Research Paper Economics

The Role of Public-Private Partnetship in Chief Minister's Health Insurance Schemewith Special Reference to Tamilnadu, India

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ABSTRACT

This article tries to analyses the efficiency ofpublic-private partnerships (PPPs)of Kalaignar Insurance Scheme. Government of Tamil Nadu announced a "Kalaignar Insurance scheme for Life saving Treatments" on July 23rd 2009 in collaboration with Star Health and Allied Insurance Company. The scheme covers below poverty line (BPL) families of the 27 welfare boards as well as families earning less than Rs.72,000/- per annum. Under this scheme sum insured is Rs.1 lakh for 51 type of diseases for 4 years and eligible to get treatment only at the empanelled Hospitals both private and government hospitals. This is the first community health insurance project in Tamil Nadu covering the entire population. This scheme has been launched for the entire state; it covers roughly about half of the population of Tamil Nadu. A public private partnership is promoted among the Insurance Company

Keywords: Kalaignar Insurance Scheme, Healthcare sector, Innovative Practices, Public-Private Partnerships

Introduction

The Healthcare sector comprising of hospitals and allied services such as medical education, equipment, diagnostics and pathological laboratories and medical insurance is a complex market, distinct from other sectors. The share of private expenditure as to the total expenditure on health has grown from about 60% to almost 80% over the last decade. The current share of public expenditure on health is 20% with a view to raise government expenditure on health as a proportion of GDP from 0.9% to a target of 2-3% by 2012 and the government launched the National Rural Health Mission (NRHM) in 2005.1 At present the central government and the state governments cumulatively contribute 0.34% and 0.56% of GDP respectively to healthcare and related services. There are an increasing number of private players changing the nations' health delivery landscape beyond recognition.2there are four key issues driving growth in the healthcare industry in India.

Population Growth: This is the prime driver of growth in the healthcare sector. With the population currently at 1.1 billion and increasing at the rate of 2% p.a. it is estimated that by 2050 the population will reach 1.6 billion. This massive population is due to a decrease in infant mortality (in turn a result of better medical facilities and government emphasis on eradicating diseases such as hepatitis and polio among infants).3

Expanding Middle Class: parallel to India's thriving economy is rapid urbanization and creation of an expanding middle class with more disposable income to spend on healthcare.

Rise of Disease: Among the urban population there have been a significant number of health problems which may be called lifestyle diseases. Unhealthy diets, sedentary work and affluent lifestyle have given rise to hypertension, cancer, diabetes, obesity etc. Lifestyle disorders are expected to grow in the future at a faster rate than infection diseases in India and to result in an increase in cost per treatment.

Medical Tourism: With specialty and super specialty hospitals equipped with the latest equipment and the best surgical procedures at relatively inexpensive charges on the rise has made India a hub for people from the west to get treatment here is giving birth to a concept called medical Tourism.2

2. Types of Healthcare in India

There are seven types of Healthcare in India such as Public Healthcare, Private Healthcare, Primary Healthcare, Nursing Homes, Secondary Care Hospitals, Tertiary Care Hospitals, and Quaternary Care Hospitals.A Public Health is a state responsibility, however, the central government does contribute in a substantial manner through grants and centrally sponsored health programs/schemes. There are a number of hospitals who offer free services to the poor who are unable to pay for their treatment.4

The private health sector consists of the 'not-for-profit health sector includes various health services provided by Non-Governmental Organizations (NGO's) charitable institutions, missions, trusts, etc. Healthcare in the for-profit health sector consists of various types of practitioners and institutions. The licensed practitioners range from general practitioners (GPs) to the Super Specialists, various types of consultants, nurse and paramedics, licentiates, and Rural Medical Practitioners (RMPs). An average household contributes 4-6%of its household income to healthcare with close to 80% going to the private sector.

Primary HealthCare (PHC) is generally clinics with one or more general practitioners. Though these are not equipped for ICUs and surgeries they are the most important contact point for healthcare in rural India and have limited private players.

Nursing Homes can have one or more doctors and at least 20 beds. There are various types of nursing homes such as ophthalmic, orthopedic, cardiac, dental clinics, Ear Nose Throat (ENT) clinics and maternity homes.2

Secondary Care Hospitals are bigger hospital with typically 100-300 beds with surgical wards and ICU facilities. They can be further classified as general hospitals and specialty hospitals while general hospitals offer inpatient facilities along with radiology, emergency care, general surgery and few departments such as obstetrics pediatrics, gynaecology etc., and dedicate 10% of their bed to ICU use. On the other hand specialist care such as cardiology, neurology, dermatology etc., moreover these hospitals dedicate 25% of their bed to ICU usage. Examples: Manipal Specialty Hospital Bangalore.5

Tertiary Care Hospitals have around 300 beds and doctors offering top of the line facilities in specific specialties, Examples SankaraNethralaya (Chennai), Escorts Heart Institute and Research Centre (New Delhi), National Institute of Mental Health and Neuro Sciences (NIMHANS) etc., while these are single specialty hospitals there are multispecialty tertiary hospitals as well which offer a number of specialty services under one roof.17

Quaternary Care Hospitals are hospitals offering super specialty surgical procedures including advanced cardiac, joint replacement, neurological, etc., Osmania General Hospital (Hyderabad) and Apollo Children's Hospital (Chennai) are examples.2

3. Objectives of the study

- To study about Health Care sector in India.
- To study about the Public Private Partnership in Health Care Sector.
- To study the importance of Public Private Partnership in Chief Minister's Health Insurance Scheme in Tamil Nadu.

4. Public private Partnership in Healthcare sector

In west Bengal, private doctors have been hired on contract basis of staff PHC's. In Uttar Pradesh, there are similar efforts to contract private doctors to fill empty rural health centers and also special transport funds to provide outreach services. Municipal hospitals have developed arrangements with private doctor's fee-or-service in the hospitals on revenue sharing basis. And two pilot districts are providing sterilization services in nursing homes, using government doctors and supplies in private facilities. The key in this case is training of nursing home staff and promotion of services availability to the public.6

Gujarat had more than 700 private obstetrician/gynecologists (OB/GYN) practicing in rural areas. The disparity is not surprising, since private sector specialists receive salaries typically five times higher than those earned in comparable positions in government service. A series of consultations with both public and private partnership (PPP) called "Chiranjeevi-Yojana" which realigned health system human resources by relocating obstetric gynecology services from the public sector to the private sector in Gujarat.7, 18

There are other means of working with the private medical sector to reach public health goals. Important policy initiatives have been explored in Delhi, Rajasthan and Punjab. Briefly, they involve joint investment with private sector through offer of land for building of hospitals in exchange for certain hospitals were to set aside beds, plus free services and medicines, for the poor. This has been achieved with varying success. Rajasthan has also been the site of many recent regulatory advances involving private sector medical providers and alternative financing. Private practitioners, including non- MBBS doctors, have routinely been involved in training in family planning and other health areas.4

Tamil Nadu has also been encouraging Public-Private Partnerships to facilitate the provision of ancillary services. While the state continues to provide most medical care, it is experimenting with private sector collaborations for ambulance services, facility maintenance, medical equipment, sanitation and construction. In addition, Tamil Nadu is establishing PPPs to provide health care access in tribal areas. Presently, it has collaborations with the private companies and NGOs for mobile outreach clinical services, blood banks and provision of training and support for community health workers in remote areas.7, 18

5. Types of Public Private Partnerships

The delivery of health care in almost every country, involves some form of Public-Private Partnership. In countries were care is delivered mainly through the public system. Many inputs such as pharmaceuticals and support services are sourced from the private sector.8 Based on Research literature it is possible to identify varies types of public private partnership in health sector around the world. Among the types of partnership are:

Contracting (Contracting out and Contracting in); franchising; social marketing; joint ventures; subsidies and tax incentives; vouchers or service purchase coupons; hospital autonomy; build, operate, and transfer; philanthropic contributions; health co-operatives; grants-in-aid; capacity-building; leasing; and social health insurance;9 However, among all the partnership models, contracting has been the most common form. Contracting is a tool that formalizes the relationships and obligations between the different actors in the health system. PPP was formed was through contracting out of the clinical and non-clinical services. On clinical side it included specialty care services, laundry services, security, etc. The contracting out of thee non clinical services such as dietary services, laundry services, security etc., was done in states such as Maharashtra, Tamil Nadu, and West Bengal. In recent times a new trend of contracting out of the specialized and super specialized health care departments has emerged. Maintenance of equipment's and facilities is another area where contracting out is done.10, 11

The private sector is actually a conglomerate of various sub sectors: for profit or corporate, non-government, voluntary and informal. It is a mix of individuals' e.g. Private practitioners and organizations (NGOs) working in various fields: advocacy, service delivery, community empowerment, etc., and sometimes dealing with other sectors in health. It is largely uncontrolled and unorganized, with limited management and administrative capacity. The official 'for-profit' sub sector can be roughly categorized into individuals and institutions. The individuals are Registered Private Practitioners (RPP) of modern medicine or allopathic doctors and Indian System of Medicine (ISM) practitioners. There are 70,000 private hospitals and nursing homes in India, 85% of which are of small size (under 25 beds). The 'not-for-profit' sub sector has been classified in various ways: either by type, by authority, by country origin or some times by source of control. The informal sub sector encounters government doctors with private doctors, non-qualified practitioners of allopathic medicine (quacks), traditional practitioners, community health workers, traditional birth attendants, Dais, Anganwadi workers, faith healers, local medicine men etc. Contracts are generally seen as the tool that makes privatization possible.5

6. Models of PPP in Hospitals

The model in which a public authority contracts with a private company to build or run the hospital is, inevitable seen mainly in countries with national health services, where various models have been developed as shown in table :5

TABLE NO.1
Model of PPP in the Hospital Provision

MODEL	DESCRIPTION
Franchising	Public authority contracts as private company to manage existing hospital.
DBFO (design, build finance, operate)	Private consortium designs facilities based on public authority's specified requirements, builds the facility, finances the capital cost and operates the facility

BOO (build, own, operate)	Private authority purchases services for fixed period (say 30 years) after which ownership remains with the private provider.
BOOT(build, own, operate, transfer)	Public authority purchases services for fixed period after which ownership reverts to public authority.
BOLB(buy, own, lease, back)	Private contractor build hospital, facility is leased back and managed by public authority.
Alzira Model	Private contractor build and operates hospital, with contract to provide care for a defined population.

Sources: D.C.Joshi, Hem Chandra – Trends on Contracting in Health Care

7. Pros and Cons of Collaborating with the Private Sector in Health

One of the critical issues in PPP throughout the world is the timely release of grants to reimbursements to the private partner. 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.9 one of the major gaps in partnership agreements has been a lack of specific conditions related to the quality of services to be delivered to the beneficiaries. Coordination between the stakeholders is another area of potential conflict. Differences in personalities and their respective styles could jeopardize the functioning of the partnership.12

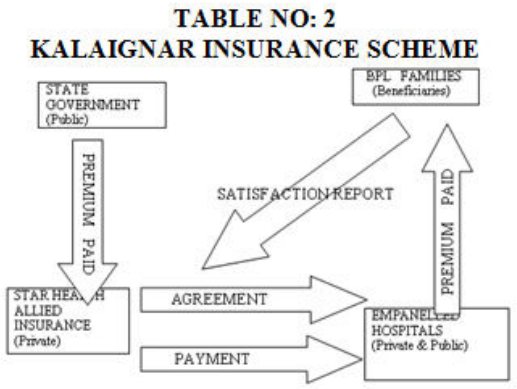
There are pros and cons in all the three sub sectors of PPP. In the case of informal sub sector client oriented accessibility is the main pros. Poor quality care and maintaining low cost are main demerits of the informal sub sector. As far as the not-for-profit sub sector is concerned, providing high quality services and targeted to the poor community are main advantages. Small coverage inadequate resources and maintenance of low cost are the main demerits. With regard to the profit sub sector has certain advantages such as providing high quality of service, wider coverage, innovation and efficiency.9

There are relatively few partnership projects that are exclusively meant for the patients from Below Poverty Line (BPL) families (Urban Slum Health Project, ArogyaRajksha and ChiranjeeviYojana Schemes) 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. In Tamil Nadu Kalignar Insurance Scheme (KIS) is targeted to cover the families of the 27 welfare boards as well as families earning less than Rs.75, 000/- per annum.13

8. PPP in Kalaignar Insurance Scheme in Tamil Nadu

The Tamil Nadu Government has launched the "Chief Minister Kalaignar Insurance Scheme for Life Saving Treatments" on July 23rd, 2009 for providing quality and free healthcare for the economically weaker sections and the downtrodden. The scheme to cover all families to various welfare boards as well as families earning less than Rs.72,000/- per annum which is being implemented through Star Health and Allied Insurance, a private insurance company. These insurance companies will enable over one crore poor and downtrodden families to receive specialized treatment costing up to Rs.1 lakh for 51 types of diseases. The government has released the list of diseases, treatment and surgical procedures covered by the scheme.14 this project was started with the prime objective of extending quality health system by utilizing the facilities available with the private sector. The cost of quality healthcare at private hospital is an unbearable burden for the economically weaker sections of the society. The KIS addresses these issues and targeted to cover the poorest of the poor/low income/unorganized groups.15

TABLE NO: 2
KALAIGNAR INSURANCE SCHEME



KIS has covered the dream of access to quality medical care and providing financial protection against high medical expenses into a reality for the below-poverty-line (BPL) population. A public private partnership is promoted among the Insurance company, the private sector hospitals and the state agencies is what is driving the scheme is an efficient and cost-effective manner.13 This project has offered a win-win situation for everyone concerned, the government insurance company, healthcare providers and the general public.

9. Conclusions

A review of successful programs in other states such as Rajasthan and Andhra Pradesh may provide some valuable lessons in implementing policy changes. These two states have been at the forefront of private-public partnerships, with mostly successful results. They have used tax concession, subsidies, training; joint investment, accreditation and other tactics to gather the maximum use of their private sector and so save public resources for use with the poorest of the poor.4 Partnership initiatives ranged from super-specialty tertiary-care hospitals (Apollo Hospital, Raichur; SMS Hospital, Jaipur) to primary care (Karuna Trust in Karnataka) to slum Communities (ArpanaSasthya Kendra, Delhi; Urban Slum care in the district town of Adilabad, Andhra Pradesh).14 Community Health Insurance initiatives in two states were also documented (ArogyaPaksha Scheme in Andhra Pradesh; Yeshasvini Scheme in Karnataka) 19

In the new proposed scheme yet to be launched there are a lot of promising changes like increase in coverage of medical conditions covered from 642 to 950, coverage for inpatient investigations and other charges incurred for 5 days even though it does not warrant investigations done as an outpatient. The current Insurance Scheme is efficient and effective as it has already proved by providing benefit to a massive 1, 17,013 patients. PPP can be effective means of providing rational, affordable and comprehensive care to the entire population provided that the private partners are chosen with care.16 It may be concluded that the government should find out ways to improve the quality of health care in government hospitals, so that a major part of the scheme amount funded from public money goes back to the government so that it can be ploughed back for the public at large. This is sure to increase the totality of the proposed scheme.

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