Public-Private People Partnership: Winning in collaboration
# Table of contents

<table>
<thead>
<tr>
<th>Imperatives for public private people partnership</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>The PPP model: Money talks</td>
<td>4</td>
</tr>
<tr>
<td>Healthcare PPPs: The <em>Bharat</em> story</td>
<td>10</td>
</tr>
<tr>
<td>Adding another dimension to PPP: People</td>
<td>16</td>
</tr>
<tr>
<td>PPP: Constraints and challenges</td>
<td>18</td>
</tr>
<tr>
<td>The need of the hour</td>
<td>19</td>
</tr>
<tr>
<td>To summarise</td>
<td>21</td>
</tr>
</tbody>
</table>
Imperatives for public private people partnership

Sustainability of healthcare systems across the globe is now threatened by barriers such as rise in healthcare spending, mushrooming population and epidemiological transitions towards non-communicable diseases. While healthcare expenditure by the Organisation for Economic Co-operation and Development (OECD) nations is forecasted to rise from 9.9 to 14.4% of the gross domestic product (GDP) by 2020, emerging nations face an even steeper hike, as they seek to bring down high infant mortality rates, increase longevity and combat myriad diseases.

For example, Malaysia with spending of 353 USD per capita each year, is over eleven times lower than the OECD average of 4,002 USD1. Moreover, global recession has only exacerbated the need for governments to chalk out ways to fund these investments and deliver health services in a cost-effective manner.

Over the next decade, healthcare spending in developing economies is expected to double in real terms, thereby outstripping GDP growth. By 2020, infrastructure spending for the OECD as well as the BRIC (Brazil, Russia, India, and China) nations will increase to 397 billion USD.

In emerging economies, financing healthcare delivery continues to be a major challenge while delivering the goal of universal healthcare. For instance, India invests around 3.9% of its GDP on healthcare, whereas countries such as Indonesia spend 2.7% of the overall GDP on the healthcare sector6.

Also, creation of quality healthcare infrastructure requires humungous requirements. As per estimates, India’s healthcare infrastructure requirement of an additional 650,000 beds translates to a capital investment of 165,000 crore INR by 20177.

Given this scenario, governments across the globe are increasingly looking at the public private partnership (PPP) model in order to solve the larger problems prevailing within the avenue of healthcare delivery and wellness. As PPPs move from replacing crumbling inpatient structures to managing healthcare delivery, the impact on overall costs is far more substantive and sustainable.

PPPs are now redefining their structure and evolving towards a wider paradigm to also include ‘people’ participation and community engagement. Hence, the 3Ps within the PPP framework are now transforming into the 4Ps structure-public private people partnerships. Additionally, community engagement needs to be the cornerstone of PPP initiatives. This becomes all the more critical in a consumer-focused industry such as healthcare.

Healthcare in India: A mixed bag

- **Affordability:** The growing burden of non-communicable diseases will cost the country 236 billion USD in the disability adjusted life years (DALYs) lost. Moreover, huge costs incurred for the treatment of diseases such as cancer, cardiac and stroke cannot be borne by a single healthcare delivery system.

- **Accessibility:** Approximately 45% of the population in India has to travel a distance of 100 kms in order to access quality healthcare services. Most of the rural population still does not have access to quality care, and service levels within public hospitals are insufficient to meet growing demand.

- **Infrastructure:** The country’s bed density is still the lowest among the BRIC nations, and approximately 70% of the available beds are concentrated within the top 20 cities of the country. The urban-rural divide in healthcare infrastructure and the disease profile of the country presents a significant challenge to the system.

---

1PwC PPP Report South East Asia
2World Bank 2011
3PwC NATHEALTH whitepaper ‘Enabling access to long term finance for healthcare in India’, 2013
• **Human resource**: The doctor-nurse ratio to the total population is inadequate, thereby posing a huge manpower deficit, especially in the rural areas. The issue of talent and skill set gap is aggravated by the large number of under-utilised allied *ayurvedic/unani/siddha* homeopathy (AYUSH) personnel within the system.

• **Financing**: Most of the country’s health expenditure is supported by private spending, primarily the out-of-pocket (OOP) route, with public funds constituting an insignificant portion of the total health expenditure. In India, less than 25% of the total population is covered by health insurance.
The PPP model: Money talks

PPPs are defined as a broader partnership between private players and the government, in which the latter enters into a contract (usually on a long-term basis) with the former for the provision of a public service.

Historically, within the purview of PPPs, healthcare has largely been overshadowed due to a strong focus on projects implemented in other industry sectors such as energy, telecommunications and transportation. Currently in India, healthcare projects are estimated to constitute only around 10% of the total number of PPPs implemented. Globally, over the past two decades, several developed as well as developing economies have to various degrees, financed healthcare initiatives through the PPP model.

Evolution of the PPP model: Paving the way for local demands

Compared to the global scenario 30 years ago, today, hospitals in particular, and the healthcare sector in general have undergone a complete metamorphosis.

For instance, during the 1990s, the UK was a fertile ground for PPPs in healthcare since the government had vastly under-invested in the National Health Service (NHS) hospitals. As a result, nearly every new NHS hospital within the UK, approximately 100 buildings in 12 years, was built as a result of a PPP initiative. It is unlikely that the NHS, the world’s largest single-payer health system, could have taken on such an aggressive construction initiative without the support of partnerships that came to be known as the private finance initiative (PFI).

How can PPPs improve health systems?

PPP mechanism

Private sector partner

Contract

Government

New healthcare facility or clinical and non-clinical services are delivered by private partners to consumers

Financial compensation, transfer existing assets, policy vision

Private companies

- Low barrier to entry and attractive proposition
- Investment opportunity given funding and clearly defined need

Health system

- Improve health infrastructure and health services provisions
- Improve outcomes

Government

- Enable governments to leverage private sector expertise and investment to service public policy goals

Source: PwC analysis
The scope as well as the structure of PPPs are now changing and are based on specific needs and context. For example, the PPP model in the Turks and Caicos Island as well as the Kingdom of Lesotho not only looks at creating a robust healthcare infrastructure, but also provides a mechanism to access skills and technology.

PPPs are challenging the notion that private healthcare is meant to be accessed by the affluent sections of the population, while public healthcare is meant for the poor. Rather than creating or exacerbating inequities in healthcare, PPPs can equalise care for all sections of the population. Since service delivery becomes integral to PPPs, technology also plays a critical role in healthcare PPP transactions. For instance, the PPP project of setting up proton beam therapy centres in France and Germany has demonstrated that partnerships can be forged by the government in funding high-cost technology therapies.

**PPP in healthcare: Critical drivers**

Instituting a PPP model in the healthcare sector, especially in the emerging economies, becomes crucial given the prevailing constraints in such economies such as limited scope of primary care, outdated healthcare facilities, paucity of doctors and nurses, shortage of hospital beds, and a growing private health sector accessible only to the upper-middle class populace.

Increasingly, PPPs in healthcare are built on common drivers which include factors such as fiscal capabilities of the government, resource constraints, and government technical expertise in executing such transactions.

**Catalysts for PPPs in healthcare**

<table>
<thead>
<tr>
<th><strong>Drivers</strong></th>
<th><strong>Large scale investments:</strong> The need for huge infrastructure investments spurred by changing disease profile and patient expectations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Drivers</strong></td>
<td><strong>Budget constraints:</strong> Financial pressures and low level of public spending in several developing countries</td>
</tr>
<tr>
<td><strong>Drivers</strong></td>
<td><strong>Better procurement:</strong> Leveraging the strengths of the private sector in bringing about efficiency of operations. Moreover, the role of the government is now changing from that of a provider to a monitoring body,</td>
</tr>
<tr>
<td><strong>Drivers</strong></td>
<td><strong>Access to skills and knowledge:</strong> Securing private sector skills as well as expertise in running clinical activities within health facilities</td>
</tr>
<tr>
<td><strong>Drivers</strong></td>
<td><strong>Service capacity:</strong> Limited capacities to deliver healthcare services due to obsolete infrastructure</td>
</tr>
</tbody>
</table>
In order to increase the penetration of healthcare services, governments across nations are focussing not only on creating quality infrastructure, but also on joining hands with private partners to achieve operational efficiency and better utilisation of healthcare facilities.

**Successful metrics in PPP**

PPP initiatives within healthcare are now increasingly focussing on critical aspects such as better procurement and value for money. Hence, the yardstick for measuring the success of such projects is moving away from earlier established parameters such as the availability of healthcare services towards better health outcomes.

**Measuring the success of a PPP structure**

- Measurement of infrastructure PPPs
- Measurement of PPPs in the area of clinical services

**Value for money calculation**

- Estimated cost of the public sector delivering the project (100 USD million)
- Expected cost of private sector delivering the project (95 USD million)
- Difference in cost (5 USD million)
- Value for money = 5%

**Operational benchmarks**
- Clinical benchmarks
- Workforce productivity
- Patient outcomes
- Waiting periods
- Patient satisfaction

Source: PwC analysis

The healthcare industry is now moving beyond the value for money (VFM) calculation objective. As PPPs expand their horizons into improving healthcare delivery and patient outcomes, the public as well as private sectors must agree upon more complex measurements that address both short-term as well as long-term goals. Moreover, the development of new models has necessitated the need for chalking out innovative payment mechanisms which incentivises risk-sharing partnerships.
PPP initiatives: The global view

PPPs rolled out across various nations have demonstrated a significant impact on areas such as healthcare infrastructure and clinical services. Such initiatives are not a model in themselves as much as an enabler of solutions.

Delivering integrated primary and secondary care to citizens, Spain

<table>
<thead>
<tr>
<th>Project objective</th>
<th>Delivering integrated clinical care</th>
</tr>
</thead>
</table>

**Background**

In the late 1990s the existing university hospital in the region of Valencia had become obsolete and needed an upgrade. However, budget constraints forced the regional government to look for innovative solutions. Eventually, the construction and operation of the hospital was contracted out to private companies. The successful private sector parties were responsible for the construction of the hospital as well as the provision of all primary, secondary and tertiary care services for the defined catchment area.

**Highlights**

The Alzira PPP is one of the most widely cited PPP projects in the area of clinical services. Citizens residing within the region have the choice to visit any hospital, with their catchment hospital being responsible for bearing 100% of the cost. Conversely, when outstation patients visit the Alzira hospital, the operator only recovers 85% of the cost incurred. This is a strong incentive to provide high quality services in order to maintain patient confidence and loyalty.

Spurring competition and consumer choices, the UK

<table>
<thead>
<tr>
<th>Project objective</th>
<th>Create a competitive environment</th>
</tr>
</thead>
</table>

**Background**

The NHS historically suffered from long waiting times, poor health outcomes, and low staffing levels when compared with other similar EU and OECD countries. It aimed to create an environment of competition so as to reduce waiting times by allowing patients to pre-book appointments and increase patient choice through mobile and modular units.

**Highlights**

By partnering with private organisations through the independent sector treatment centres (ISTCs), the NHS hopes to increase capacity, drive productivity and innovation, and improve the overall health outcomes of the population. Towards this, procurements were carried out in two waves- Wave-1 and Wave-2, with key learnings from Wave-1 being applied to Wave-2, which included the abolishing of minimum guaranteed volumes.

Encouraging private partners to compete with government health service providers requires an incentive that may initially be higher than the cost of the service. In this case, the UK government provided volume as well as income guarantees to private partners.
Funding high-end technology therapies, France and Germany

Project objective
Funding proton beam therapy centres

Background
With an upfront cost of 125 million USD, proton therapy is one of the world’s most powerful tools to fight certain types of cancer. Proton therapy delivers powerful radiotherapy waves that precisely and selectively kills cancer cells while at the same time reducing damage to the surrounding tissues. However, setting up a centre for proton therapy is an expensive initiative for many public healthcare systems. Operational challenges within proton therapy centres include lowering the risks of treatment through further clinical studies.

Highlights
In France, a private partner took over the responsibility of financing, building, operating as well as the maintenance of the technical operations of such a centre, in this case, the government rents the beam time over the course of the contract. In Germany, the private partner, Siemens is both the manufacturer as well as the equity partner for two such centres.

PPPs in proton therapy also imply that the private and public sector together can shoulder large technological healthcare projects in order to reach a common goal: improve the quality of health outcomes through innovative ways.

Improvement of emergency and hospital services, Brazil

Project objective
Private sector involvement in the improvement of emergency and hospital services

Background
Brazil’s first ever PPP looks at improving the emergency as well as the hospital services for a population of one million people. Located in one of the most under-served districts in the country (Salvador, Bahia), the Hospital do Subúrbio is the first hospital construction within this metropolitan region in the last 20 years, having been in operation since August 2010.

Highlights
A private consortium formed between Promedica and Daleka is responsible for equipping, maintaining and operating both the clinical as well as the non-clinical services of the hospital for a period of 10 years. They will invest around 32 million USD in equipment alone, with 22 million USD disbursed in the first year alone. This PPP in healthcare has led to the creation of 1,800 and more new jobs and will also look at treating 175,000 patients annually.

The hospital reached 80% occupancy within just one month of its inauguration. According to Bahia’s Secretary of Health, this initiative is a big step forward for the country’s healthcare sector, and offers private operators the opportunity to showcase that they can bring on board greater efficiency in clinical services, and thereby challenge the existing status quo of the state-provided healthcare services.
Public private integrated partnership in the Kingdom of Lesotho

Project objective

Innovation in the healthcare system through public private integrated partnerships

Background

Lesotho is a small, mountainous nation of 11,720 square miles (30,335 square km), surrounded by the Republic of South Africa, with a population of around 2 million people. The country’s main healthcare challenge is the HIV/AIDS pandemic with a prevalence rate of 23% among the adult population. The healthcare system in Lesotho is predominantly publicly funded (51% of the total health expenditure, 57% public hospitals), and healthcare spending represents 11.1% of its GDP.

Highlights

The project was the first public private integrated partnership (PPiP) initiative established in sub-Saharan Africa.

PPiP’s position a private entity or consortium of private partners in a long-term relationship with the government in order to co-finance, design, build and operate public healthcare facilities and to deliver both clinical as well as non-clinical services at those facilities for a long period of time.

In addition to engaging a consortium of private sector partners to rebuild the national referral hospital and associated clinics within the capital city of Maseru, the Lesotho PPiP also engages the consortium to manage the delivery of hospital as well as clinic services over an 18-year contract period.

The key goal of the project is to increase opportunities for local economic empowerment. Thus, several private sector consortium partners are locally-owned, and the contract includes specific targets for increasing the number of Basotho healthcare providers and hospital managers over the period of the contract.
Healthcare PPPs: The Bharat story

Development of healthcare infrastructure is critical in order to spur the GDP growth rate of a country. The link between healthcare and economic growth of a country suggests that a five-year gain in life expectancy leads to an increased GDP growth rate (0.58% from 0.06).

Healthcare PPP market in India: A reality check

The healthcare industry in India is one of the fastest growing social sectors and is estimated at approximately 75 billion USD. It is estimated to grow at a CAGR of 15% annually and by 2020, the industry is expected to reach 220 billion USD. The government of India has identified PPP as an effective model in improving the accessibility of healthcare services.

In order to increase the accessibility and affordability of healthcare across the country, the government has been actively engaging with the private sector. It is mandated to protect the poor from becoming further disadvantaged and impoverished due to hospitalisation. However, the physical infrastructure in the public system is far from adequate to cater to the healthcare needs of the poor.

To bridge this gap, the government of India has rolled-out the National Rural Health Mission (NRHM) in order to address the healthcare requirements of the underserved rural areas in India. Under the NRHM, PPP in healthcare has been given special priority and the purchase of healthcare services from the private sector to strengthen the public healthcare infrastructure has been reinforced. As per the 12th Plan, PPP will play an important supplementary function in the development and improvement of healthcare infrastructure across the country.

The NRHM strategy includes the promotion of PPPs for gaining managerial efficiency as well as ensuring achievement of public healthcare goals.

State of healthcare PPPs in India: A diagnosis

The healthcare PPP market in India is still in its nascent stage and has a varied degree of success across different states. PPP in infrastructure (roads and highways), power, ports and telecom has displayed significant progress. Out of a total of 758 PPP projects across sectors, only eight fall under healthcare with a contract value of 1.833 crore INR.

![Bar chart showing PPP projects (volume) and PPP projects (value in crore INR)]

Source: PPP India database, Department of Economic Affairs, Ministry of Finance
In terms of project volume, healthcare PPP projects in India constitute only 1% of the total projects and the investment share is abnormally low at 0.5%. Mobilisation of private sector expertise investment and expertise in healthcare is yet to take-off in India. Healthcare being a social subject is distinct from other infrastructure sectors such as power, roads and highways, ports, etc due to the following reasons:

- High capital expenditure
- Involvement of a direct beneficiary
- Provision of service delivery
- Strong quality and monitoring mechanisms (due to the large amount of clinical care involved)

Therefore, the PPP structure has to be designed taking into consideration the social sensitivities and patients’ right to quality medical care. Such a model needs to be legitimised as a means of service delivery in order to be adopted widely. In regions where such actions have been taken, PPPs have flourished. Gujarat and Andhra Pradesh for instance, have enacted enabling legislation, while Karnataka has advocated a strong policy statement on PPPs for infrastructure. In the absence of a robust government system, the private sector has little incentive to improve efficiency and reduce cost.

**In India, PPP projects are gradually being adopted across all segments of healthcare**

| Super speciality hospitals and medical colleges | Punjab Institute of Medical Sciences (PIMS): 750 beds  
Shillong Medical College: 500 beds |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostics</td>
<td>Contracting CT or MRI in Sawai Mansings Hospital, Jaipur</td>
</tr>
<tr>
<td>Dialysis centres</td>
<td>B Braun Dialysis Centres, Andhra Pradesh with 11 centres in operation housing 111 haemodialysis machines</td>
</tr>
<tr>
<td>Mobile medical units</td>
<td>Mobile medical units (MMUs) provision under the NRHM in Odisha and Uttrakhand</td>
</tr>
</tbody>
</table>

PPP models within large tertiary care hospitals have not been successful due to the complex structure and inadequate participation from major financiers. However, lighter formats (diagnostics and dialysis services) which are less complex and easier to operate, have reported positive business outcomes.
B Braun Dialysis Centre PPP, Andhra Pradesh

Project objective
Improving accessibility to dialysis care in the state

Background
In order to improve the quality and accessibility of dialysis care, the government of Andhra Pradesh selected B Braun Medical (India) Private Limited, a subsidiary of B Braun Melsungen AG, one of the world’s leading healthcare suppliers headquartered in Germany, to establish and operate dialysis centres in 11 tertiary care state-run hospitals on a build, operate and transfer (BOT) basis for a period of seven years. It pays the private operator an agreed price for each dialysis.

Highlights
Dialysis is provided to the BPL population through the state sponsored health insurance scheme, Rajiv Aarogyasri. Its robust payment mechanism ensures timely payment to the private operator and seamless service to the people.

Innovations in PPP
An important development which is gradually changing the healthcare accessibility and affordability paradigm is the advent of a state sponsored health insurance scheme. The government plans to cover over 300 million people by 2015 under the Rashtriya Swasthya Bima Yojana (RSBY). This will enable patients to choose their treatment in the private sector and, at the same time, will equip the government to focus on primary healthcare to create health awareness.

This scheme runs in partnership with an insurance company to which the government pays a certain premium per household. Schemes such as Yeshaswini and Rajiv Aarogyasari mitigate the risk of inadequate tertiary care in public hospitals by enrolling the private provider under the scheme and improving accessibility.

Rajiv Aarogyasari Health Insurance Scheme, Andhra Pradesh

Project objective
Enhancing the financial accessibility to healthcare

Background
Catastrophic medical expenditure and low affordability of the under privileged population results in limited access to quality care. With an aim to reduce out of pocket expenses, Rajiv Aarogyasari Health Insurance scheme was launched by government of Andhra Pradesh in 2007. It provides financial protection of up to 2 lakh INR to families living below the poverty line annually, for the treatment of serious ailments that require hospitalisation and surgery. The scheme covers a total of 938 treatments.

Highlights
The scheme helps in addressing the access to care for BPL population and enhances patient choice of care provider. Inclusion of tertiary care services and attractive packages helped connect private providers which improved utilisation and occupancy. In addition, quality control and operational monitoring of the scheme were enhanced with the help of technology.

PPPs in primary care: Expanding accessibility to healthcare
Partnerships in primary care and active involvement of voluntary not-for-profit organisations over the recent years, have strengthened health programmes and helped augment the delivery of public health services. The Karuna Trust model adopted in Karnataka, for instance, highlights the fact that partnerships can be crafted in an innovative way, which can not only address local primary healthcare requirements, but can also curb the issue of rural impoverishment (through the health insurance scheme), prevent further disease progression (through focus on preventive care), and build a healthy community (through local community mobilisation),
Karuna Trust PPP, Karnataka

Project objective: Management of primary care centres in order to deliver essential health services to the rural population

Background
The Karuna Trust is a voluntary charitable organisation working with an objective to build a sustainable model for delivering primary healthcare services, through a group of socially-committed healthcare workers. The trust manages 68 primary health centres across eight states in India—Karnataka, Andhra Pradesh, Odisha, Arunachal Pradesh, Manipur, Maharashtra, Meghalaya, Rajasthan and providing care to over 1 million people.

With a view to improve the state of primary healthcare infrastructure, in 2002, the government of Karnataka entered into a partnership with the Karuna Trust for better management of primary health centres (PHCs) within the state.

Highlights
The objective of this partnership is to adopt an integrated approach for better management and maintenance of PHCs and sub-centres, thereby improving efficiency and overcoming any difficulties experienced by the state in the area of public sector management. More specifically, the Karuna Trust aims to ensure better management of human resources at the PHC level, by filling job vacancies and reducing the trend of absenteeism among workers.

Around 90% of the cost is borne by the government, while the remaining 10% is incurred by the Trust. The model focuses on improving the health of the community through all aspects of preventive, promotive as well as curative care, and also looks at implementing existing national health programmes. In order to prevent the impoverishment of the rural poor and mitigate medical costs, the Trust has also launched a health insurance scheme in partnership with the National Insurance Company and the government of Karnataka. Staff members regularly participate in the gram panchayat meeting in order to support various health initiatives. Community mobilisation through women self-help groups has also been initiated so as to disseminate awareness about aspects such as immunisation and women health.

This model has led to a significant improvement of health outcomes such as the infant mortality rate which has touched a figure 19 per 1,000 live births within the state, (significantly lower than the national average of 48), and the maternal mortality rate has touched 81 (the national average is 254 per 100,000 live births).

Akha boat clinics, Assam

Project objective: Bringing healthcare closer to the patient through outreach activities

Background
The Centre for North East Studies and Policy Research (C-NES) is an NGO that was established in 2000 in order to improve the conditions of those living in the north-eastern states. The NGO is committed towards improving the health status of the 25 lakh people living in the Brahmaputra islands, and who are constantly affected by floods. Limited availability of healthcare facilities in socially-excluded and flood-prone areas of the state of Assam makes C-NES an important provider of basic as well as affordable healthcare services in these areas.
Highlights
The programme was initially operating on a UNICEF grant that provided the first boat clinic. It later received support from the government of Assam and the NRHM. Boat clinics bring health services to the socially, geographically and economically secluded population residing on the Brahmaputra river islands. These boat clinics are organised once in three months in each district, across 13 districts of the state. Around 15 to 20 camps are conducted per month and nearly 150 to 200 patients are checked every day. In total, the programme reaches out to 10 lakh people within this area. These clinics are organised within local school buildings and tents situated near the boats. Every boat clinic has a 15-member team, including three doctors, a general nurse-cum-midwife (GNM), auxiliary nurse midwives (ANMs) and a laboratory technician. The clinic has an OPD, a pharmacy as well as a laboratory for blood tests and other check-ups.

A 2008 study by the UNICEF indicates that 92% of the households within the region were found to be utilising this service, while 78% of the people are informed about an upcoming health camp with at least one day’s notice in advance.

108 ambulance service, a pan-India initiative

Project objective
Provision of emergency medical services and improving emergency response

Background
Accidents and natural calamities (such as cyclones and tsunamis) require a strong emergency response mechanism. The number of road accidents per lakh population increased from 30 in 2004 to 42.5 in 2010. The number of deaths recorded per lakh population due to road accidents rose from 8.6 in 2005 to 11.4 in 2010. The GVK Emergency Management and Research Institute (EMRI) commenced operations in the area of emergency response services within Andhra Pradesh in August 2005, with a fleet of 30 ambulances across 50 towns in the state. Under the NRI-IM, the state government decided to enter into a PPP with GVK EMRI in 2005.

Highlights
In the subsequent years, the 108 Emergency Service began to offer services across nine states in India. The objective of the partnership was to provide comprehensive round the clock emergency response services and later expand its scope to address the needs related to pregnant women, infants as well as children in situations of serious health emergencies. The range of services offered now include transport of accident victims, transport of pregnant women and pre-hospital care services. As of December 2008, EMRI had 1,300 ambulances operating across nine states in India.

Merrygold Health Network, Uttar Pradesh

Project objective
Improving the reproductive and child health status

Background
The state of Uttar Pradesh (UP) lags behind the rest of the country in the area of reproductive and child healthcare services. This is reflected in the high maternal and infant mortality rates as well as high fertility rates, thereby suggesting a lack of services in the area of family planning. The use of institutional facilities for child-birth deliveries is low, especially among the poor. This unmet need for family planning and institutional deliveries is high, thereby indicating a large gap with respect to service provisioning.

Highlights
In this context, PPPs have emerged as a strategy for tapping the private sector while providing affordable and quality services to the vulnerable section of the population. Social franchising, a PPP model, emerged as an option that can tap the private sector for providing quality
reproductive and family planning services in the state of UP. The Innovations in Family Planning Services (IFPS) Project came into existence as a joint endeavour of the government of India and the United States Agency for International Development (USAID) in September 1992. The project was facilitated by the formation of a state health society and the State Innovations in Family Planning Services Agency (SIFPSA) in order to guide the implementation of all project activities.

In order to improve the reproductive and child indicators, the Merry Gold Health Network (MGHN) was created in order to harness the potential of social franchising in establishing a range of private healthcare providers within the state that will address the RH/FP needs of the people residing in the urban, poor and rural areas. The network was designed as a three-tiered ‘hub and spoke’ model in order to enable better outreach.

**Introduction of basic healthcare courses in schools, Haryana and Himachal Pradesh**

**Project objective**

**Introducing patient care assistant courses in schools in Haryana and Himachal Pradesh**

**Background**

India faces a shortage of skilled human resources which is limiting the growth of the healthcare sector in the country. The sector has a low doctor-nurse ratio as compared to other emerging countries coupled with issues such as inadequate skills and competency levels of the allied health workforce. In addition, there are no occupational standards to streamline and standardize skill development of the allied healthcare workforce. The Healthcare Sector Skill Council (HSSC) is a PPP initiative, constituted by the National Skill Development Council (NSDC), the Confederation of Indian Industry (CII) and leading healthcare service providers representing both the public and private sector. It is a not-for-profit organisation, registered under the Societies Registration Act, 1860. It was incorporated in August 2012 with an objective to create a vibrant ecosystem for vocational education and training for allied health in the country.

**Highlights**

The Council has identified and adopted a three-pronged approach. It is actively engaged in the avenue of vocational education and training for the allied health workforce in the country. For the first time in India, it developed a set of Occupational Standards for 27 job-roles within the avenue of allied healthcare.

The Council, in close cooperation and partnership with the Department of Education, has introduced patient care assistant courses in more than 99 schools across Haryana and Himachal Pradesh, covering more than 3000 students. Under the project, the state's Department of Education has provided funding not only to set up skill centres across 99 schools, but has also outsourced the responsibility of rolling out training activities and skill-building initiatives to three HSSC-accredited training institutes, that is, Vidyanta Skills Institute Pvt Ltd, Max Institute of Health Education and Research (MIHER) and Skill Tree Consulting (P) Ltd. This initiative will aid the workforce in improving the employability of the students taking up these courses and will also help them gain knowledge about basic healthcare such as personal hygiene, primary medical care, immunisation, waste management, basic life support, etc which is vital in their day-to-day life.
Adding another dimension to PPP: People

Health being the primary cause for concern of every policy, community participation is gaining prominence in India. Women’s participation and ownership in health initiatives has witnessed significant development. Community based organisations including various NGOs are participating actively with the government in order to improve accessibility of health services.

Community engagement

The NRHM has initiated partnerships with NGOs and civil societies in several states. In Orissa, such partnerships are devised in the field of reproductive and child health (RCH) through mother NGOs (MNGO) for the marginalised population of the un-served and under-served areas. Technology, as an enabler, is playing an important role in enhancing community participation in healthcare development. Mobile phones are increasingly being used to improve healthcare quality and accessibility. In Madhya Pradesh, SMS tracking is being used to maintain a record of newborns post discharge. SMS reminders to frontline workers as well as to the family help reduce premature child deaths. This system has reduced the mortality rate from 9.5 to 5%.

Rogi Kalyan Samiti (RKS), NRHM

Project objective

Improving the financial and administrative functions of the public hospital

Background

Effective implementation of public health programmes and ensuring the timely delivery of care requires a robust administrative and financial management of public hospitals. The Rogi Kalyan Samiti or Patient Welfare Committee was formed under the NRHM in various states for the management of public hospitals. It is an innovative way of ensuring people’s participation in healthcare and improving service levels in public health facilities.

Highlights

The broad objective of RKS is to ensure compliance of minimum standards of facility and accountability of health provider to the community. The RKS is a registered society and acts primarily as an NGO. It involves people’s representatives, community members with select government officials who have financial authority and can make policy decisions.

The RKS can utilise government assets and services to levy user charges and can also determine the quantum of charges. It can additionally raise funds through donations, loans from financial institutions, grants from the government and other donor agencies. It has significantly transformed the way public hospitals function and has improved financial and administrative autonomy. This has resulted in improved efficiency and service quality.
Drive Against Diabetes (DAD) 2013, CII and the MCGM

Project objective
Creating awareness about diabetes and its prevention through large scale citizen screening programmes

Background
There has been a steady rise in the incidence of diabetes in India with a prediction that 80 million Indians will become diabetic by 2025. This makes the country the ‘diabetes capital’ of the world. Within India, the city of Mumbai has the maximum number of people suffering from this disease. Therefore, on 13 November 2013, the Drive Against Diabetes (DAD) 2013 campaign was organised covering the length and breadth of Mumbai, in conjunction with the World Diabetes Day. This drive was a partnership between the CII and the Municipal Corporation of Greater Mumbai (MCGM) with the objective to mobilise the citizens of the city to screen themselves for diabetes.

Highlights
This drive was a unique PPP initiative wherein partners set up over 500 screening camps across MCGM ward offices, hospitals, dispensaries and various public places such as railway stations, airports, as well as landmark points of the city such as the Mantralaya, Marine Drive, etc. MCGM supported this campaign by mobilising over 700 paramedics across the city in order to test individuals across the corporate sector in the city. Over 40 member companies of the CII as well as pharmacy outlets participated in this initiative by covering numerous public places in Mumbai. Over 60 corporate locations hosted camp stations and within these camps, over 30,000 employees from the workforce community were successfully screened. All screened participants were provided with a ready-reckoner of simple lifestyle habits and healthy dietary practices that can prevent them from becoming diabetic.

The private sector came forward to provide screening kits as well as diagnostic support alongside training and capacity building for paramedics. An advocacy campaign was rolled out across Mumbai and included outdoor hoardings and banners on buses, bus shelters, as well as theatres, thereby encouraging the local populace to participate in the campaign and get themselves screened. Though one lakh individuals were tested for diabetes, this campaign however was successful in reaching out to a far larger number of people in the city.
PPP: Constraints and challenges

One of the common myths associated with PPP projects is that they lead to privatisation and commercialisation of healthcare and spur medical inflation. However, PPP is not a form of privatisation; the public sector does not hand over the reins to the private sector. Rather, the two sectors form a long-term partnership under which many assets remain in public ownership. The objective is to form a collaborative framework where the private sector’s technical expertise can be leveraged for the transformation of healthcare delivery.

The following are the major challenges faced by PPPs in India:

- **Trust deficit:** The lack of a common objective has resulted in a trust deficit between the government and the private sector. The government often tends to overlook the financial viability of the business model for the private operator.

- **Inadequate regulatory framework:** There is a need for a central regulator in healthcare which can set the standards for the service quality and care provisions. Quality standards prescribed by agencies such as the NABH are not strictly adhered to in PPP transactions, resulting in inconsistencies while measuring KPIs. It also needs to develop model concession agreements and bid documents for various healthcare projects. The Planning Commission is in the process of developing these. When institutionalised, they will provide standardised quality parameters, performance indicators and technical specifications.

- **Lack of government fiscal support:** Delay in payments and budgetary constraints often result in the disruption of services by private providers and subsequently end the project. An imbalanced risk-sharing is also a key concern. Governments often provide a one-time contribution at the commencement of a project in the form of land or existing infrastructure. The lack of recurring fiscal support thereafter, often impacts operational viability.

- **Underdeveloped institutional capacity:** PPP transaction and structuring requires technical expertise and a sound knowledge of PPP structuring, contract documents and contract management that by far, the government has failed to supply.

- **Lack of a socio-political stance:** PPPs can potentially achieve equity and enhance accessibility to affordable and quality health services for the underserved. However, the misconception that the government is moving towards privatisation of healthcare has to be done away with.

- **Unavailability of a pricing mechanism and benchmarking:** In the absence of a pricing formula, the majority of such transactions normally adhere to the CGHS pricing for delivery of services. Private operators opine that this pricing is not viable for them.

- **No standardised mechanism for beneficiary identification:** PPPs intend to deliver healthcare benefits to the target groups. In the absence of a standard monitoring framework, identification and verification of the BPL or the underserved population is a hindrance.

- **Subdued corporate participation:** Large PPPs have not seen much success, largely due to the minimal interest expressed by corporates. Private providers feel that entering into a PPP arrangement with the government will include interference in their operations and control over the management. Furthermore, the cost structure of such corporates has not yet been successfully aligned with the PPP structure.
The need of the hour

What the government needs to do:

- **Develop sound healthcare PPP policy framework**: The ‘National PPP Policy Framework for Healthcare’, which will act as the central guiding document for health PPPs, needs to be implemented across India. A strong policy and regulatory framework will foster private participation.

- **Develop institutional mechanism**: Standardised and transparent master guidelines and concession agreements with standard collateral and exit clauses are essential. Model concession agreements that are currently being worked upon by the Department of Economic Affairs will instill confidence in the PPP framework. It is also important to form nodal agencies at the local level to create an enabling environment for private players.

- **Contractual flexibility and continued sharing of risk and rewards**: The private operator in a PPP contract should be treated as a partner and not as a contractor. It is important for both, the government as well as the private operators to be flexible in contract negotiations and collaborate at every phase. There must be continued sharing of risk and reward and the government must provide fiscal support to the private operator.

- **Develop appropriate pricing and incentive mechanism**: This will enhance the performance standards as well as the quality of care. It is also important to use an appropriate pricing structure with an effective financing mechanism to ensure that the project is viable for the private operator while maintain the affordability of services for the poor.

- **Benchmark and identify best practices**: Impact measurement of major healthcare PPPs should be undertaken and their outcomes should be documented. This will keep them in check and will also help in addressing the sociopolitical constraints. This should be coupled with establishing regional level ‘healthcare PPP centres of excellence’ in collaboration with the private players and international development agencies that provide technical expertise and training.

What the private operators need to do:

- **Implement business models with fair margin and higher volume**: Understand the social obligations under healthcare PPP’s and actively participate. The focus should be on the economies of scale principles for enhanced profit margins.

- **Collaborate with the government**: Collaborate with the government for developing the master template for model concession agreements and guidelines for healthcare PPPs.

- **Benchmark**: Impact measurement of the major healthcare PPPs should be undertaken and their outcomes should be documented. This will keep them in check and will also help in addressing the sociopolitical constraints.

- **Focus on low cost inclusive business models**: The focus should be on lowering the costs in order to be better aligned with the PPP transactions.

- **Develop strategies and models with the government**: New PPP models need to be worked out in order to ensure the availability of human resources and their capacity augmentation.

- **Disseminate experiences**: Learn from past experiences and create a repository of all projects so that they can be benefitted from in the future.

- **Focus on building trust**: Improving communication and trust with the end consumer by developing internal patient welfare committees.

- **Partner with non-profit organisations**: This will enhance human resource capacity building and training.

- **Adopt preventive care**: Promoting preventive and wellness care programmes for the welfare of the community.
What the community needs to do:

- **Develop preventive care models:** Radical changes in behaviour to avert the critical health risks are required. Adoption of preventive health practices will check disease progression and improve healthcare outcomes.

- **Health insurance plans:** Enroll under an insurance plan to reduce out of pocket payments and cut down on the medical costs as well as forming a community health insurance.

- **Develop community based primary care models:** Appropriate educational programmes can be initiated at the rural levels in order to raise awareness around health issues. Community participation can serve as the backbone of the patient referral transport system.

- **Leverage technology:** Tele-health adoption has the potential to remove access barriers and bring healthcare closer to the patient. Rural people, especially women, can be trained to use mobile healthcare applications. A local call centre connected to a centralised hospital and managed by local residents can potentially take care of timely medical care and considerably improve healthcare outcomes.

What the citizens need to do:

- **Adopt of preventive healthcare practices:** This will check disease progression and improve healthcare outcomes.

- **Manage self-health:** This can be ensured through direct involvement with the healthcare providers and proactively making clinical decisions.
To summarise

Demographical and epidemiological transition is now forcing the government to deliver cost-effective healthcare while maintain highest quality standards. Non-communicable diseases will burden the healthcare systems and the quantum of care required cannot possibly be delivered by the government alone.

The spiraling healthcare cost in developed countries and high out of payment in the emerging countries had spurred the growth of PPPs. In emerging countries, private expertise and geographical reach is increasingly being tapped by the governments to address healthcare accessibility. These governments need to begin by reviewing their overall healthcare system in order to be able to appropriately balance primary, secondary, tertiary and community care.

Learning from other sectors is also essential. PPPs in the infrastructure sector have benefited from the transparent master guidelines and concession agreements with standard collateral and exit clauses that have enabled long term funding. Scaling up PPPs in the creation of healthcare infrastructure will require a similar standardisation of concession agreements and collateral and exit clauses.

Going ahead, the central government will need to establish a national PPP framework that enables local health systems to tailor solutions. The private sector needs to relook at various ways by which it can share risk and accept fair margins within the healthcare industry.
About PwC's Healthcare practice

PwC’s global reach and resources helps governments, businesses and healthcare industry players accomplish their missions in today’s dynamic and competitive environment. We provide health organisations with expert guidance not just on healthcare issues in their local markets but in global markets as well. We have a credible track record in working with providers, payers, and pharmaceutical life sciences companies that vouch for our role in improving their operational performance.

We also advise our public sector clients in the areas of public private partnerships, research and evaluation, public health system strengthening and program management.

Dr Rana Mehta
Leader, Healthcare
PricewaterhouseCoopers Pvt Ltd
Building # 88, 8th Floor, DLF Cyber City Gurgaon
T: +91 (124) 4620 757
Email: ransumehta@in.pwc.com

Ashok Varma
Executive Director
PricewaterhouseCoopers Pvt Ltd
DN 56- 57, Sector V, Salt Lake, Kolkata
T: +91 (33) 4404 3099
Email: ashokvarma@in.pwc.com

Authors

Prakash Sharma
Senior Manager, Government Reforms and Infrastructure Development (GIRD)
PwC India

Mushahid Ali Khan
Senior Consultant, Healthcare
PwC India

About PwC

PwC helps organisations and individuals create the value they’re looking for. We’re a network of firms in 157 countries with more than 184,000 people who are committed to delivering quality in Assurance, Tax and Advisory services. Tell us what matters to you and find out more by visiting us at www.pwc.com

In India, PwC has offices in these cities: Ahmedabad, Bangalore, Chennai, Delhi NCR, Hyderabad, Kolkata, Mumbai and Pune. For more information about PwC India’s service offerings, visit www.pwc.com

PwC refers to the PwC network and/or one or more of its member firms, each of which is a separate legal entity. Please see www.pwc.com/structure for further details.

About CII

CII is a non-government, not-for-profit, industry-led and industry-managed organisation, playing a proactive role in India’s development process. Founded in 1895, India's premier business association has over 7100 members, from the private as well as public sectors, including SMEs and MNCs, and an indirect membership of over 90,000 enterprises from around 257 national and regional sectoral industry bodies.
Disclaimer

This publication has been prepared for general guidance on matters of interest only, and does not constitute professional advice. You should not act upon the information contained in this publication without obtaining specific professional advice. No representation or warranty (express or implied) is given as to the accuracy or completeness of the information contained in this publication, and, to the extent permitted by law, PwC, its members, employees and agents accept no liability, and disclaim all responsibility, for the consequences of you or anyone else acting, or refraining to act, in reliance on the information contained in this publication or for any decision based on it.

This publication contains certain examples extracted from third party documentation and so being out of context from the original third party documents; readers should bear this in mind when reading the publication. The copyright in such third party material remains owned by the third parties concerned and PwC expresses its appreciation to these companies for having allowed it to include their information in this publication. For a more comprehensive view on each company’s communication, please read the entire document from which the extracts have been taken. Please note that the inclusion of a company in this publication does not imply any endorsement of that company by PwC nor any verification of the accuracy of the information contained in any of the examples.

© [2014] PricewaterhouseCoopers Private Limited. All rights reserved.

In this document, PwC refers to PricewaterhouseCooper Private Limited (a limited liability company in India) an India member firm and may sometimes refer to the PwC network.

Each member firm is a separate legal entity.

Please see www.pwc.com/structure for further details.