22. Public-Private Partnerships

In view of the increasing PPP models, state specific PPP policy and an independent PPP division should be established outside the health department for health programmes in the state.

All new PPP's should be carefully examined at the highest level for its potential benefits and accompanying risks and should be reviewed on a regular basis for its public health benefits. Specification of services, monitoring indicators, grievance redressal systems and other inbuilt mechanisms should be in place from early stages.

All programmes / services / activities under PPP model at state and district levels should be evaluated by a technical committee to define scope of services and investment patterns for maximum health returns.

Public-Private Partnership (PPP) is a co-operative arrangement between two or more public and private organisations, with the principal objective of providing services by sharing/supporting public infrastructure, facilities, existing services and others through mutual agreements on an agreed-upon framework. PPP in the healthcare sector is an approach to address public health and social development problems, amidst resource constraints, through public, private and development organisations (110).

A Public-Private Partnership begins with setting objectives, ensuring that stipulated services are delivered economically, effectively, and efficiently. They also serve to ensure that the public's best interests, the private sector and the community, are served through an appropriate allocation and sharing of returns and risks between partners(111). PPP primarily involves bringing in the expertise and resources of each partner in their area of competence that would be lacking in existing systems/facilities/programmes/projects. It is characterised by the sharing of investment, risk, resources, responsibility and rewards between partners in a way that best meets clearly defined public needs, based on agreed frameworks of implementation. Few advantages of PPP include

(i) Extending the reach of messages and programs of health importance to a large segment of the public, including - accessing specific populations that are hard to reach (such as tribal pockets), speeding up responseand innovation cycles, solving problems through new technology, updating the skills of the workforce, and others.

(ii) Enhancing programmatic credibility due to strategic partnerships among the sectors allows for private-sector management skills for the development, management and operation of the public health services.

(iii) Enabling the governments to develop public assets faster and at a lower cost for taxpayers than by conventional public procurement, thereby reducing the borrowing burden for the Government as resources can be raised by private firms and bringing about taxable equity by supplementing scarce public funds through access to private capital.

(iv) ensuring quality and client satisfaction due to focus on performance-based standards, enhanced quality control and assurance, and contractual accountability, and

(v) providing the opportunity for equal distribution of public health responsibility among private partners, while the public sector can also focus on other distal factors such as long-term service planning and management, an environmental clearance that affect Health in the longer run.

Increasingly, PPP models are becoming an amalgamation of different contracts to suit the needs of the target population and health needs. There are various models in PPP like a) build-operate-transfer, b) lease contract, c) concessions, and d) joint ventures.

Karnataka is one state which has been experimenting with the PPP based model in the health sector for a long time. The state is often lauded at the national level for implementing some innovative PPP models, and few of them are being scaled up for implementation in other states. Some examples of the PPP model in the state include;

- Management of Primary Health Centres was contracted out by GoK to Karuna Trust in 1996 to serve in the tribal community and hilly areas to provide health services and maintain and manage the primary health centres and sub-centres.
- Telemedicine and TeleHealth Project was initiated by Govt. of Karnataka, Narayana Hrudayala (NH) hospital, Bangalore and ISRO, to provide telediagnosis and consultation for cardiac care.
- Thayi Bhagya scheme implemented since 2008 to address the issue of Infant Mortality Rate and Maternal Mortality Rate is modelled based on Chiranjeevi Maternity Healthcare Scheme of Gujarat. Under the scheme, recognised Private hospitals would get an amount of Rs. 3.00 Lakhs for every 100 deliveries conducted in their institution as an incentive.

- Yeshasvini health scheme provides access to cardiac care to farmers who are members of farmer co-operative societies through health insurance. It was launched in 2003 by GoK to rural people
- Citizen Help Desk scheme implemented in 17 districts and other general hospitals located in Bangalore City and elsewhere to involve local community-based organisations to improve the services in the hospitals and guide the patients for seeking proper and timely medical care
- Arogya Bandhu is a unique model that has become a trendsetter in involving NGOs in jointly running the Primary Health Centres and Specialist Services in Community Health Centres (CHCs).
- Mobile Health Clinics is a partnership programme to boost the Quality of life of unreached Populations with a vision of reaching the unreached, pro-poor public, private partnerships for the Health of the underserved.
- Arogya Kavacha 108 was launched on November 1, 2008, is a highly acclaimed, cashless emergency ambulance care for the victims of fire, motor vehicle and other accidents and medical emergencies and is managed under the PPP model
- The Rajiv Gandhi super-speciality hospital in Raichur Karnataka was functioning under the PPP model between GoK and Apollo Hospitals Ltd, providing tertiary care services to the backward region of the state.
- Raktha Vahini is a unique scheme of providing blood and its components for all emergencies, focusing on mother and child health emergencies (cashless) in 7 high focus & 7 'C' category districts through an MoU with Red Cross, Bangalore.
- Mother and Field NGO Scheme is an attempt to engage a popular mother NGO at the district level and field NGOs in four backward blocks of the district to design interventions and implement after the baseline survey, to improve the uptake of government health services by the vulnerable and deprived segment of the social strata of the population.

The PPP model in health care has contributed to improvements in health care. For example, the Karuna Trust, which adopted PHCs on the PPP model, was able to show an overall improvement in the functioning of the PHCs, and more importantly, they have demonstrated improvement in health indicators, particularly in the context of mother and child health care in the area they serve. However, the existing PPP models have several Issues and challenges that have a significant impact on the arrangement's success and should be mitigated in the early stages.

- There is no PPP policy for Health at the national level. Some states have taken the initiative and developed draft health PPP policies, although the respective state governments have finalised none.
- In view of the increasing PPP models in many areas of health care, an independent unit/division should be established outside the department that should examine and strengthen the contractual agreements. Usually, this is within the department that can lead to bias and conflicts of interest.
- Measurable output/outcome indicators are essential for monitoring and evaluating the partnership's performance, and these are commonly found missing; when present are usually non-specific. The absence of such defined outcomes ultimately leads to allegations of lack of transparency by both partners and can result in unregulated profit-seeking behaviour.
- Well defined institutional framework is essential for monitoring the level of compliance or deliverables by the contractual partner are crucial for PPP programmes. Outsourcing this responsibility to an external project/technical support unit has merits and demerits and has emerged in some ongoing programmes like National Aids Control Programme.
- Strong grievance redressal mechanisms are to be established from the early stages of PPP, and mechanisms should be an integral part of contractual agreements. Such mechanisms are routinely absent, leading to difficulties and long-standing legal battles.
- Absence of established accreditation standards for ensuring Quality of health care service delivery adversely impacts the Government's ability to ensure consistent service from the private partner. As a result, the Quality of services provided through facilities under PPP arrangements varies widely.
- From an economic angle, calculating the costs of health services offered is required to create empirical evidence in terms of the cost of service agreed upon. The role of state health accounts is also restricted, which does not allow it to compute the cost of each health service being offered.
- The projects/schemes should be evaluated or assessed by the third-party organisations and documented as case studies.

The sustainability of the PPP model is a significant challenge, and the reasons for such projects being non-sustainable are many (112). PPPs can damage the credibility of public health institutions when collaboration confers legitimacy and credibility on programmes that increase health care costs and affect the Quality of services

Regardless of all the activities and initiatives under PPPs across the state, transparency, accountability, monitoring, evaluation, and continuous feedback to both parties remain the cornerstones for the success or failure of such models.

Building partnerships...

In Karnataka, given that the private sector is actually providing sizeable outpatient and inpatient care, it is better to take the neo-pluralist view which proposes openness to partnerships but at the same time take necessary steps to mitigate the risks(113). Karnataka has been the forerunner in rolling out Public Private Partnerships in health sector. Several examples like EMRI 108, running govt. health centres by private agencies, mobile health clinics, outsourcing services have stayed for long and have not been systematically evaluated. The results over time have been mixed with none being exemplary. A joint study of Karnataka Health Systems resource centre(114) (KSHSRC) and Deloitte Touche Tohmatsu India Ltd. reviewed existing PPPs in the state and reported several deficiencies (like absence of monitoring and evaluation mechanisms, lack of grievance redressal mechanisms or defined quality/accreditation standards (114) (KSHSRC et al, 2012). Globally, only those countries, which have had strong public health system (not necessarily public provisioning) - with investment in staff and infrastructure for regulating the private sector; for stringent contract management; and for stronger monitoring mechanisms in place - have had success of making private sector work for public health goals. Strong institutional mechanisms are required to build robust PPP mechanisms in the state than the existing approaches.

Institutional mechanisms for strengthening PPPs

I. Universal Health System (UHS)

Moving beyond Universal Health 'Coverage' (UHC), a UHS can offer comprehensive services based on everyone's needs by virtue of being a human (social justice) without any means-testing, such as Below Poverty Line or citizenship thereby catering to the most vulnerable, and irrespective of one's ability to pay (for eg. it could be insurance premium or co-payment in a UHC). UHS provides for greater solidarity, risk pooling and cross subsidization. The current fragmented, insurance based system 'covering' different 'package' of services hinder the continuum of care, while a UHS provides for both backward and forward integration of services including portability. UHS also holds the promise of integration of primary health care with the social determinants of health. For the vulnerable, UHS can provide 'universalisation of social protection in health'. Moving towards a unified system demands the presence of a convening authority which guides both the public and the private sector towards the overall goal of the health system

II. Regulation

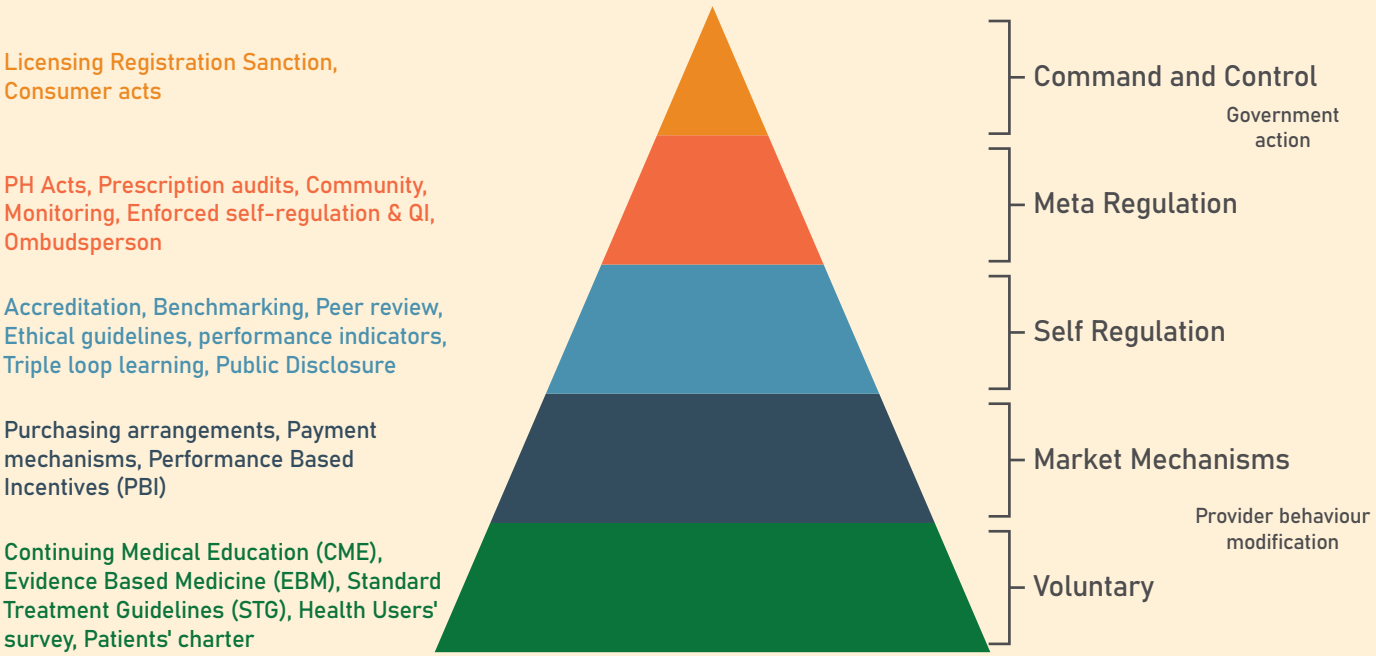
Regulatory instruments for provision of health services are directed towards High costs of care; better quality of care; ethical conduct of providers and equal availability of health care . In the presence of serious gaps in the design of regulatory policies in the country, one regulatory approach would not work and there has to be a combination of approaches. Braithwaite and colleagues (2005) (116) advocate for a Responsive regulation Pyramid in which the approaches are arranged in a hierarchical order from the voluntary to the command-and-control approaches (Figure 21).

There are two broad approaches to improve quality of care - Quality improvement and Quality Assurance and in that order and requires a combination of strategies to achieve the quality objectives. The policy instruments of voluntarism, economic instruments, self-regulation, meta regulation and command-and-control are employed in a gradually escalating fashion..

Considerable gaps exist in the regulatory policies at each level and for each domain of health services. Several regulatory instruments have to be put in place to shore up the regulatory scenario as a prerequisite to ensuring efficient and quality services even if PPPs were to be implemented. Figure 22 provides a draft outline of the sort of mechanisms that could be put in place as an adaptation of the responsive pyramid (116).

Figure 21: Approaches for establishing responsive partnerships

Responsive Pyramid (Adapted from Braithwaite et. al. 2005)



III. Need for an autonomous convening authority

Establishing an autonomous convening authority for management of PPPs is very much needed considering gaps in implementation of the policies. The public health system (the Directorate) is overworked and understaffed and have to make choice between service provision and convening. The public health systems also need to be guided towards providing quality services with accountability and hence the convening authority must be independent with sufficient technical staffing and with adequate powers for making right decisions in the interest of public.

- The autonomous agency shall be established outside the department with suitable checks and balances and shall be responsible for ensuring standards of both the public and private facilities.
- The agency shall be strengthened with substantial funds, skilled and professional staff, and infrastructure both for its routine functions and also for such items as capacity building and standards setting.
- The whole regulatory architecture shall be centered around the issue of patients' rights and entitlements.
- Convergence of the various agencies responsible for the delivery of health services in both urban and rural areas.
- Reasonable standards with the involvement of all stakeholders are set; information disseminated; facilitating compliance and minimizing the scope for corruption also taking into account the diversity existing among the providers and accordingly modulated; else it might lead to a situation where some of the small time rational providers (who might be the only access to the people) might be crowded out.

A. Patients' Empowerment

This has to be enabled through such policies as a public health act coupled with providing patients an overarching rights and entitlements framework. A beginning can be made through the voluntary mechanisms of the facilities putting up a patients' charter to a set of rights which provide the patients the entitlement to seek care anywhere. This has to be backed up by a Grievance Redressal Mechanism with an Ombudsperson appointed (similar to the banking and insurance industry). Public should be empowered about facilities through such mechanisms as report cards, public disclosure about clinical facilities (for eg. Infection rates) and pricing schedules.

B. Project Management Team

A dedicated team is needed for contractual management doing periodic monitoring and evaluation of the facilities as well. Negotiation and setting of the prices for the various procedures involving all stakeholders and monitoring the prices

charged by the providers as well has to be ensured. It could also be entrusted with such tasks as providing performance based incentives. The team would also set the type of payment mechanisms for the empaneled providers including timely disbursal of funds.

C. Quality Assurance Team

A dedicated team has to be set up for quality assurance both from the public as well as the private providers with the tasks of setting of standards periodically, facilitate evidence based medicine, continuous medical education , accreditation of both private and public facilities, conduct annual audits, licensing mechanisms and standard treatment guidelines. It should also inspect the facilities before giving license under the Karnataka Private Medical Establishment Act and identify only such facilities which adhere to the standards. Figure 2 provides details on setting up such mechanisms for making PPP's provide ethical, rational, timely, cost-effective care.

IV. The Public system as a big volumes purchaser

The unified health system under a single convening authority can utilise its purchasing power to implement and step in as a big volumes purchaser and leverage that to regulate the costs, quality and performance . Currently, in the absence of a unified system, the public authority is not able to bring its full monopsony power to bear and showing the volumes for the private sector to feel the inevitability of having to be part of it. But for a big volume purchaser to be effective, it should be able to enforce minimum standards of care as a precondition for empanelment, also ensure reliable and timely payments to the private providers which would be one more added incentive for the private sector to consider joining in the proposed unified system.

During the Covid-19 pandemic, Karnataka government has shown the way forward as an example by becoming a 'convening authority' for the hospital beds where it negotiated with the private facilities to earmark 50% of their beds for Covid treatment referred by the state government or the municipal corporations. There was also an attempt at capping the prices of testing and treatment. However there were some teething problems in implementation like some of the facilities charging higher prices for diagnostics, or that the private providers complaining about the government not paying the private facility the dues for Covid related treatments. So, if the government could take these baby steps during Covid pandemic they could use this as a precedence to move towards a unified system.

V. Payment Mechanisms

The payment mechanisms like fee-for-service, capitation, DRG payments and so on should be carefully examined to avoid any unethical and harmful practices by provider. All the PPPs suffer from supplier-induced demand due to the perverse incentives, of fee-for-service mechanisms, provided for the irrational treatments (117).

VI. Referral Systems

UHS as a unified system can provide for integration of all the types of providers under a single umbrella in a nested manner (referral systems) and could become provider agnostic. The current problem of people reaching any facility without proper gatekeeping could also be overcome and the burden on the tertiary facilities could be lessened. A good beginning in Karnataka has been the provision of gate keeping introduced by Ayushman Bharat Arogya Karnataka (ABaRK) in which one cannot reach a private facility and avail the AB-ARK scheme without referral services from a public facility. This must be expanded for all the treatments and to some extent this will result in more rational care, keep the costs down and also increase footfall into the public health facilities for the treatments that are available there by reducing the supplier-induced demand ; all with checks and balances put in place.

Using a Toolkit methodology

The preceding sections demonstrate that considerable investments have to be made to establish institutional mechanisms for making PPPs more effective, rational, quality oriented and provide 'value for money'. But instead of stopping at the prescriptions of 'what' needs to be done, there is a need to move towards the 'how' of implementation. A tool kit approach to implementation should be developed, piloted and should become a mechanism for implementation and should provide a roadmap for further activities (118).

"Medical education does not exist to provide student with a way of making a living, but to ensure the health of the community"

- Rudolf Virchow

Figure 22: Proposed Schema with institutional mechanisms for operationalisation of Public-Private Partnerships