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THE IMPACT OF PUBLIC-PRIVATE PARTNERSHIP IN PUBLIC HEALTH OF KARNATAKA

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Abstract: **Karnataka has been one of the pioneer states in the country in providing comprehensive public health services to its people by establishing Primary Health Units to deliver curative, preventive and promotive health. The changing demographic profile of the State results an increasing population in the 15-59 age group. A pre-requisite to reap this 'population dividend' is to ensure a healthy and empowered population. Although figures for most health indicators are encouraging in Karnataka but, there are wide inequities in the health status within the State. These range from geographic inequity such as urban/rural, north/south, gender based disparities and age wise disparities that cut across all aspects of the health system. Even with several policies and reforms within the health sector, the State continues to grapple with preventable diseases like diarrhea and tuberculosis and faces issues such as malnutrition and low vaccination rates. NFHS III (2005-06) examined the reasons for poor utilization of government facilities across the states of India. The results show that 64% households in Karnataka do not use a government facility, as compared to 47% in Tamil Nadu and 50% in Kerala. In Karnataka the primary reason was poor quality of care as reported by 51% of respondents. The other major reasons were facility not being nearby was responded by 45% of respondents, timing by 25%, waiting time by 32% and staff absent by 14% of respondents. As a result 71.1% of per capita expenditure on health in Karnataka is by the private sector and out of pocket contribute up to 80% of the total financial resources for health care.**

Deficiencies in the public sector health system has forced poor and deprived sections of the society to seek health services from the private sector. Evidence indicates that, in many parts of the State, the private sector provides a large volume of health services but with little or no regulation. The private sector is not only the most unregulated sector but also it is the most potent and untapped sector. To address the inefficiency and inequity in the health system, Karnataka has initiated many health sector reforms. One of these reforms has been to collaborate with the private sector through Public Private Partnership (PPP) to reach the poor and underserved sections of the population.

The research study compiled 12 in-depth case studies of public/private partnership projects across the State. The case studies examined issues such as scope and objectives of the public and private partners, mechanisms used, performance monitoring, payment mechanisms, stakeholder/beneficiary perspectives and sustainability of the partnership. Each case study was exclusive in terms of the scope, coverage and the purpose of the partnership. The study also provides insights into how they work, how the poor have been targeted, constraints and bottlenecks, implementation and management of partnerships and performance of these partnerships in reaching the targeted population. The paper argues that, if well designed and implemented in stages, PPP is an innovative mechanism that benefits the poor. It would be unfair to categories PPP as privatisation or marketisation because most of the partnerships that are designed to deliver health services. This paper highlights significant policy perspectives on public/private partnership in health sector. Operational issues in the context of equity, accessibility to the poor and the deprived groups are discussed.

1. INTRODUCTION

Karnataka has been one of the pioneer states in the country in providing comprehensive public health services to its people by establishing Primary Health Units to deliver curative, preventive and promotive health. The changing demographic profile of the State results an increasing population in the 15-59 age group. A pre-requisite to reap this 'population dividend' is to ensure a healthy and empowered population. Although figures for most health indicators are encouraging in Karnataka but, there are wide inequities in the health status within the State. These range from geographic inequity such as urban/rural, north/south, gender based disparities and age wise disparities that cut across all aspects of the health system. Even with several policies and reforms within the health sector, the State continues to grapple with preventable diseases like diarrhea and tuberculosis and faces issues such as malnutrition and low vaccination rates.

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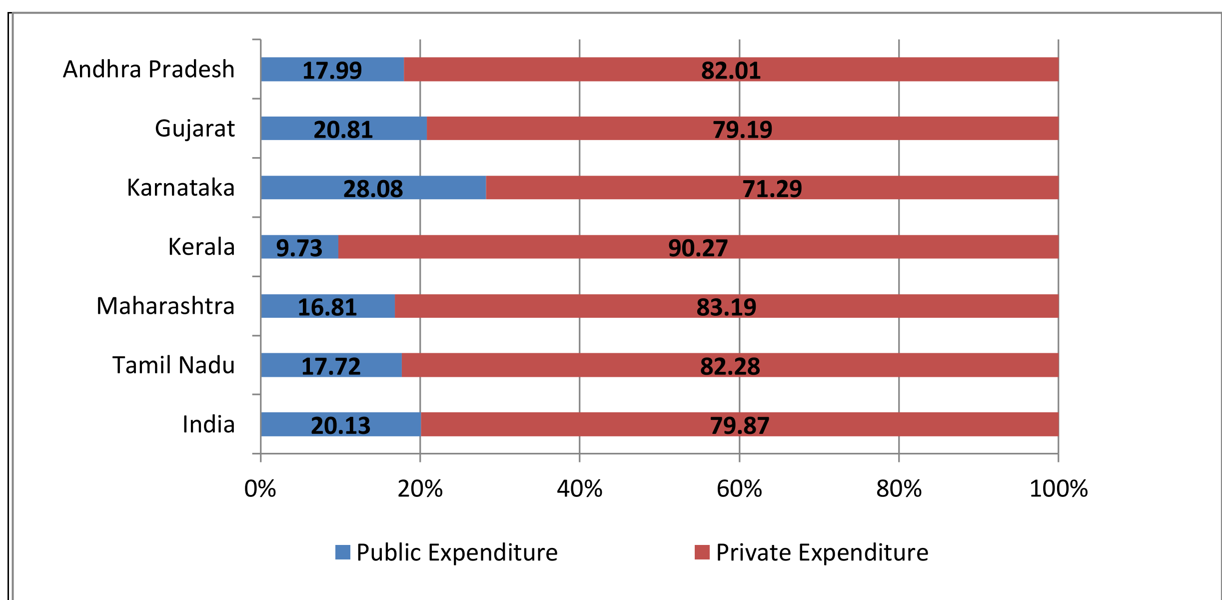
2. KEY FINDINGS FROM PPP SCHEMES IN KARNATAKA

Since 1992 involvement of private sector in health service delivery is significance. However, in the last decade, several states and central government have experimented with private sector in order to provide health care services using private service providers. It is encouraging to see the increase in public expenditure in health by the state government. Amongst the comparable states, Karnataka has the highest spend on health by the public.



Source: *National Health Accounts, 2004-05*

The research article has taken the 12 partnership models that have been studied and analyzed to understand their strengths and weaknesses, and the learning's and inferences that can be drawn from the existing models and practices that are running successfully in Karnataka. After careful review of these models the article compiled the operational issues in the management and functioning of the schemes in depth. The models are analyzed under two broad frameworks: operational issues in the management of the partnership and policy perspectives on public-private partnerships. A brief overview of the models is provided in Appendix 1.

Major observation was there are no uniform procedures adopted for the identification and verification of authentic BPL beneficiaries. Decisions about who qualifies as BPL patients are left to the interpretation of hospital managers. As a result, complaints often lead to confrontation between patients and hospital management. An observation by one staff member at Raichur's Rajiv Gandhi hospital sums up the difficulty in verifying the antecedents of BPL patients.

In most of the partnership projects user charges are not permitted. In those projects where a user-fee is allowed, the quantum of collection is too meagre to meet the operational expenses. How the user-fee is to be accounted for during the grant allocation by the government is not made clear in the partnership agreements. The models reviewed in this paper shows that there are no uniform policies about user-charges. No mention is made either on the basis of fixing the rates of user-charges or on how the revenue from the user-charges will be used. Some charges are in the form of direct fees paid by patients; others are in the form of insurance premiums. The funds received by the private agency are either in the form of grants-in-aid or global budgets. Case analysis indicates that government grants under private partnerships are invariably directed toward primary care services. This finding repudiates the claim in some quarters that partnership with the private sector would divert government resources toward specialist care services.

Some partnerships agreements mandate the private sector to submit periodic reports but most indicate a monitoring mechanism without specific details. It is widely believed that, in government contracts, there is a tendency to pay less attention to the performance indicators. This is based on a premise that the public sector itself does not function efficiently and therefore would not be able to identify performance standards and specifications. Another premise is that if those who are in-charge can use contracts to obtain performance from the private contractors, they should use their influence to get required performance from their own workforce.

Another critical issue is related to the difference between the private-for-profit agencies and not-for-profit agencies in terms of the quantum of the grant or budgetary support. While the for-profit agencies receive full grants or reimbursement, the not-for-profit agencies (NGOs) are not given full budgetary resources. For NGOs, grants from the government are in fact sustenance for their existence. Interestingly, the government on the one hand is circumspect about granting incentives to the non-profit private sector whereas on the other hand there have been excessive concessions to the private-for-profit sector. It would be interesting to examine whether this is due to better negotiating skills in the private sector or due to a philosophical approach towards not-for-profit agencies by the government. There is also a widespread perception that it is acceptable for a for-profit agency to negotiate financial details and profit margins whereas a similar approach by a not-for-profit agency would be spurned. Such distinct differences could be seen from the manner in which the government of Karnataka supports Raichur's Rajiv Gandhi Hospital and the Karuna Trust to run the PHCs. While Karuna Trust is given a maximum of only 90% of the salary costs of staff and other material support, the Rajiv Gandhi hospital gets full reimbursement of all expenses plus a service fee. There are no explicit incentives stated or agreed in any of the partnership agreements. A positive incentive for private partners is that their experience of working with government may help them in securing more contracts in the future.

Beneficiaries in all the partnership project sites viewed the services received by them in a positive manner, though often they were not aware of any partnership. In general, feedback from the beneficiaries has been that the services are better now than in the past. Very few patients have been turned away from receiving services. Despite an overall positive feedback from the beneficiaries, some concerns require attention from the authorities. Though most of the concerns are project specific, a common complaint has been about the insufficient availability of drugs, thus forcing patients to buy these from the market. Another concern expressed by beneficiaries as well as private agencies is a lack of clarity about who should pay user-fees and who is exempt. The main concern of the staff working under the private partners has been that of high workload, long hours of work, lower pay, job insecurity, political interference and staff turnover. The public

health staff is not kind in their comments about the private partnership projects, although they are willing to work with them.

3. POLICY IMPLICATIONS

Some issues and challenges that have arisen when studying various PPP models and arrangements in the health sector across the State. These issues have a significant impact on the success of the arrangement and should be mitigated before the commencement of the project.

- There is no PPP policy for Health at the national level. Some of the states have taken the initiative and developed draft health PPP policy, although none of them have been finalized by the respective state governments.
- Output/outcome indicators are important for monitoring and evaluating the performance of the partnership. Output/outcome indicators should be measurable and clearly defined at the inception phases of agreement. The absence of such defined outcomes ultimately leads to allegations of lack of transparency by the private partner as well as unregulated profit seeking behavior.
- It is also essential to clearly define the institutional framework for monitoring the level of compliance or achievement of the private partner on a regular basis. Other trends like outsourcing - this responsibility to an external project/technical support unit staffed by contractual resources have emerged in some of on-going programmes like National Aids Control Programme.
- The institutional forums which wither partner can approach to address their grievances as well as specific grievance redressal mechanisms are usually not an integral part of the contract.
- 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 vary widely.
- There is no effort being done to calculate the cost of each health services offered, there is a need for creating empirical evidence in terms of cost of service. The empirical data will help in defining the cost of each service offered. The role of state health accounts is also very restricted and limited, which does not allow it to compute cost of each health service being offered.
- The projects/schemes should be evaluated or assessed by the third party organizations and should be documented as a case studies.
- To conceptualize and to develop a shelf of projects for implementing under PPP, the Government has to set up PPP Cell in the State.

4. METHODOLOGY

The research study compiled 11 in-depth case studies of public/private partnership projects across the State. The case studies examined issues such as scope and objectives of the public and private partners, mechanisms used, performance monitoring, payment mechanisms, stakeholder/beneficiary perspectives and sustainability of the partnership. Each case study was exclusive in terms of the scope, coverage and the purpose of the partnership. The study also provides insights into how they work, how the poor have been targeted, constraints and bottlenecks, implementation and management of partnerships and performance of these partnerships in reaching the targeted population. The paper argues that, if well designed and implemented in stages, PPP is an innovative mechanism that benefits the poor. It would be unfair to categories PPP as privatisation or marketisation because most of the partnerships that are designed to deliver health services. This paper highlights significant policy perspectives on public/private partnership in health sector. Operational issues in the context of equity, accessibility to the poor and the deprived groups are discussed.

5. CONCLUSION

Overall, Investments in health ensures healthy and productive citizens who can contribute to the economic progress of a nation. Better health is focal point to human happiness and well-being. However, higher investments in itself may not

ensure better service delivery to the population and it needs to be accompanied by concomitant measures to improve governance and make the system more transparent and effective. It must be noted that reform efforts have been mainly top-down and if the reformers are serious about PPPs, then the other stakeholders - private providers, organizations, consumers must be involved in the process.

PPPs need to be used judiciously and need to be customized to suit local conditions/situations as they have the potential to completely transform the landscape of healthcare service delivery and infrastructure. This challenge is further exacerbated by the fact that the private sector is completely unregulated. Hence, in lieu of conditions such as limited clarity at the execution level about PPPs and its role in implementing health service delivery, an attempt to document the case studies, their experiences across the state as well as country and draw a roadmap for implementing PPP for health in the state which actually includes policy planning and implementation processes, analysis of the existing scenario and key issue identification, implementation, monitoring and impact assessment are great need of the hour.

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APPENDIX -1

No.	Name of the PPP Model	Type	Govt. Entity	Pvt. Entity	Geographical area	Cumulative progress (As on 2011)
1	Vajpayee Arogyashree Scheme	Health Coverage	GoK provides funds through Suvarna Arogya Suraksha Trust which handles all payments	Implementation Support Agency; Empanelled Private and Govt. Hospitals	Seven Districts in Gulbarga and Belgaum divisions in North Karnataka	*Physical:* 14, 700 Surgeries *Financial:* Rs. 87.15 crores.
2	Management of Primary Health Centres	Performance Management Contract Out	GoK	Karuna Trust	Gumballi and Sugganahalli	-
3	Telemedicine and Tele Health Project	Tele-diagnosis and consultation	GoK and Indian Space Research Organization (ISRO)	Narayana Hrudayalaya	Selected District Hospitals	-
4	Thayi Bhagya	Maternal Health Services	GoK	Recognized Pvt. Hospitals	-	*Physical:* 90,339 (Govt.-57,972) *Financial:* Rs. 22.19 crores
5	Yeshasvini Health Scheme	Health Insurance	GoK	Empanelled Private Hospitals	-	*Physical:* 2,502 deliveries (461 caesarians) *Financial:* Rs. 1.02 crores

The models are studied in detail and key learning's are as follows:

- Vajpayee Arogyashree Scheme was envisaged to improve the access of quality healthcare services for ailments such as heart, lung, liver, paediatric congenital malformations, cancer, renal disease, neurosurgery, cochlear implants, and prosthesis and trauma cases to the poor and marginalized sections of the society. The scheme started in February 2010, currently covers around 18 lakh BPL card holders and it is completely cashless for beneficiary. It has also extended to 7 more districts in Belgaum division.

- Management of Primary Health Centres (PHCs) was contracted out by GoK to Karuna Trust in 1996 to serve in the tribal community and hilly areas with an objective to provide health services, maintain and manage the primary health centres and its sub-centres. Trust takes complete responsibility of providing all personnel at PHC and sub-centres (SC) within its jurisdiction. Maintenance of assets, arrangement of essential drugs and addition if any at free of cost. It provides round the clock health services, emergency services, outpatient consultation, inpatient facilities, provision of diagnostics services like ECG, X-ray, laboratory services, vaccines/immunization, implementation of national health programs, ambulatory services etc. Some of the key learning's of the schemes are greater autonomy for PHC functioning and management, active involvement of government functionaries in the planning, acceptance by the community and success of this models is replicated in other states like Arunachal Pradesh.

- To provide tele-diagnosis and consultation for coronary care, Telemedicine and Tele Health Project was initiated by Govt. of Karnataka, Narayana Hrudayala (NH) hospital, Bangalore and ISRO. The project aims to provide coronary care units function of selected district hospitals that are linked with NH where in coronary care technology with technical support from ISRO and clinical expertise by NH. Services offered under the project are radiological diagnosis, VSAT/Telecommunication link for video-conferencing for online tele-examination of medical diagnosis and follow-up advice, referral for advanced investigation or surgical care at NH. Key outcome of the project are cost effectiveness, easy and accessible services and effective treatment to the beneficiaries.

- Thayi Bhagya is being implemented since 2008 to address the issue of Infant Mortality Rate and Maternal Mortality Rate. This scheme is modeled based on Chiranjeevi Maternity Healthcare Scheme of Gujarat. Special provision for 7 backward North Karnataka and Chamarajnagara Districts, where the health parameters like institutional deliveries are poor and the maternal and infant deaths are relatively high. Under the scheme, recognized Private hospitals will get an amount of Rs. 3.00 Lakhs for every 100 delivered conducted in their institution as an incentive. Maternal services to BPL pregnant women – delivery and surgical treatment limited to first two live births, availability of OBG, anaesthetist and paediatrics services for 24 hours and availability of blood banks are the services offered to the patients at free of cost.

- Prime objective of the Yeshasvini Health Scheme is to provide access to clinical care to farmers, who are members of farmer co-operative societies through health insurance. It was launched in 2003 by GoK to rural people. Farmers who were part of cooperative societies for more than 6 months were eligible for this scheme, along with their families. The premium to be paid is Rs 60 per person and the cover includes free out-patient services and subsidized rates for diagnostic services at network hospitals. Each member is eligible for around 1600 different type of minor surgeries costing upto a maximum of Rs. 200000 including cardiac by-pass surgery. It also provides free out-patient consultation in any of the 160 network hospitals and medical as well as diagnostic investigations at nominal rates. It is largest self-finances community based health insurance scheme and provides low cost health care services to the needy.

- Citizen Help Desk scheme implemented in 17 districts and other general hospitals located in Bangalore City and elsewhere numbering 37 [18 under National Rural Health Mission (NRHM), 19 under Karnataka Health Systems Development and Reforms Project (KHSDRP)] in order to involve local community based organizations to improve the services in the hospitals and guide the patients for seeking proper and timely medical care. It shows that, there is a reduction in patient's waiting time and the patient grievances are redressed at the local level. The specialist's time has also been optimized due to appropriate referral assistance and counseling provided by these desks.

- Arogya Bandhu is a very unique model which has become a trend setter in the country of involving NGOs in jointly running the Primary Health Centres and Specialist Services in Community Health Centres (CHCs). So far 56 PHCs and Specialist Services in one CHC of Santhemaralli Chamarajnagar district are enrolled and function under this scheme.

- Mobile Health Clinics is a partnership programme to boost the Quality life of unreached Population with a vision of reaching the unreached, pro-poor public private partnerships for Health of underserved. It is one of the innovative and practical ways of need based revolution in the Health Sector of Government of Karnataka, India. 125 MMUs (28 from NRHM and 97 from KHSDRP) are in services for providing basic primary health and mother and child health care to the people living in far flung and difficult areas of the State.

- Arogya Kavacha 108 was launched on November 1, 2008, is highly acclaimed, cashless emergency ambulance care for the victims of fire, motor vehicle and other accidents and medical emergencies. Till 2011, more than 2.56 crores calls received and attended to about 18.8 lakhs emergencies, out of which 5.96 lakhs are pregnancy related accounting to 43%.
- The Rajiv Gandhi super-speciality hospital in Raichur Karnataka, was built at a cost of Rs 600 million. This economically backward region of the state has no modern health facilities so people are forced to travel long distances to seek specialist medical care. As government was unable either to deploy or retain specialist doctors, the hospital was lying unused. Apollo Hospitals Ltd, a corporate hospital chain, was seeking to establish its own hospitals in the region, but it was not sure about building a super speciality hospital. The respective dilemmas of the Government of Karnataka and Apollo Hospitals Ltd were highly conducive for establishing this partnership for mutual benefit. Through this partnership, the Government is able to provide free services to the poor, and Apollo Hospitals Ltd is able to establish its business operations without having to invest in constructing physical infrastructure. The corporate hospital is able to pay well for its staff so it could retain the desired manpower. Similarly Chamarajanagar, a predominantly tribal district, had only primary care facilities at its district hospital. For any superspeciality care, people had to travel far.
- Raktha Vahini is a unique scheme of providing blood and its components for all emergencies with a focus on mother and child health emergencies (cashless) in a 7 high focus & 7 'C' category districts through an MoU with Red Cross, Bangalore at a nominal cost of Rs. 520 per bag. The blood is transmitted through the regular bus services in a cold storage box to the mother blood bank at the district head quarters from where the functional First Referral Units (FRUs) draw their requirement periodically.
- 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 in order to design interventions and implement after baseline survey, mostly through improved IEC activities in the selected sub-centres and villages with an objective to improve the uptake of government health services through timely accessing the health care facilities by the vulnerable and deprived segment of the social strata of population.