhra Pradesh

- AP MOHFW contracts NGOs to manage health centres in the slums of Adilabad.
- The project has established 192 Urban Health Centres
- 5 Mahila Aarogya Sanghams (Women Well Being Associations) were formed under each UHC

Objective:

- Increase the availability and utilization of health and family welfare services.
- Build an effective referral system
- Implement national health programs

- Increase health awareness
- Better health seeking behavior among Slum dwellers
- Reduce morbidity and mortality among women and children

- Govt of AP constructs buildings for UHCs
- Provide honorarium and supply drugs

Community Health Insurance Scheme in Karnataka

- Karuna Trust in collaboration with NHIC and Gov of Karnataka.
- Launched in 2001
- Covers Yelundur & Narasipuram Taluks.

- To prevent impoverishment of the rural poor due to hospitalization and health related issues
- Annual premium is Rs 22 (Less than Rs 2 a month)
- Extra payment is possible for surgery
- Insurance valid for one year

- If admitted to any government hospital an insured gets Rs 100 per day during hospitalization-Rs 50 for bed charges and medicine and Rs 50 as compensation for loss of wages-up to max Rs 2500 within a 25 days limit.
- If continue- should be renewed

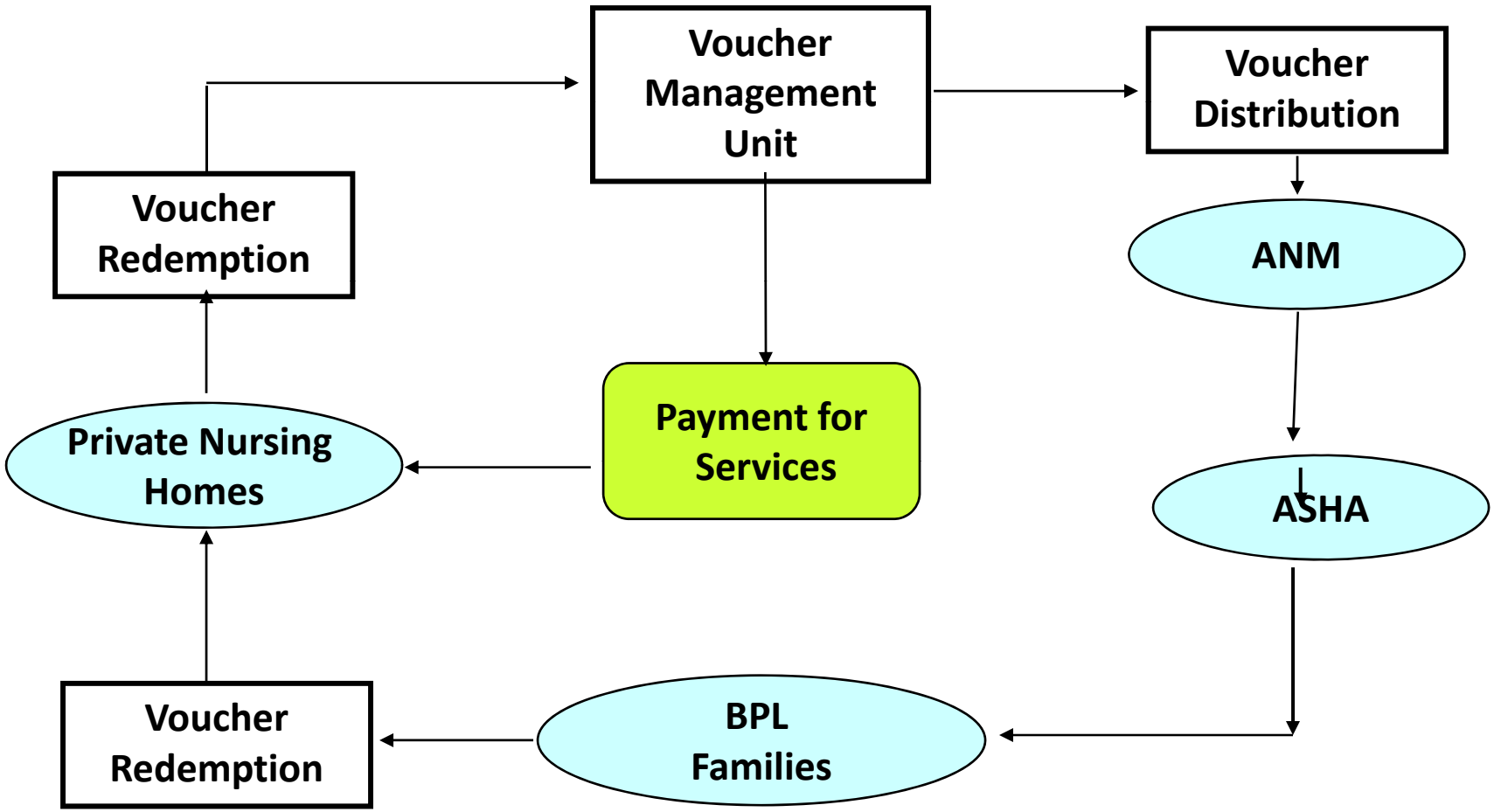
Sambhav Voucher Program

- Initiated to increase coverage of RCH services by improving access to the service delivery systems.

Goal

- Reduce MMR &IMR

The Voucher Distribution Channel



Description of Voucher

Each voucher has three parts :

- One part for the ASHA,
- One for the Private Nursing home and
- One for the voucher management Unit.

Color Codification of Vouchers:

- Pink for: Antenatal care services
- Green for: Delivery and Sick newborn Care
- Orange for: Post natal care services
- Blue for: Family Planning Services

Payment Packages

- Maternity Package and Neonatal Package – Fixed amount for every 100 deliveries including amount for 25 neonates admitted for every 100 deliveries
- Family Planning Package – Case by case payment

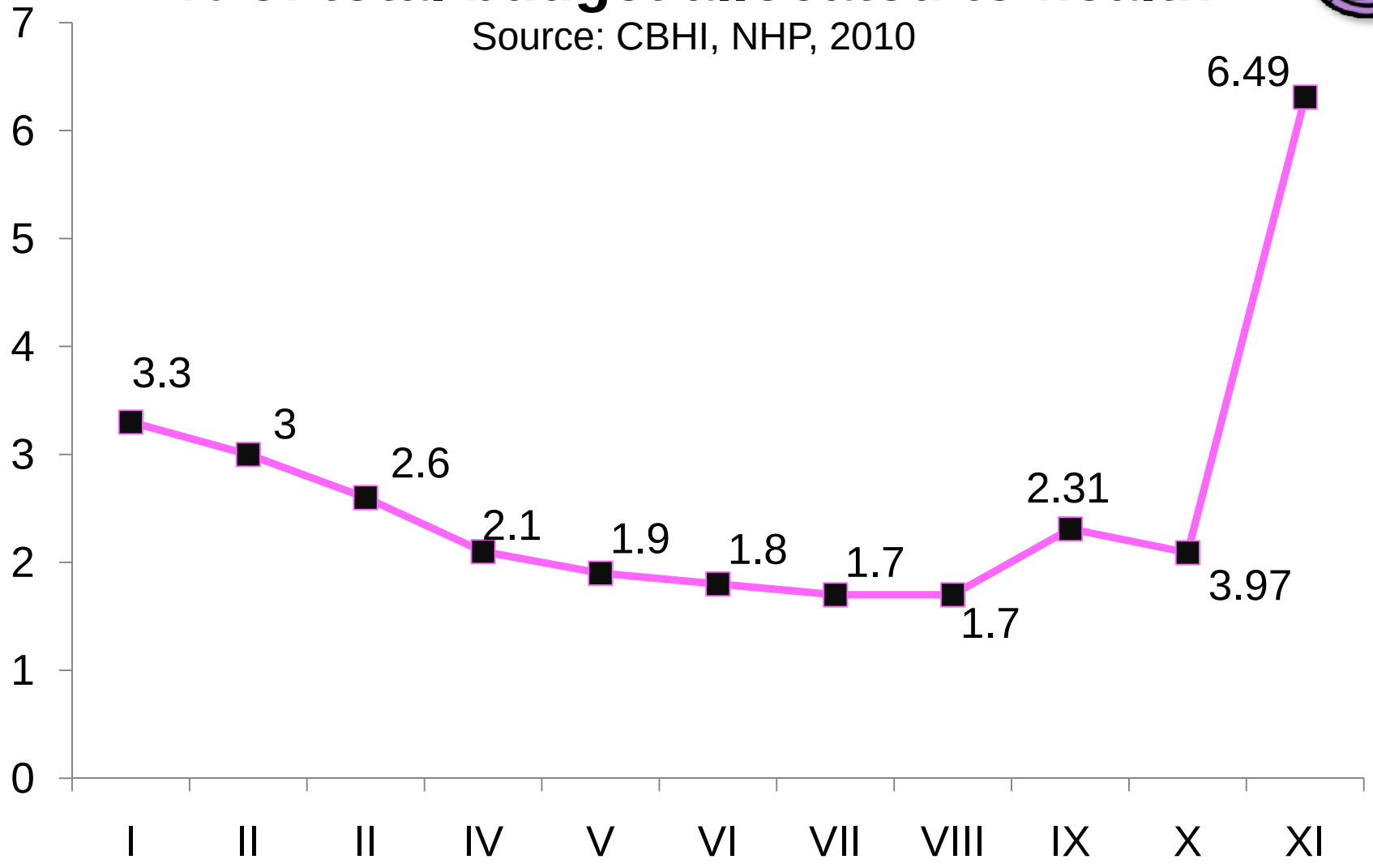
Health Expenditure

Health Expenditure-India	2008-09	2009-10	2010-11
Govt. expenditure on Health and family welfare(Rs crore)	17661	21680	25154
Govt. expenditure on Health and family welfare as % of GDP	.32	.35	.36
Govt. expenditure on Health and family welfare as % of Total Exp. From Union Budget	2.0	2.1	2.3

Source: www.cbgaindia.org
http://www.cbgaindia.org/files/featured_articles/What%20Does%20Budget%202010%20Imply%20for%20the%20Social%20Sector.pdf

% of total budget allocated to health

Source: CBHI, NHP, 2010



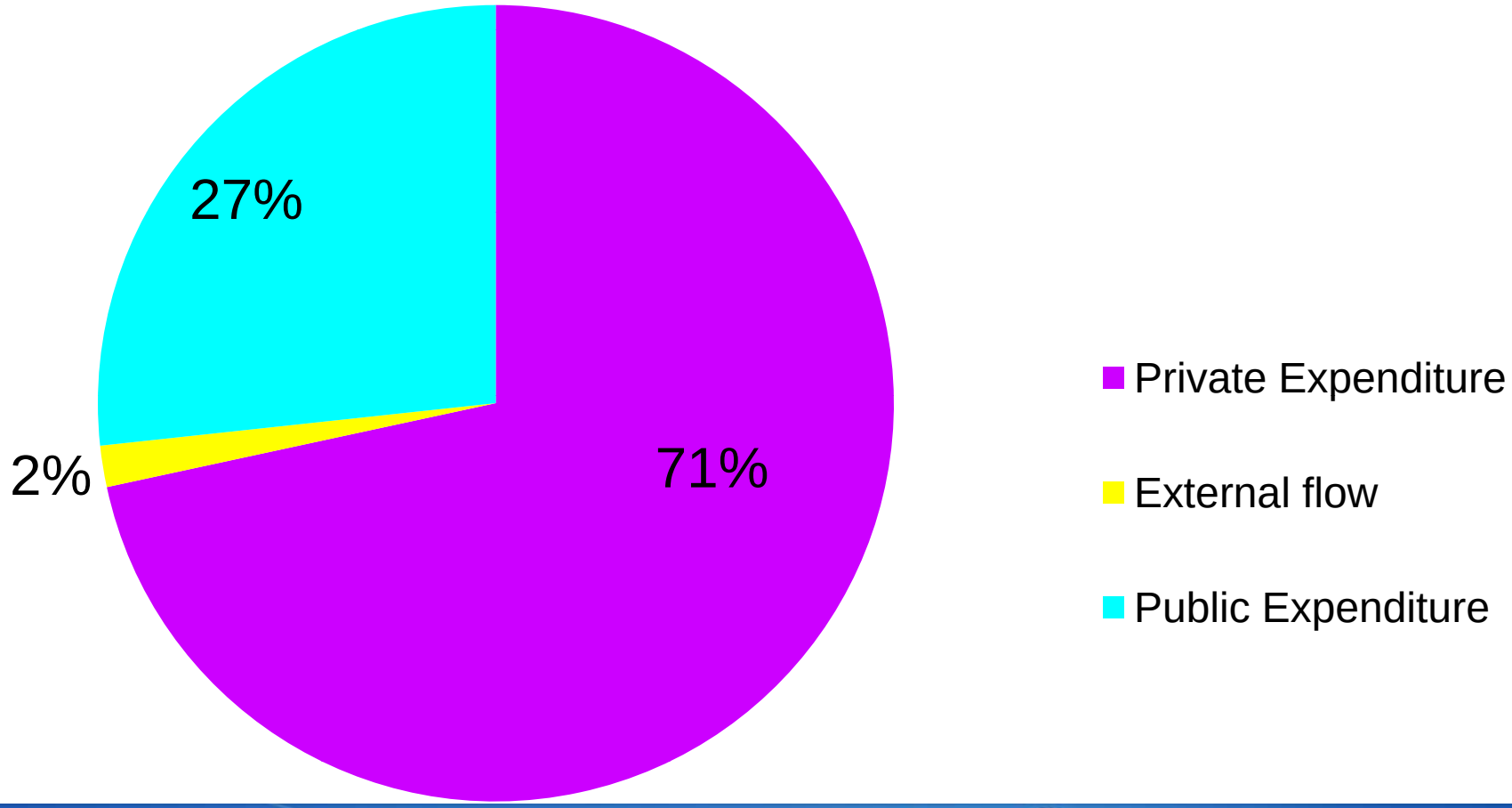
Total Health Expenditure-Rajasthan

Total Health Expenditure-Rajasthan	2008-09	2009-10	2010-11
Medical and Public Health (Cr. Rs.)	1584.59	2168.29	2440.14
Family Welfare (Cr. Rs.)	288.9	420.95	488.34
Medical and Family Welfare (Cr. Rs.)	1873.49	2589.24	2928.48
Medical and Public Health as % of GSDP	0.79	0.99	-
Family Welfare as % of GSDP	0.17	0.19	-
Medical and Family Welfare as % of GSDP	0.93	1.18	-
Medical and Public Health as % of Total Budget Expenditure	3.88	4.36	4.49
Family Welfare as % of Total Budget Expenditure	0.71	0.85	0.90
Medical and Family Welfare as % of Total Budget Expenditure	4.58	5.21	5.39

Source: Rajasthan Budget Books, Finance Department of Rajasthan (Budget Analysis Rajasthan Centre, Jaipur)
(www.barcjaipur.org)

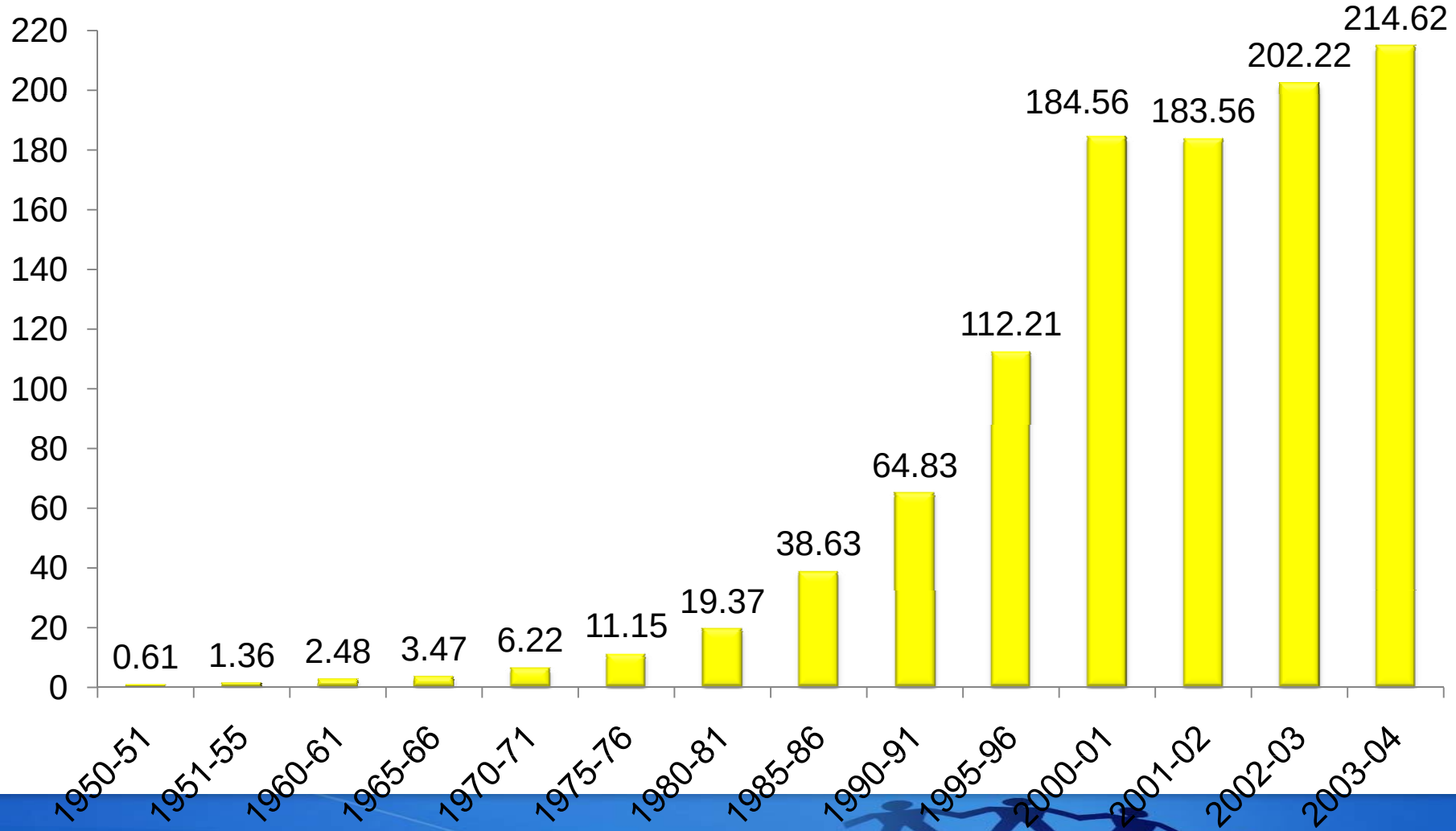
Share in Health Care Spending

source:CBHI,NHP-2010



Per Capita Public Exp. on Health

Source: CBHI, NHP, 2010



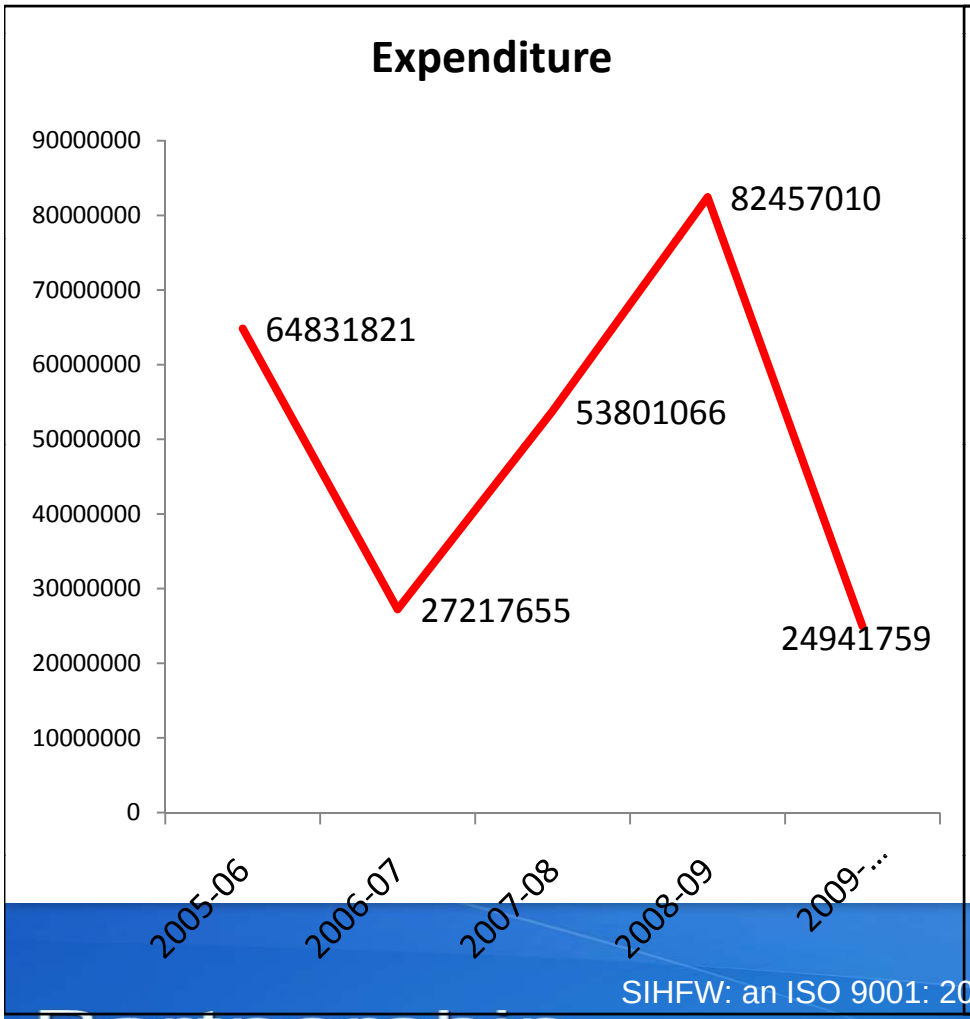
Healthcare Financing – Rs. billion

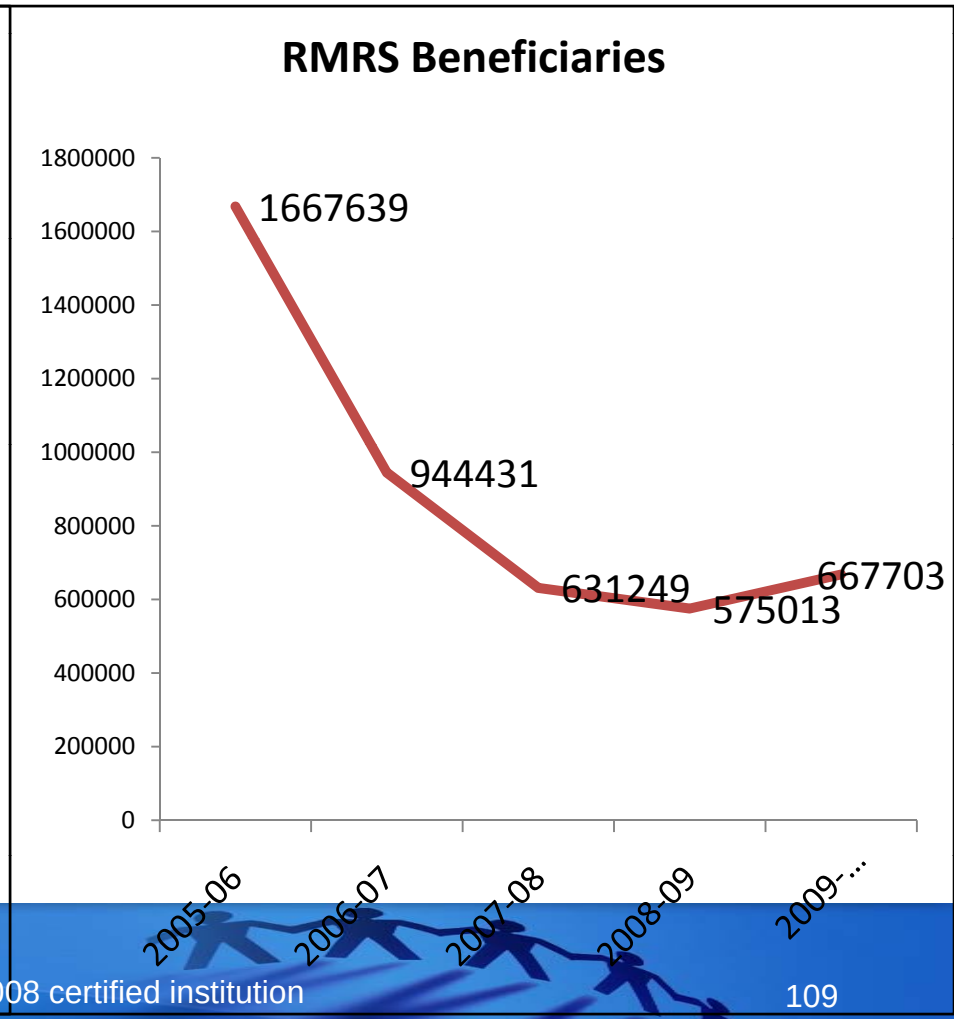
	1993-94	1994-95	1995-96	1996-97	1997-98	2000-01	2002-03BE
Public Centre	7	11	12	13	14	23	35
State	68	72	89	99	113	156	186
Total	75	83	101	112	127	179	221
%Govt.	2.91	2.13	2.98	2.94	2.70	2.91	3.17
%GDP	0.87	0.81	0.86	0.83	0.83	0.81	0.85
Private	195	279	329	373	459	982	1200
%GDP	2.27	2.75	2.77	2.73	3.00	4.46	4.62

Source: Public Expenditures - Finance Accounts up to 2001 and Budget for 2003; Private – CSO estimates on Consumption Expenditure 1985 series; BE = Budget Estimate

RMRS: Progress

53 Hospitals 368 CHCs 1504 PHCs





Thank You

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