

Proposal for on Public Private partnerships for Emergency Obstetric Services in the State of Chhattisgarh.

Objectives of the Proposal :

- To actively involve the private sector in the provision of emergency obstetric services that the poor can access.
- To increase access of the poor to essential and emergency quality reproductive health care services.
- To increase absolute numbers of health care providers and facilities providing emergency obstetric care and surgical obstetric and gynecological services.
- To enhance all efforts at maternal mortality and morbidity reduction by forging a synergy between existing public service , private service and community level work(Mitanin programme).

Rationale of the Proposal:

Chhattisgarh State has currently only 15 centres that provides comprehensive emergency obstetric care- which the poor can access. This is inclusive of all the two medical teaching college hospitals, districts hospitals and CHCs.

The ideal needed is estimated at one hospital for every one lakh population. Even if we take into account urban concentrations we should be having at least about 150 hospitals.

This year under the strengthening FRU programme the number of Cesarean section hospitals in the public sector may double or even triple (15 to 30 CHCs are expected to become Emergency obstetric care capable). This would be far short of the required number of hospitals.

There is therefore an urgent necessity to make private sector hospitals also available for such public health goals- so as to improve access of the poor. By private sector hospitals we mean commercially run hospitals as well as hospitals run by public sector industries and mines, mission hospitals, and worker and NGO run hospitals. If we add all of them then the number of cesarean section capable hospitals would go up by another 30 hospitals. And we need to do it such a way that there is a real increase in outreach- not merely a diversion of development focus and patient load from public to the private sector with no net gain to the public.

The situation is truly alarming. A normative block on one lakh population has about 2500 births per year. Of these institutional delivery in the public health system accounts- from sub-center to district hospital to only about 120 cases per year even in better performing

districts. There are states in India where the figures are approaching 2000. Of the 2500 births, we can expect 375 births to be complicated- requiring qualified attention beyond the skills of a trained traditional birth attendant. Though identifying high risk cases helps it is still not adequate to predict which cases will have complications and hence the current recommendation that all cases have delivery in a place where qualified help is available and which has referral links to a place that can do Cesarean section. For of these cases at least 125 would have required Cesarean section. If the national mortality rate is applicable to Chhattisgarh then of every 2500 births 10 women die in pregnancy. Informally many CHC BMOs seem to have noted about 15 to 20 deaths in a year. The gap between the 15 known deaths and the theoretical expectation of “ 125 cases requiring Cesarean in each block in each year” section is large and should alarm us. Though most of these cases requiring Cesarean section do not translate into maternal deaths they do lead to high degree of still birth and neonatal mortality and brain damage in children and maternal morbidity (which is known to be 35 times higher than maternal mortality). Even maternal mortality is we fear **much** higher than reported.

How do we bridge this gap between current and desired extent of provision of obstetric care? How do we reach out to the medically underserved areas? We are already working on a 4.5 crore programme to strengthen public health systems in 32 blocks so as to create 32 FRUs with all the necessary linkages. Given the acute shortage of specialists especially in the distant districts, the state has gone in for an approach to multi-skilling general duty medical officers with specially designed six month courses to make them .

But even with such innovative efforts the FRU gap remains impermissibly wide and a violation of the state’s commitments to the provision of essential health care. Therefore we propose to engage and draw in the large private sector in the attainment of these goals.

Whenever there is a discussion of the involvement of the private sector – there are six key questions that would need to be answered?

- a) how do we ensure that the poor access such services- currently private sector is prohibitively costly and the poor would not be able to pay even fair rates. Any PPP scheme should demonstrably reduce the costs of care to the poor as compared to what they are paying today.
- b) How do we ensure quality of care- currently most private sector care operated in a highly unregulated environment and where consumer awareness is very poor. Any PPP should be able to guarantee a basic minimum quality of care.
- c) How do we ensure that the partnership is bringing in private investment into health systems- not a transfer of public fund into private corpus. Such transfers are seldom justifiable in any context, but in some governance contexts could become an invitation for vested pressures. Besides without private investment, the private sector would have no need to be cost-efficient .
- d) How do we ensure that the partnership represents an additionality over existing services- not merely the diversion of existing public sector clientele into the private sector- thus weakening the public health system at a time when the scope of the private sector is still far from clear.

- e) How do we ensure that there are adequate systems for monitoring – both quality, and the reimbursement claims made and the access to the poor and they are reasonably secured from vested pressures.
- f) How do we ensure that reimbursements made to the private clinic for the management of the poor are prompt , efficient and with dignity . This along with partner – friendly policies for accreditation ,inspection, monitoring should ensure that an environment is created so that the best of the private sector – in terms of fair play, and social responsibility are encouraged to participate and do not get harassed by the processes involved .

To this end the state proposes to invest 2 crores in a promotional, management and regulatory framework for promoting private sector involvement in acheiving these goals. Three independent schemes of private sector involvement – the Mitr Chikitsak, the Mitr Chikitsalay and the Mitran Kendra(also called Mitran hospital) scheme. These three would be brought under a common professional ,autonomous state-funded state-level management structure. The scheme would also involve another approximately 7 crores per year on reimbursement costs estimating that there are 50 centers each of which does about 60 C-sections, 360 institutional deliveries, 600 sterilizations and about 200 other minor surgeries or consultations of other categories of cases per year. These reimbursement costs to the state would reduce- not in absolute terms – but in terms of cost of care per poor patient attended to- after the first two years as insurance mechanisms begin to supplement cases by case reimbursements.

This approach extends not only to cesarean sections but a variety of RCH services that require specialist skills. Repeated studies and our own surveys have shown very high unmet needs in family planning even for tubectomies. Indeed in Durg women awaiting sterilization camps have even taken out a procession in protesting repeated postponement of the sterilization camp. Despite many efforts most health facilities – even many district hospitals do not offer sterilization facilities on any day of the week or even month. The availability is confined to episodic camps. One of the basic goals should be that for any population of 1 lakh population, sterilization services should be available in at least one center in that area for at least two or three days- every week !!! This gap too cannot be closed without involving the private sector. Most private clinics and nursing homes do not even offer such services. Here active promotion of service delivery is required.

If this is the situation in such an existing high priority area like tubectomies and vasectomies- the situation is equally critical in other areas like the provision of safe abortion services or sick neonatal care or reproductive tract infections. Though, in comparison to C-sections, it would be quite possible for medical officers in CHCs and PHCs who are not specialists, to be trained for these services, the agency entering a partnership would need to be accredited for these services as well as poor women who are being given access for C-section cannot be denied access for sick neonatal care , tubectomies and RTIs – all closely related situations in a number of cases.

The Services to be included:

The main focus of services is for emergency obstetric care. Only where this is available would the other package of services be considered.

Other services that would be included in underserved areas are the following:

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1. Contraceptive services-(U)
 - a. Female sterilization-
 - i. conventional
 - ii. Laproscopic
 - b. Male sterilization
 - i. Conventional Vasectomy
 - ii. No scalpel vasectomy.
2. Safe motherhood services
 - a. Institutional deliveries
3. Emergency Obstetric Care
 - a. Caesarean sections
 - b. Medical termination of pregnancy.
4. Sick neonatal care
5. Laboratory service – Hemoglobin, Urine, Blood Grouping,
6. Minor urogenital surgery – hydrocele, circumcision, hemorrhoids and abscesses
7. RTIs/STIs

Those services marked with asterisk are to be delivered only by qualified medical doctors.

DETAILS OF THREE SCHEMES:

The Mitr Chikitsak “Contracting – In”

All private health service practitioners may be empanelled with the PMC. For medical doctors this is done at the state level and for paramedicals at the district level.

The empanelment would be for a specified one or more facilities.

When the public facility needs their service- they would invite them and then according to the fees fixed for that service – would reimburse their expense then and there.

Though there is no compulsion to do so it is expected that they would attend whenever called – unless they are already attending to an urgent case elsewhere. In case they leave station or are unavailable for some time they should give due notice to the public health facility.

The prescribed drugs and treatment should broadly conform to standard treatment guidelines and the essential drug list of the public health facility. These are published and available.

The main principle behind this scheme is that if by bringing in a doctor the existing investment in infrastructure and equipment that goes into a CHC or district hospital, fructifies into emergency services this is a desirable outcome. Many such facilities, often places which were once offering these services up languishes, due to a lack of such specialist – once the existing specialist retires or is transferred. Retired government doctors may be the largest number of specialists who would opt for these terms.

Mitr Chikitsalay .

The clinic can become accredited as a private sector partner of the RCH programme. For this they have to apply to PMU in the prescribed format. A two-person team would visit their hospital or center and if found to meet the minimum standards laid down it would be accredited for the purpose. In case there are gaps they would be requested to complete those gaps and then they would be accredited. Accreditation is accompanied by signing an MOU between the PSP and the PMU. Accreditation is not just for the hospital or center as a whole. We will specify which services or package of services each hospital or center has been accredited for. Medical centers are accredited at the state level and paramedicals at the district level.

Once they are accredited any patient their hospital/center attends to , who is below poverty line will be reimbursed for any of the services on our list at the rates specified. For those patients for whom reimbursement is claimed no other charges may be made.

Similarly for those services marked as U(Universal) any patient seen by them irrespective of their poverty level status is reimbursed at the rates specified . All they have to do for either situation above is to maintain accounts and case records in the formats specified by us and claim reimbursement on a monthly basis. Settlements of claims would be made within one month of receiving the claim, provided the papers are in order.

The PSP has also a duty to facilitate those contracted to monitor the programme, so that the integrity of the system can be maintained.

There are three types of centers in this scheme – Public sector undertaking hospitals, not for profit hospitals, commercially run hospitals

The Mitan Hospital Scheme:

This is a scheme to build a state led franchisee hospital which provides high quality care at fair costs and expands such health care provision to reach hitherto medically underserved areas.

Some features of this are similar to the earlier scheme. Thus, if a hospital is interested in the scheme they should apply for the same in the prescribed format. Then like with the earlier scheme they would be visited and accredited. They would be accredited as Mitan Hospitals(also called Mitanin kendras). They may now advertise themselves as a Mitan Hospital. The difference is that all the patients they see for a wide range of RCH services would have fixed fair rates irrespective of whether they are being reimbursed for it are

not. The central thread of the programme is to build volumes of patients ensuring that the poor too are able to access these services. There would be a standard logo created for this purpose. If they are accredited as Mitan Hospital they would have to pay a franchisee fee of Rs. 60,000 in four installments – Rs 15,000 per quarter.

In return for this payment the Mitan kendras scheme would provide the following services:

- a. An administrative assistant paid by Mitan hospital who would help in the administration (same person as the Mitan kendras promoter) and also in maintenance of quality – including regular checking of OT with microbial swabs.
- b. A link up with an ambulance service that would bring cases to you and help with your referral needs.
- c. Assistance in getting bank credit for setting up or expanding their hospital.

The Mitan Hospital MOU however specified that *all* your patients must be charged only at the specified rates (in contrast to Mitr Chikitsalays where only those for whom you are asking reimbursement are charged these rates.). **This is justified as the system is creating the volumes. But in effect it is entering a voluntary “regulated private sector” regime.**

The fact that many category of services would be reimbursed by the state and that in effect patients would get free treatment should help build volumes in Mitan hospitals. Operations done by doctors working in the public sector would not be reimbursed in either the mitr chikitsalay or the Mitan hospital scheme so as not to shift patients from public to private sector. **The aim is to increase net numbers of providers- not shift them around.**

Also under consideration as a parallel development is a social insurance package linked to self help groups for vulnerable groups so that invisible costs of care (like transport and food for attendants of a patient) are attended to .

As the scheme crosses its first two years the insurance package can be expanded with complete social insurance for the most vulnerable groups , part payment of insurance premiums by the government for other poor sections and full payment by beneficiary for those categories defined as being to afford it. **In the long run such an insurance coverage and third party payments would work out as more economic than case by case reimbursement for BPL patients.** We are however initiating the programme only with case by case reimbursement as the focus now is on developing better regulated quality care private health care provision that the poor can access.

The optimisation of reimbursement costs to ensure greater cost efficiency in providing access to the poor would develop in the next stage. At this stage –at modest patient load of 3000 CS per year and about 18,000 institutional deliveries per year and about 30,000 sterilizations and another 30,000 other procedures per year the reimbursement costs to the government would be about Rs 7 crores.

The Pricing of Services

Prices are fixed by comparison to benchmark facilities (some identified NGO run centers) to understand basic costs and with some space for price elasticity calculations as well.. These would be annually adjusted with concurrence of GOI where reimbursement is called for -according to increase of prices of other commodities by an agreed upon mechanism.

Rate of Services _ as tentatively agreed on with GOI minstry of FW (protocol based – not for reimbursement).

- 1.ANC Pack – Rs200
- 3.ANC lab pack: -Rs.90
- 4.Institutional delivery with specialist assistance: Rs 1700.
- 5.C-Section- Rs.5500
- 6.Incubator charges : Rs 200/day
- 7.RTIs- Rs. 50 fees + Rs. 50 lab
- 8.Minor Urogenital Surgery: four most freq: Rs 350
- 9.Hysterectomy: Rs 6000.
- 10.MTP- upto 10 weeks: Rs.400
- 11.MTP : 10 to 20 wks:Rs. 800

Rate of Servics where BPL would be reimbursed.

- 1.Institutional delivery: Rs 1300
- 2.C-Section- Rs. 2800 (in effect Rs. 4100)

Rate of Services – where all clients would be reimbursed.

- 1.Sterilisation- Rs.700
- 2.IUD – Rs.80

Monitoring

Monitoring will be done by external team. The team will be responsible for overall monitoring of the programme.

Two teams will do the monitoring –

Team 1 will verify 25% of referrals: Patients would be visited at home after discharge to check what their complete payments have been.

Team 2 will verify 25% of verified referrals.

Thus if there were 100 referrals to a Mitr Chikitsalay or Mitan Hospital then team 1 will see 25 of this and team II will see 5.

Team 1 is an NGO or management firm appointed by the PMC and reporting directly to it.

Team 2 is appointed by the national authority – and till such time by the PMC in consultation with district chief medical officer and reporting to both.

Terms of Reference to monitoring team : Illustrative:

1. The team will inspect all the facilities at regular intervals.
2. Monitoring of the process will be done by checking the registers/ Administrative Assistant's report – both during regular visit and during surprise visits.
3. A 25% sample of Patients who have received service from these facilities would be met, interviewed and this would simultaneously be cross checked with data available from the registers. Checking would aim to detect any excess charging of patients
4. A 25% of referring persons would be interviewed for correct and prompt payment of referral fee. Checking would be of timely reimbursement and mode of payment of the incentives.
5. The availability of equipment, drugs and other commodities will also be checked and verified.
6. Patient satisfaction will be assessed on the basis of interview of the patients.
7. The time taken to verify and submission of the report will be less than 2 weeks.
8. The payment will be negotiated and roughly total monitoring costs would be about 8% of total prices of procedures done – lesser amounts may be negotiated where cases cluster more. These payments are subject to budget availability and negotiation that is made.

The Mitanin Referral Fee.

There is now a proposal under Janani Surksha yojana to pay for referral for institutional delivery . This would be extended to cover the Mitan Kendra and Mitr Chikitsalay as well. The Mitan Kendra (but not Mitr Chikitsalay) pays 10% of the total receipts given to all the Mitanins who are referring the cases, irrespective of the case. This may also be given as a group incentive to the village committee. A similar amount is available for payment from government hospitals as referral incentive and is part of the existing scheme and the effort would be monitor the prompt payment of the govt referral scheme also with the same monitoring mechanism.

Payment and accounting mechanisms.

Mitan Hospital's Administrative Assistant ensures that referrals are paid for and quality norms and agreed on processes are followed.

PMC supplies bills. And these are used for all receipts of the clinic. Against these the actual pattern of cash flow can be seen. After checking this only incentive is paid to clinic coordinator.

Referral slips have been given to Mitanins for this, Each slip has three parts. One with referral, one with patient and the third is given to doctor , collected by kendra promoter and given to the Mitan kendra . This is used by monitoring team for sample verification.

Reimbursement by the Govt :

Procedures:

1. The Private Sector partner will maintain his accounts as per standard requirements of accounting.
2. All services that are provided to the client for which reimbursement is being sought would have bills drawn up with corresponding bill numbers.
3. Any payments received from the client directly would have receipts with counterfoils with receipt numbers.
4. The Mitr Chikitsalay or Mitan kendras would file his claim in the prescribed format - which is a one page simplified format along with the bills. Along with this he or she would be required to fill up a one page simplified standardized case summary/discharge summary for each patient. On submission he or she would receive 70% of the payment claimed for. The remainder would be paid within a month after verification. There would be an upper limit to what would be paid as 70% preliminary payment before verification.
5. In each district there would be one or more PMC representatives appointed. They would receive the claims, check that the forms are correctly filled then and there, transmit the claims to the headquarters and make the payments as authorised. A tie up with a bank would facilitate this. Within a month of filing the claim the complete payment would be ensured. The payment would be by local check and would be delivered at the doorstep of the private sector partner. The attempt would be to make the payment time as low as 7 days . The PMC representative may be an accounting or management firm or even individual with whom an MOU is signed. For this work and expense a small fee would be paid- about 2% of the transaction amount.
6. Accounts at the state level would be maintained by an accounting/auditing firm and therefore one can get utilisation certificates and audit statements -frequently and promptly.

Budget Requirements for One year :

Approximate Case Load and Reimbursement Costs in a district where one EmOC center has been recruited as a partner:

Item	Nos. Per Month	Per Unit Cost	Total Cost per mnth
C-section	5	6000	30,000
Institutional deliveries	30	1500	45,000
Sterilisations	50	800	40,000
Others	50	200	1,000
A. Total Monthly	Reimbursement		1,16,000
B.Total Annual			13.92 lakhs

Reimbursement cost for 50 PPP centers: Rs 696 lakhs(81. 31%)

Please note referral refunds costs may be included .This fund also lies underutilised.

Programme Management Costs:

A> Variable Programme Costs: shown below for 50 franchisees:/partners

1. Monitoring and Accounting Support

Monitoring 1 st level	Appox 25% cases:	Rs100 per case or 10% of A	11,600
Monitoring 2 nd level	Appox 5% of cases	2% of A	2320
Accounting costs		2% of A	2320
Total for one month			16,240
Total for 12 months			1,94,880

1. Monitoring & Accounting Support for 50 partners per year: **97,44,000**

2. Upgradation of Skills 0.6/partner: Rs 30,00,000

B> Fixed Programme Costs**1.. Programme Administration Costs:**

One CEO, 3 prog. officers and one CA firm /per mnth	:	Rs. 85,000
Travel Costs for state office	:	Rs. 15,000
Office costs for state office	:	Rs. 30,000
5 field officers @ Rs 6000pm:	:	Rs. 30,000
5 filed officers travel and support costs	:	Rs 10,000
Total programme management costs per month	:	1,60,000
Per year	:	19,20,000

2. Promotion Costs:

Brochure /ads/visits:	:	Rs 1,50,000
Accredittation visits: 200 partners* 1500	:	Rs 3,00,000
Training expenses 100* Rs400/day * 10 days	:	Rs 4,00,000
Melas – other promotional activity:	:	Rs 5,00,000
Total Promotion Costs per year:	:	Rs 13,50,000

Total Annual PPP Programme support Costs : Rs 160.14 lakhs (18.69%)