Promoting Public Private Partnership (PPP)
In
Health Services

Policy of Public Private Partnership for Non-Communicable Diseases (NCDs)

1. Introduction

Sustainable Development Goal (SDG) 3 intends to “ensure healthy lives and promote well-being for all at all ages” and targets a one-third reduction in premature mortality from non-communicable diseases (NCDs) through prevention and treatment and promote mental health and well-being by 2030. The emergence of NCDs poses a renewed threat to the financial protection of the population, which is related not only to the high costs of treatment, but also compounded by the long duration of treatment for what are often chronic illnesses or long term disabilities.

The National Programme for Prevention and Control of Cancer, Diabetes, Cardio Vascular Disease and Stroke (NPCDCS), launched in October 2010, aims at institutionalizing the response to NCDs and supplementing state efforts through setting up of NCD Cells at the state level and integrating it within the National Health Mission (NHM) framework. Over the years, services under the NPCDCS has gradually expanded. Attendance at NCD clinics witnessed a 118 percent year-on-year increase from 2014-15 (59.24 lakhs) to 2015-16 (129 lakhs) (MoHFW, 2016). State NCD Cells have been set up in 36 states and Union Territories, 322 districts in the country already have District NCD Cells and 318 of them have NCD Clinics. There are 1705 NCD clinics at the CHC level and 221 Intensive Care Unit (ICU)/ Intensive Care Unit (ICCU) have been set up.

Challenges

Despite concerted efforts at the national and state levels over the last few years in establishing the NCD service delivery network, the system continues to remain constrained with a set of systemic issues. Constrained fiscal space within states to provide increased allocations for NCDs, large infrastructure gaps, especially in rural areas, and significant gaps in human resources, especially at the level of specialists are the key challenges. Shortage of infrastructure and human resources for health has led to 72 percent of the population in rural areas and 79 percent in urban areas to seek healthcare in the private sector1 . This has exacerbated the situation demanding a multi-pronged response from the Government to augment its NCD response capacity, especially at the secondary levels to decongest tertiary facilities at the state level and expand access to secondary and basic tertiary level services at the district level.

Addressing the challenges

Continuing with its efforts to strengthen the national response to NCDs and addressing the gaps referred to above, the GoI is providing technical and financial support to the states. It is also exploring options of leveraging the strengths of the private health sector

to infuse greater efficiencies and resources for strengthening its response to NCDs. Innovative options of engaging with the private sector may enable access to NCD services at the government hospitals delivered by the private partner to augment the gap in the operational capacity to deliver NCD services, while continuing to strengthen the capacity and response of the public health system.

NITI Aayog, GoI's premier "think-tank" is mandated to provide the Centre and states with strategic and technical advice on evidence-based policy-making in various sectors including health. In line with this mandate, NITI Aayog is collaborating with the Ministry of Health and Family Welfare (MoHFW), Government of India and exploring opportunities to enhance private sector engagement through public-private partnerships for addressing the growing burden of NCDs in the country. The World Bank has been appointed to provide technical assistance for development of the PPP model and a draft model concession agreement for engaging with the private sector. It is envisaged that the draft model concession agreement will be finalized based on the pilot in select district hospitals in one or two states.

To address some of these challenges, the Government of India is launching a framework for 'Public Private Partnerships for Non-Communicable Diseases in District Hospitals' (the Project).

2. Objective of the Project

To improve access to quality screening, diagnostic and treatment services related to cardiology, oncology and pulmonology in district hospitals through public private partnerships.

It is expected that the Project will contribute towards:

a. improving access to the above NCD services at the district level and also decongesting tertiary facilities at the state level;

b. reducing out-of-pocket expenditures on diagnosis, treatment and care; and

c. creating infrastructure and augmenting capacity at district hospitals to provide at least basic tertiary care and advanced secondary care related to the three NCD specialties (cardiology, oncology and pulmonology) in the medium and long term.

3. Intended beneficiaries and their identification

3.1 NCD services under the Project will be accessible to everybody. For this Project, the patients can fall under two categories:

a. Patients referred by the Government:

'Patients referred by the Government' will be those patients who are identified by the State Government and authorised by it to receive cashless NCD services under this Project and on whose behalf the State Government will reimburse the Private Partner at agreed rates. Prior authorization for such patients will be done by the designated government official of the District Hospital. This category will also include patients enrolled under any central or state government health insurance scheme.

b. Self-paying patients:

All other patients can receive services under the Project against payments at the agreed rates and all such patients will be referred to as 'self-paying patients'.

4. Considerations for selection of district hospital

4.1 Depending on the current availability of the services, disease profile of the population, anticipated client load in the catchment area, the State Government may decide to set up either a 50-bed initially with a scope to expand later or a 100-bed PPP facility within the identified District Hospital for select NCD services.

4.2 The Project can be considered in those District Hospitals that meet the following minimum conditions:

a. The District Hospital should be located in Tier 2 or 3 cities. The Divisional Headquarters may be considered initially, but as the health services/ players increase, these may be planned for mofussil towns.

b. The District Hospital should have not less than 250 functional beds.

c. As the purpose of the PPP is to augment the current capacity at the District Hospital the hospital authorities should be able to allocate the following minimum space (indicative) for setting up the PPP facility: i. 30,000 square feet for a 50-bed facility ii. 60,000 square feet for a 100-bed facility

d. It is preferable that for a 50-bed facility, minimum 75 percent of this space requirement is within the built-up structure of the existing district hospital and the for the remaining, vacant land within the premises of the same District Hospital could be allocated by the State Government. Similarly, for a 100-bed facility, it is preferable that a

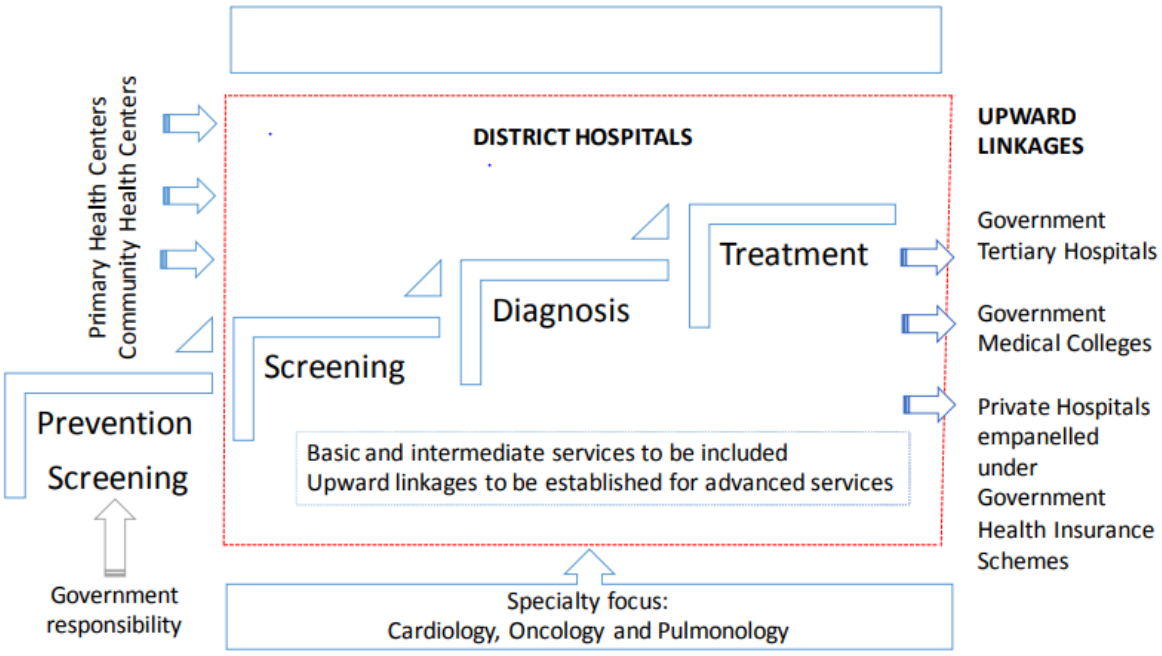
minimum 50 percent space is available within the existing structure of the district hospital.

e. The district hospital should have an average per day OPD of around 1000 patients in the last two years. This is indicative and the purpose is to ensure that the district hospital is reasonably well functioning and has a fair patient load.

5.2 Upward and downward linkages

5.2.1 For the purpose of this Project, downward linkages imply linkages of the PPP Project Facility with the Primary Health Centers (PHCs) and Community Health Centers (CHCs) in the district where the Project is being implemented. Additionally, this may include linkages will PHCs, CHCs and district hospitals in neighboring districts also.

5.2.2 Upward linkages mean linkages with high level of facilities for treatment of conditions not covered under this Project and / or of complicated cases which cannot be handled by the PPP project facility. Such referral facilities will either be government tertiary hospitals, or government medical colleges or private health facilities that are empanelled by the State Government for providing treatment under one or more government health insurance schemes in that order of preference. See figure below:



5.2.3 To ensure that the PPP design is integrated within the public health system, State Government will endeavor to establish linkages with population based screening programmes under the NPCDCS at the level of sub-centers/ Health & Wellness Centres, PHCs and CHCs.

5.2.4 The State Government will ensure appropriate communication to all PHCs and all the NCD Clinics functional at the CHCs under the NPCDCS for referring patients to specialized services under the Project.

5.2.5 The State Government will also establish linkages with existing national and state initiatives such as the emergency transportation /ambulance services for patient referrals and health protection schemes such as RSBY/ National Health Protection Schemes/ state level health insurance schemes to leverage upon the facilities and resources to arrive at greater synergies.

5.2.6 In the first instance, all referrals to higher facilities for complicated cases which cannot be managed under the Project shall be to a government institution or to private facilities empanelled by the State Government under one or more health insurance schemes (in that order of preference) being implemented by the State Government.

5.2.7 In all such cases, it is recommended the Private Partner forward the case for referral to the Medical Superintendent (MS) of the District Hospital or her/his authorised representative for a decision which would be taken by the latter in consultation with the patient within a timeframe mutually agreed upon between the Private Partner and the district hospital authorities keeping in mind and clinical condition and best interest of the patient.

5.2.8 Table below provides an overview of types of services at different levels including at the district hospital under the PPP (the private partner will only provide the services indicated at the district hospital, for all other levels only linkages with existing services are envisaged):

Services	Community	PHC / CHC	District hospital PPP	Government tertiary hospitals / medical colleges	Upward referrals for higher treatment at private facilities[5]
Prevention	Yes	Yes	Yes	Yes	No
Screening	Yes	Yes	Yes	Yes	No
Diagnosis	No	Yes	Yes	Yes	Yes
Treatment	No	Yes	Yes	Yes	Yes

5.3 Services shared with the district hospital

a. The NCD services offered under the Project may need to share one or more support services with the district hospital in which it is co-located.

b. Subject to necessary approvals, the shared services may include the following but not limited:

i. Ambulance services

ii. Blood Bank

iii. Physiotherapy services

iv. Bio medical waste disposal

v. Mortuary services

vi. Parking facilities

vii. In-patient payment counter

viii. Hospital security

ix. Sanctioned electrical load

5.4 Facilities proposed under PPP:

a. As already mentioned, services under this Project can be offered through two different options: a 50-bed facility or a 100-bed facility. Details of facilities proposed to be available under both the options are provided below:

No.	Facility	50-bed facility	100-bed facility
1	Out-patient department	Yes	Yes
2	In-patient beds[6]	40 beds	75 beds
3	ICU beds	10 beds	25 beds
4	Operation theatre	2	2
5	Cathlab	1	1
6	Laboratory services (pathology)	Yes	Yes
7	Radiology services	Yes	Yes

b. The Private Partner will ensure the following under the Project:

a. Availability of general OPD services as per the timelines of the District Hospitals.

b. Availability of specialist OPD services as per the timelines of the District Hospitals.

c. Availability of round the clock emergency services for all 365 days a year.

d. Availability of at least one dedicated Advanced Life Support and one dedicated Basic Life Support Ambulance on call round the clock for all 365 days a year.

e. Pharmacy within the Project facility functional round the clock for all 365 days a year.

f. Access to blood bank and other support services as described in Section 5.3.

6. Roles and responsibilities of partners

6.1 Roles and responsibilities of the private partner

During Project Upgradation:

a. Undertake a facility survey and prepare detailed design and plan for upgradation and expansion of the facility, including new construction, if required. The plan should include but not be limited to:

i. Architectural drawings including civil, electrical and plumbing specifications and implementation schedule.

ii. Bio medical equipment plan along with load specifications including details of procurement, installation and testing, downtime of equipment and alternate plan during downtime to ensure continuity of services to patients at no addition cost.

iii. Plan for quality control and inspections during upgradation.

iv. Plan for ring-fencing the existing services at the district hospital, prepared in consultation with the district hospital authorities to ensure continuity of services being offered at the district hospital.

v. Detailed human resource deployment plan including number of medical, para medical, administrative and support staff that the private partner proposes to deploy.

b. Upgrade as per approved plan and commission the facility for start of operations.

c. Set up all clinical and non-clinical support services as required including bio-medical and nonmedical waste management, sewage treatment plant, effluent treatment plant, firefighting system, air conditioning, plumbing, medical gas pipeline and all other medical and nonmedical support services required. as specified in Section 5.

d. Ensure service continuity during upgradation / ring fence the existing services.

e. Recruit all human resources within the agreed time frame.

f. Establish referral linkages with government health facilities at the sub-district levels within the catchment area and with tertiary facilities within and outside the state for referral of cases for services not offered under the Project.

During Project operations and management:

g. Be responsible for all clinical services, non-clinical support services, operations and management of the Project facility including maintenance of infrastructure and equipment to ensure continuity of high quality services. This may include replacement of medical and non-medical equipment as and when required to ensure that quality of services are being maintained.

h. Subject to approvals, Private partner may be free to set up other commercial services that add value to beneficiaries in a hospital setting (like cafeteria, bookshop, ATM, etc.)

i. Ensure appropriate insurance cover for the entire Project facilities including annual maintenance contracts for all equipment.

j. Maintain medical records as per the laws of the land.

k. Monitoring and quality control of all services rendered under the Project.

l. Design and maintain a management information system for the project and submit required reports to the State Government within the prescribed timeframe.

6.2 Roles and responsibilities of the State Government:

a. Review and approve upgradation plan submitted by the Private Partner.

b. Allocate built-up space and vacant land to the Private Partner as per the Plan within the agreed time frame. The allotted space should be without any access barriers and free of all encumbrances.

c. Facilitate referral linkages with sub-district level facilities and tertiary level facilities.

d. Develop eligibility criteria for determining the patients who would be referred by the State Government for cashless services under the Project and system for and pre-authorisation of patients.

e. Provide Viability Gap Funding in form of capital grant as determined through the bidding process.

f. Provide access to district hospital amenities as per the agreed plan referred to in Section 5.3 ‘Services shared with the district hospital’.

g. Set up and manage a counter for collection of all payments for services from the self-paying patients.

h. Ensure depositing of all such revenues collected in a timely manner into the designated Escrow account.

i. Undertake verification of all reimbursement claims made by the private partner.

j. Undertake period verification of medical records.

k. Timely reimbursement of payments on behalf of the patients referred by the State Government who have been treated at the Project facility.

l. Ensure smooth coordination between the district hospital authorities, private partner and other entities such as the District NCD Cell, State NCD Cell, and the Contracts Management Cell.

m. Overall Project monitoring, audits and quality control.

n. Set up the governance and management structures for smooth functioning of the Project and timely redressal of grievances.

o. Adhere to all provisions of the Agreement.

7. Financial structure of the PPP

7.1 Principles:

a. The patients referred by the Government as well as the self-paying patients will receive the same standard of clinical care.

b. There will be no reserved beds or no quota of beds for free services.

c. The State Government can refer as many patients as it can up to the capacity available in the Project facility under this Project.

d. Self-paying patients will be able to seek services at the facility.

e. The State Government will reimburse private partner for the patients referred /approved by designated authority in the district hospital.

f. All patients except those reimbursed by the government would pay at the agreed rate.

7.2Revenue Sources:

For services rendered under this Project, the private partner will have two sources of revenues:

i. From the State Government

ii. From self-paying patients

From the State Government:

The State Government shall ensure reimbursement to the Private Partner on behalf of patients referred by the State Government through one of the following options:

<u>For patients enrolled under the RSBY/ NHPS or any other state government health insurance scheme:</u>

i. The Project facility would be empanelled under the NHPS / State Government Health Insurance Scheme and all reimbursements for such enrolled patients up to available sum insured under such Scheme will take place through the contracted Insurance Company. The Private Provider shall follow all guidelines related to preauthorization and claims submission.

ii. For those patients enrolled by the State Government under one of its insurance programs and for whom the available sum insured is either zero or inadequate for seeking services, the Private Partner will send a pre-authorization request to the Medical Superintendent of the district hospital or her /his authorised representative. The Private Partner will be reimbursed by the State Government only for the preauthorized procedures and up to the agreed rates for the services finalized thorugh this PPP model.

<u>For patients not enrolled under the NHPS or any other state government health insurance scheme but are eligible to be government referred patients under this Project:</u>

iii. The Medical Superintendent of the District Hospital or her /his authorised representative will, as per the provisions under this Scheme, authorise and refer all such cases to the private partner.

c. The State Government, if it so desires, can decide to purchase 100 percent of the services or can indicate a cap on number of patients that the Government can refer in a year and for whom it can reimburse the private partner.

From Self-paying Patients:

d. All self-paying patients will directly pay for services out of pocket at the agreed tariff, which shall be transparently displayed.

7.3 Payment Administration

The State Government will be transferring payments to the Private Partner under three streams:

a. Viability gap funding through a one-time capital grant as determined through the bidding process; and

b. Partial usage payment wherein the State Government will reimburse the private partner only for the services received by the patients referred by the State Government up to a ceiling.

c. Revenues collected from self-paying patients.

Policy Challenges:

The main concern is that the private providers will be able to cherry-pick the most lucrative districts where patients have a higher paying capacity. The Private providers will concentrate on better-off districts, leaving the poor and remote districts for the public sector to manage. This will further weaken the ability of public hospitals to attract and retain trained doctors and other health workers.

The promise that patients covered by government health insurance schemes would access care free of cost needs to be seen in the context of recent surveys which show that just 12-13% of people are covered by public-funded insurance.

The scheme may expose thousands of patients to unethical practices by private providers, compromises in quality and rationality of services and additional 'top-up services'. A specific section in the document on 'risk management' is primarily concerned about risks of private providers, with very little about robust mechanisms to protect patients from unethical practices.

It is proposed that the nested private facility will provide NCD care to two categories of patients — those referred and paid for by government schemes and self-referred patients who will pay from pocket. In the absence of a minimum number of beds reserved for the former, how can we prevent predominant capture by the latter? How will financial protection be provided to the near-poor who have to self-pay? Even if package costs for the latter are transparently displayed, who will negotiate those costs and prevent add-ons during hospitalisation?

If private sector participation were to be via empanelment of independent private facilities, the contract can be time-bound, with provision for early termination or non-renewal for poor performance. When the private sector unit is embedded within the district hospital through investment in infrastructure and equipment, and is initially contracted for 30 years, it would be difficult to dislodge a poorly performing private partner. The scope for litigation will be high in this arrangement.

Sharing of services, such as the blood bank, is efficient in concept but can be contentious in practice. Apart from complexities of administrative coordination, how will competing demands be handled?

Is the government seeing the PPP as temporary gap-filling during the phase of public sector capacity build-up? However, if this model of 'one hospital, two systems' is envisaged as a permanent feature, the risks and returns of such cohabitation require serious scrutiny. Cannot the financial support provided to the private sector be directed to create public sector capacity?

Looking forward:

The notion that the government is forfeiting its role in public health care is totally misplaced. The National Health Policy (NHP) 2017 clearly prioritises strengthening of public health systems as a key approach. However, it also recognises a critical gap-filling through strategic purchasing to be directed towards those areas and those services for which currently there are no providers or few providers. It further envisages that the order of preference for strategic purchasing would be public sector hospitals followed by not-for-profit private sector and then commercial private sector in underserved areas.

Despite recent efforts, current capacities in public facilities to manage disease conditions in cardiology, pulmonology and oncology are practically non-existent in Tier-II and Tier-III towns in most States, even in the private sector. It leads to overcrowding in tertiary-level facilities in big cities, compromising quality of care and leading to high out-of-pocket expenditures. The waiting time in premier public institutions like AIIMS, Delhi for certain procedures can range from several months to a few years. The disease burden on account of NCDs is increasing rapidly. A 2014 study by Harvard University for the World Economic Forum shows that India stands to incur a cost of $2.17 trillion between 2012 and 2030 due to cardiovascular diseases alone. The government cannot remain oblivious to the present need, even while building capacity of the public health system.

While the proposal envisages that care will be provided free for BPL families and those covered by government insurance schemes, the rates will be negotiated at Central government health scheme/State government insurance rates for others so that even the non-poor will receive care at a rate much lower than market rates. This is a significant improvement over the status quo.

The success of the initiative would, however, depend upon the PPP contract design and institutional capacity to monitor and manage such contracts so that public interest is safeguarded, there is value for public money and there is a reasonable return for private player.

In a mixed health system, it could be efficient to engage the services of the private sector to supplement the capacity of the public sector. However, cost and quality must be controlled for delivering appropriate and affordable care with accountability.