PUBLIC PRIVATE PARTNERSHIPS IN HEALTHCARE

OUTSOURCING OF HAEMODIALYSIS SERVICES IN DELHI

A CASE STUDY

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SUPPORTED BY: OXFAM INDIA

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PHOTO CREDIT

Cover page photo downloaded from http://www.rajivgandhisuperspecialityhospital.org/RGSSH-INFRASTRUCTURE/Dialysis-Center.jpg

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I. INTRODUCTION

Though several Public Private Partnerships (PPPs) in healthcare have been reported in Delhi, those documented and studied have been mainly of two types: (i) those where the government has entered into purchasing agreements with private hospitals through insurance schemes such as RSBY etc., and (ii) those where private hospitals have been provided land at concessional rates by the government and are required to provide free treatment to a stipulated proportion of indigent patients. The functioning and performance of the RSBY and several other insurance schemes of state governments have been studied and their performance and problems have been highlighted. Similarly, the free treatment scheme for patients belonging to the economically weaker sections (EWS) against concessions to private hospitals has been well documented and studied. The government itself now acknowledges and recognizes the problems in their implementation and has now put in place mechanisms to ensure proper implementation of this scheme[1].

There is a general policy document of the Planning Department, Delhi government on public-private partnerships (March 2014)[2]. This document is essentially the guidelines on PPP issued by the Department of Economic Affairs, Government of India. It lays down several models of the public-private interaction; it also lists out PPP in super-specialty health care facilities, medical research and treatment facilities.

Delhi's previous experience with healthcare PPPs

During the study, an attempt was made to understand the experience of Delhi state with respect to PPPs in health, and the current status of some of the PPPs was reviewed. The Delhi government website gives the status of PPPs in health sector and lists the following as "Projects under Planning/Pipeline" [3] (Table 1). Some of these projects are already undergoing implementation.

Table 1: PPP projects in health sector in Delhi

S. No.	Project Name	Department/ Agency	Estimated Cost (Rs. crore)	Structure BOOT/BOT	Likely date of award
1	Rajiv Gandhi Super Specialty Hospital	Health & Family Welfare Dept.	100	Develop, Operate, Maintain, Transfer	RFP to be issued
2	DDU Janakpuri Super Specialty Hospital	Health & Family Welfare Dept.	75	Develop, Operate, Maintain, Transfer	RFP to be issued
3	CATS Ambulances	Health & Family Welfare Dept.	36	Buy, Operate, Maintain, Transfer	Work was awarded
4.	Radio diagnostic imaging facilities	Health & Family Welfare Dept.	30 (Phase I)	Buy, Operate, Maintain, Transfer	RFQ to be issued
5	Dialysis Centres	Health & Family Welfare Dept.	6 (Phase I)	Buy, Operate, Maintain, Transfer	RFQ to be issued
6	Greenfield Secondary level hospitals	Health & Family Welfare Dept.	-		Feasibility report under preparation

Desk review of information from government websites on PPPs in health in Delhi indicated involvement of the private sector by the Delhi government in provision of diagnostic imaging and dialysis services. The functioning status and effectiveness of the following PPPs were understood:

[1]http://pib.nic.in/newsite/PrintRelease.aspx?relid=113446
[2]http://www.delhi.gov.in/wps/wcm/connect/doit_planning/Planning/Public+Private+Partnership1/Guidelines+on+Public+Private+Partnerships/
[3]http://www.delhi.gov.in/wps/wcm/connect/doit_planning/Planning/Public+Private+Partnership1/PPP+projects+in+Govt.+of+Delhi (March 2014)

i. Rajiv Gandhi Super Specialty Hospital and Janakpuri Super Specialty Hospital

The review of media reports[4][5][6] on the two hospitals, primary interviews with the Medical Superintendent (MS) of the Rajiv Gandhi Super Specialty Hospital (RGSSH) and a Directorate of Health Services (DHS) official, along with observations made in the hospitals, provided an understanding of the status of the PPP initiative to hand over the management of super specialty hospitals to private partners.

The RGSSH is a tertiary level hospital under the Government of NCT Delhi, spread over a 13-acre area and cost the government more than Rs. 100 crores. The RGSSH was proposed to be a 650-bedded hospital. Its construction was completed in 2009 and the government had planned to run it in PPP mode, but this proposal was subsequently dropped, as it could not attract partners. In 2012 the government announced that it had decided to hand over the management of this hospital (and another such tertiary level facility, the Janakpuri Super Specialty Hospital) to a Society comprising central and state government officials. The societies of both the hospitals were to be headed by Chief Secretary of Delhi and they would comprise top officials of the Union Health Ministry (PTI, 2012; Sharma, 2014; Jha, 2015). The present status of these hospitals is not clear, as we were told that the process of tendering to run it in PPP mode has been initiated (interview with Delhi government official, February 2016). Media reports further stated that audit reports reveal that crores of rupees are being spent on the maintenance of two hospital buildings and equipment is lying unused there. In 2011-12, RGSSH was allocated Rs. 5 crores by the Delhi government, of which Rs. 4.83 crore was spent: Rs. 1.1 crore was spent on 'office expenses', Rs. 2.80 crore on supplies and material and Rs. 93 lakh on staff salaries. The expenditure on medical treatment (of OPD patients) was a mere Rs. 2 lakh. A year later, it had Rs. 6 crores to spend, but the expenditure on actual medical treatment remained static at Rs. 2 lakh. RGSSH has been partially functional since mid-2014: as of January 2016 it was providing OPD services only in cardiology and gastroenterology. Apart from the above services, since July 2014 it has been providing a 30-bedded out-patient maintenance dialysis facility in PPP mode. JSSH was allocated Rs. 5.8 crore in 2011-12 and ran up an expenditure of Rs. 5.76 crore as expenses (Sharma, 2014; Jha, 2015).

ii. Provision of CATS Ambulances

As per documents available on Delhi government's website[7][8], in July 2009 the Health Department, Delhi government, entered into a PPP arrangement for provision of ambulance services within the NCT of Delhi. It made a contract with Fortis HealthCare Ltd. and Fortis Emergency Services Ltd. (FESL) for expansion of the ambulance fleet within the NCT of Delhi, to provide round-the-clock pre-hospital emergency medical response (ambulance) services across the city, to be co-ordinated through an Emergency Response Centre (ERC), which would be accessible through a toll-free number. This service was to be called 102 Ambulance Service and was to add a fleet of 150 ambulances. The government was to pay a sum of Rs. 25 crores towards capital costs; and also cover the costs of the categories exempted from user charges. As per the agreement, FESL had to, within 90 days of the appointed date, procure and get 25 per cent of the fully equipped vehicles registered, which was to be extended to 50 per cent within 180 days; FESL had to commence the services with the fully functional ERC within 180 days of the appointed date. FESL was given rights to collect and retain user charges as set by the government, with certain categories of patients exempted from payment. Despite several meetings and several verbal and written assurances FESL failed to abide by the milestones that had been agreed upon; it had not even procured the vehicles as per the agreed schedule. Hence in January 2010 the government terminated the agreement made with Fortis and forfeited the performance amount of Rs. 60 lakhs.

iii. MAMTA Scheme

An evaluation of MAMTA scheme was conducted by Nandan et al in 2009. In March 2008 the Government of National Capital Territory (NCT) of Delhi launched the MAMTA scheme under the Delhi State Health Mission to

[4]http://timesofindia.indiatimes.com/city/delhi/Spanking-new-hospitals-empty/articleshow/48992571.cms
[5]http://www.thehindu.com/news/cities/Delhi/east-delhis-only-super-speciality-hospital-soon-to-become-functional/article6230290.ece
[6]http://articles.economictimes.indiatimes.com/2012-12-18/news/35890816_1_hospitals-specialist-doctors-tahirpur
[7]http://delhi.gov.in/wps/wcm/connect/DoIT_Health/health/important+links/concession+agreement+for+102+ambulance+project
[8]http://delhi.gov.in/wps/wcm/connect/doit_health/Health/Important+Links/Concession+Termination+Notice+for+102+Ambulance+Project

promote institutional deliveries. Under this scheme the government partnered with private hospitals/nursing homes to provide a comprehensive package of maternal health services including institutional deliveries to women from slum areas. Private hospitals / nursing homes were to be registered under the scheme (MAMTA Friendly Hospitals-MFH), and paid a fixed remunerative package for each institutional delivery they carried out for eligible pregnant women. The above mentioned study found that there were several problems in the implementation and monitoring. The scheme had become unattractive to the private providers. Out of a total thirty-six private hospitals/nursing homes that had signed the MoU with the Government at the inception of the scheme, only twelve were providing services at time of evaluation, and these too were planning to withdraw. A majority of the hospitals/nursing homes reported that the remuneration in the scheme was much lower than the actual cost of inputs/ resources in rendering services. They were reluctant to continue with the scheme mainly due to unattractive service package, too much paper work, lack of publicity about the scheme, and delay in reimbursement of claims (Nandan et al, 2009). This scheme is no longer operational in Delhi.

Other than these three schemes, interviews revealed thatthe PPPs for radio diagnostic imaging initiative and the other with Greenfield Secondary Level Hospitals have not taken off (CEO, Deep Chand Dialysis Centre,and Health official, NHM). Preliminary inquiries with Delhi government officials revealed that one of the PPPs that was currently functional was in provision of dialysis services. Given the lack of systematic documentation and information on such PPPs in healthcare provisioning, the PPP in dialysis provision in Delhi was taken up as a case study.

II. METHODOLOGY

This study was an exploratory one, to understand the implementation, functioning and effectiveness of PPPs in health sector in the Delhi state, and how the PPP mode of health service delivery affected the state's responsibility to provide free or subsidized quality health services to its people. This was done through a situational analysis of private sector participation in developing haemodialysis centres within Delhi government hospitals in PPP mode: to examine the status and characteristics of these arrangements, their goals and performance, their financial-contracting-regulatory mechanisms. This case study was part of a larger study on understanding PPPs in the healthcare sector.

For situational analysis of PPP in haemodialysis, a qualitative case study was undertaken. Two hospitals, Lok Nayak Hospital (LNH) and Rajiv Gandhi Super Specialty Hospital (RGSSH) were selected for the study. Data collection was done through review of available literature and programme data, key informant interviews and group discussions. Informed consent was taken verbally from all respondents.

Interviews were held with the following key informants:

1. CEO of private company that had got the award for the dialysis PPP project

2. Hospital officials – Medical Superintendent (MS) in one hospital and the designated nephrologist in the second hospital

3. Doctor / staff at the haemodialysis centre- One doctor on duty at Lok Nayak Hospital, and two coordinators, one each at the two hospitals. Attempts were made to speak to the doctor outside the duty hours, but he was out of town for quite some time.

4. Patient interviews – Two individual interviews of persons undergoing maintenance dialysis in the facilities run by Deep Chand Dialysis Centre (DCDC) in two hospitals: Rajiv Gandhi Super Specialty Hospital (RGSSH) and Lok Nayak Hospital. While in LNH, the patient interview was conducted outside the hospital, the one in RGSSH was conducted in the waiting area of the hospital. After this interview a group discussion was held in RGSSH with 12 patients awaiting their turn. The researchers explained the purpose of the study to the patients, who then agreed to talk to them. The researchers could not interview other patients at LNH, as all were undergoing dialysis when we reached there.

5. Designated official for this PPP in Department of Health & Family Welfare, Government of NCT of Delhi.

Though the Memorandum of Understanding (MoU) between the Delhi Government and the private party for dialysis PPP is not available in the public domain, we were able to access and review parts of the document.

III. FINDINGS

The findings are presented in two sections:

1. Understanding policy and operational issues regarding engagement of private sector for healthcare services by the Delhi government

2. Case study of implementation and functioning of the PPP in dialysis provision by Delhi government health department.

1. Understanding policy and operational issues regarding engagement of private sector for healthcare services by the Delhi government

Though the general policy document of the Planning Department, Delhi government on public-private partnerships (March 2014)[1] provides some guidelines on engaging the private sector, no other documents of the Delhi government regarding involvement of private providers specifically in health services provision were found in the public domain. Moreover, documents for health PPPs, addressing issues such as: what are the exact nature of problems faced by the government in providing health services to the population of Delhi, what are the options available to address them, why and how will engaging the private sector address these problems, what would be the financial implications, why is the government opting for this mechanism, road-map to operationalize the mechanism, what kind of resources would be required, etc. were also not found. Therefore, the objectives of the partnerships with the private sector and the nature of strategies adopted do not seem to have been clearly laid down. This leads one to ask whether the objective of the PPPs is:

- To utilize the services of the existing private providers, while the government builds its own capacities? Will the partnership be a temporary measure?

- To promote, to facilitate growth of the private sector in a strategic way, to encourage private providers to expand their services offered, and patients or areas served, or

- To turn over (convert) public services to private operation?

Interviews with government officials explored this aspect further. According to the Health Department official in-charge of PPPs, "PPP is a new concept; it will take time to get fully functional; need more skills-capacity-knowledge (among government functionaries)"; and that "it takes around one-and-a-half to two years to develop, draw up and implement a PPP project; if somebody does it before this period then it can fail. The success of PPPs varies from case-to-case; some may fail some are successful" (sic) (interview with Directorate of Health Services official, February 2016). According to this official, two-three officials (in the Health Department) have been working informally on PPP –there was no formal PPP cell as such. This mechanism was still functioning (as of February 2016). He further stated that; "there is a consensus to have PPPs in all health service provisioning – for advanced services: diagnostics, CT imaging, dialysis; and physicians are to be involved in the process". While the dialysis PPP had been implemented, the government was working on several more projects and that"there are several in the pipeline [like] for MRI-CT services, health insurance".

In such a situation where there is no clearly laid policy guideline, the areas for PPP listed out in the Table 1 above, as well as the functioning PPP in dialysis appear to be a piece-meal or an ad hoc measure – rather than the outcome of a well-devised, well-planned component of a larger scheme/policy for involving private providers in health services. The procedural mechanism by which dialysis services, or other services, were chosen is not available in public domain. While the routine procedures for contracting with private parties, namely the process of requesting tender bids, etc., have been followed to select the private company, and memorandum

[1]http://www.delhi.gov.in/wps/wcm/connect/doit_planning/Planning/Public+Private+Partnership1/Guidelines+on+Public+Private+Partnerships/

of understanding made on the operational details, however, the epidemiologic rationale for selecting dialysis, and other options for how it could be provided, why this particular option was chosen, all such details are not available.

2. Case study of implementation and functioning of the PPP in dialysis provision by Delhi government's health department.

As of March 2016, haemodialysis centres through PPP mode were operational in two hospitals of the Delhi government - Rajiv Gandhi Super Specialty Hospital (RGSSH Tahirpur) and Lok Nayak Hospital (LNH).

2.1 Selection of the Agency

In 2012 the Delhi government decided to develop haemodialysis centres within Delhi government hospitals in PPP mode, in order to:

(i) improve the haemodialysis facilities in its hospitals, and

(ii) to provide access to high quality haemodialysis at affordable pricing.

As per information provided by a Health department official, the Directorate of Health Services (DHS) held a meeting with all 'stakeholders' in dialysis to discuss the provision of dialysis services in PPP mode. However, the profile of the 'stakeholders' were not revealed in the interview with the official. Feed Back Infra was appointed as the consultant, and feasibility studies and detailed project reports were prepared. Subsequently, Delhi government conducted a process of competitive two-stage bidding process for selection of a suitable partner[2].

Stage 1 – RFP process and shortlisted nine eligible bidders (Annexure 1)[3].

Stage 2 – RFP issued on 23rd May 2013 with a revised RFP issued on 21st June 2013 inviting proposals from the shortlisted bidders to implement the Project[4].

The project hospitals are in two clusters, and two different companies (or consortia) were to be selected to operate these facilities (Table 2).

Table 2: Details of project hospitals according to clusters

Hospital	No. of haemodialysis machines
Cluster 1	
Lok Nayak Hospital	10
Hedgewar Aarogya Sansthan	20
Rajiv Gandhi Super Specialty Hospital (Tahirpur East Delhi)	30
Total	60
Cluster 2	
Janakpuri Super Specialty Hospital (West Delhi)	25
Bhagwan Mahaveer Hospital (Northwest Delhi)	25
Pt Madan Mohan Malviya Hospital, Malviya Nagar (South Delhi)	10
Total	60

Source: Interview with the CEO of Deep Chand Dialysis Centre

[2]http://www.delhi.gov.in/wps/wcm/connect/4bb8a480430257c49f20bfb13eb04390/Rfq24.pdf?MOD=AJPERES&lmod=1400331464&CACHEID=4bb8a480430257c49f20bfb13eb04390
[3]http://www.delhi.gov.in/wps/wcm/connect/c1390a8043025e7f9f52bfb13eb04390/adda24.pdf?MOD=AJPERES&lmod=1401071692&CACHEID=c1390a8043025e7f9f52bfb13eb04390
[4]http://www.delhi.gov.in/wps/wcm/connect/15acd100430b36c29f149f62062a41f1/addendum21.pdf?MOD=AJPERES&lmod=1729471763&CACHEID=15acd100430b36c29f149f62062a41f1

After evaluation of the proposals, the Delhi government awarded the project to the following companies, on 29th July 2013. The two consortia selected, based on their quoted discount on the CGHS rates for dialysis were:

(i) A consortium of Deep Health Care and Metalite Properties Private Ltd, which was to implement the project in the cluster 1 listed above.

(ii) A consortium of Max Healthcare Institute Ltd. and Nephrocare Health Services Pvt. Ltd., which was to implement the project in cluster 2.

The selected companies were supposed to respond within a week of their selection to officially accept the Notice of Award (NOA) and immediately start the process of setting up machines. While the first consortium accepted this Notice and initiated the implementation, the second consortium wrote to the Health Department on August 13 2013, stating their inability to perform their obligations, and sought extension and clarification on critical aspects of the partnership. According to the government the two companies (in the second consortium) "raised frivolous contentions, conveniently changed stand and attempted to seek clarification under the garb of want of clarity, whereas no clarity was required as the bid documents were adequately explicit and expressive and, further, no such issues were raised during the bidding process" (Order dated 9.1.2014 of the GNCT of Delhi, Health and Family Welfare Department). Finally, after issuing a show-cause notice in September 2013, in January 2014 the government debarred the two from participating in any tender process of the government for a period of one year, for failure to accept and act upon the award issued to it in July 2013[5].

A Concession Agreement was made on 17th October 2013, between Department of Health & Family Welfare, GNCTD and M/s Deep Chand Dialysis Centre (DCDC). The consortium accepted the Concession and agreed to implement the project at its own cost and expense, in accordance with the terms and conditions laid out in the Concession Agreement with the Delhi government. The consortium incorporated M/s Deep Chand Dialysis Centre Private Limited as a SPV (special purpose vehicle) to sign the agreement as mentioned in the MoU between the company and the Delhi government.

The Delhi government has granted to M/s DCDC the Concession to:

i) Plan, design, procure and install new haemodialysis equipment;

ii) Operate, maintain and manage the haemodialysis centres; and

iii) At the end of the successful concession period hand back the project facilities, having all assets/ equipment operational and in good working condition.

The Concession Period is seven years six months from Compliance Date – namely date of issue of certificate of compliance. At the end of the 7-year period the Delhi government can bid out the project again on PPP basis.

After getting the award for this project, the consortium provided performance security of Rs. 50 lakhs to the Delhi government, valid for a year initially, to be extended within four weeks of signing of the Concession Agreement; gave an undertaking to pay success fee equivalent to 1 percent of total cost to Feedback Infra Private Limited – the Transaction Advisors. (MoU between the company and the Delhi government).

So, as of March 2016, this dialysis PPP is in operation only in the three hospitals of cluster 1 and is not in operation in cluster 2 hospitals. The dialysis centres started in LNH and RGSSH in mid-2014, while the centre in Hedgewar Hospital was to have started in March 2016.

[5]http://www.delhi.gov.in/wps/wcm/connect/ab5aa780430b644aa039b962062a41f1/Orderfmax.pdf?MOD=AJPERES&lmod=1729717537&CACHEID= ab5aa780430b644aa039b962062a41f1

2.2 Financing mechanism of the initiative

As learnt from the interviews with Mr. Aseem Garg, CEO of DCDC, and Medical Superintendent(MS) of RGSSH, and as is also clearly laid out in the MoU, user charges were to be the prime source of revenues for the company providing the dialysis in this PPP project. The haemodialysis centres are open to all patients, who are categorised into "paying patients" and "sponsored patients". Sponsored patients are those patients approved by the Delhi government for haemodialysis and other procedures at the identified haemodialysis centre on a cashless basis. The company is reimbursed by the government for the dialysis provided to these sponsored patients as per the agreed charges, from the Delhi Aarogya Kosh (DAK)[6]. This 'cashless' dialysis is available only to those who are residents of Delhi and have an income of less than Rs. 3 lakhs a year, or patients with the National Food Security Card. Paying patients are those patients other than sponsored patients who shall pay directly to the haemodialysis centre as per tariff in the Agreement, either themselves or through some insurance mechanism. The company shall be directly responsible for collection of charges from such paying patients. The private provider has to give priority to the patients referred by the hospitals located in Delhi and to sponsored patients.

2.3 Salient features of the contract /partnership

Review of the MoU between the company and the Delhi government provides information on 'scope of the project'; standard operating procedures (SOPs) and other terms, covering penalties, monitoring, feedback,grievance redressal etc. Some important details are as follows (MoU between the company and the Delhi government):

i. DCDC shall bear and pay all expenses, costs and charges incurred in the fulfilment of all the obligations laid out in the Agreement.

ii. Staffing and Employment- DCDC shall provide for the requisite personnelas laid out in the SOP schedule. It has to ensure that sufficient clinical human resource is available at all times for haemodialysis and allied services. It is responsible for recruitment of minimum required number of clinical and nonclinical personnel in the Schedule on Staffing Norms, and manage and train them for the smooth operations of the haemodialysis centres. Payment arrangements, housing, training etc. were to be the responsibility of the company.

iii. The company shall be responsible for arranging all requisite utilities like power, water and waste management. DCDC has to devise a safety plan and practice measures to ensure safety of patients, employees, staff, equipment and the facility, as in the respective Schedule.

iv. DCDC has to implement a Quality Control Program, as in the concerned Schedule. It can undertake other activities by itself or through sub-contracting arrangement and also appoint contractors, sub-contractors, agents, advisor and consultants for the tasks.

v. Ownership- The ownership of the project facility shall at all times vest in the government/hospitals and shall not under any circumstance whatsoever pass over or be deemed to pass over to the company or persons or any third party claiming by, under or through the company. The ownership in respect of the equipment/project assets shall vest with the company during the tenure of the Concession and during such period the company shall not be allowed to move/replace/sale/transfer/pledge/hypothecate/ create lien on/encumber whatsoever the equipment/assets without prior written permission of the government.

vi. Monitoring- As per the agreement, the Delhi government has the power of supervision over the development/operation and maintenance (O&M) of this project and project deliverables. The Delhi government had to set up an Expert Committee/Monitoring Committee consisting of domain experts from Department of Health & Family Welfare, Directorate of Health Services, medical colleges, hospitals and

[6]The DAN (Delhi Arogya Nidhi) and DAK schemes of the Delhi government to provide cash assistance to patients from the economically weaker sections (and having the relevant entitlement cards) for treatments involving high financial costs. The DAK is a registered society with a corpus fund of Rs. 110 crore; it is specifically aimed at supporting dialysis related expenses, in government and empanelled private hospitals (Government of NCT of Delhi 2013 p 117).

eminent experts, to periodically monitor the project development, O&M, service deliverables, including research outputs. This Committee would have representatives from the company – at least one and not more than two persons.

vii. Regular reporting requirements by the company to the government – The reporting will consist of 'service level specifications and performance indicators' of the dialysis centres operated by the company in the two hospitals.

viii. Grievance Redressal - Provisions have been made for patient feedback forms, for a complaint policy, and grievance redressal mechanisms. The company has to set up a grievance redressal cell (GRC) prior to operationalization of the haemodialysis centres. This Cell has to examine the complaints received and the company has to take remedial action immediately if the complaint is found to be valid. The government also has to constitute a grievance redressal committee (GRCom) prior to operationalization of the haemodialysis centres. This GRCom shall be a five-member committee comprising of three members nominated by the government, one nominated by the company and one independent industry expert jointly nominated. Patients or any other agency/persons may also refer complaints regarding denial or quality or services, dissatisfaction over actions taken by the GRC or any other matter related to patients, for taking appropriate action. The GRC may also refer certain complaints to the GRCom if they are of a complex nature.

2.4 Background of the two units providing dialysis treatment

As informed by the MS at RGSSH and later also corroborated in group discussion with patients, the Dialysis Centre at RGSSH started functioning in May 2014. There are five rooms with six beds each and 30 dialysis machines in all; the dialysis service is provided in four shifts round-the-clock, from 7-11 AM, 12 noon to 4 PM, 5-9 PM, and the last shift from 11PM-3AM. There are thirty patients in each shift. Patients come for 2 to 3 sessions of dialysis every week. There are two technicians in each room, and ten in all; and two doctors who monitor the patients while they are on dialysis.

From a group discussion with the doctor, the technician and the dialysis coordinator at LNH it was learnt that the dialysis centre at Lok Nayak Hospital was started in March 2013(before the PPP was initiated by the government). It is housed in one large room (about 15 ft X 30 feet). There are 12 machines crowded into this one room, with very little space between the beds. There is no separate seating space for the technicians attending to the patients, the doctor, and the dialysis co-ordinator. All these people were seated around one table in the same room. Only 10 machines were operated at a time and two were kept as spare. The staff here was: 1 manager, I receptionist, 4 technicians (one of them Senior Technician and three Junior), two ward boys, one Resident Medical Officer, nephrologist (from hospital). This centre also offered dialysis in four shifts. There was no separate waiting area for the attendants/relatives of the patients; they were seated in the corridor outside the dialysis room. According to the doctor and technician we spoke to, there were plans to increase the number of machines here to 25.

2.5 Experience and perspective of service providers providing haemodialysis

According to the CEO of the company (DCDC) the advantage of partnering with the government was that 'it had opened up a new patient segment for the company' – they were getting access to patients who would not have availed dialysis otherwise, who would not have been able to bear the cost at market prices, of Rs. 4000 per session. The company had the 'domain expertise', and ability to scale up, because of which they could manage the dialysis operations efficiently and manage more machines than the government could. In his view provision of maintenance dialysis was different from that provided in emergency care or as a temporary treatment; the two cannot be mixed up, and should be separate from management point of view. According to him the dialysis facility is a government facility and they have to give preference to sponsored patients.

According to the medical superintendent(MS) of RGSSH, DCDC was providing good services and it was a successful PPP. As per the agreement, the hospital had provided the space and made arrangements for electricity and water

supply. The company did not pay any lease or rent to the hospital or to the Delhi government. The 'business model' was one where the private partner was providing dialysis at a discounted/subsidized rate of Rs. 1073, as per the agreement. This rate was lower than the rates at which other hospitals were providing this service. There was a monitoring committee for the quality assurance of all the dialysis centres under this PPP project, consisting of expert doctors from All India Institute of Medical Sciences (AIIMS), Lok Nayak Hospital (LNH), University College of Medical Sciences (UCMS) and other hospitals. The MS stated that for grievance redressal, both the RGSSH and the DCDC had their separate committees and that they took care of all the complaints. However, information regarding composition and working of both the monitoring and grievance redressal committees was not made accessible to the researchers.

When asked about why the hospital was not providing dialysis directly, he said that the hospital planned to have its own dialysis facility as an in-patient facility, for those who needed dialysis only for a short period, as a treatment during kidney transplant. In his view the existing hospital infrastructure should not be used for maintenance dialysis for out-patients. It was not an effective/efficient use of the hospital, as it was equipped to provide specialized services and should be utilized for that only.When queried as to why a government hospital would not provide out-patient dialysis, as hospitals were meant to provide both out-patient and in-patient care, he repeated that it was not feasible. He did not provide any strong rationale for why this hospital, set up exclusively as a super-specialty facility, could not or should not provide maintenance dialysis as out-patient service, so that more patients could avail of the service at less or no cost.In his view the government should set up stand-alone dialysis facilities to provide maintenance dialysis for those who need it; it should not be set up within existing hospitals.According to the nephrologist from LNH, (who is the Nodal Officer here for authorizing the procedure for sponsored patients), the government was not investing in the machinery; and the patient load was too much for maintenance dialysis and it was not possible for the hospital to provide the services. When queried about the procedure by which the companies were selected and the PPP was operationalized, he mentioned that five people from the DHS were involved in the process and the selection of the companies was through an open tender process. In his view the life of dialysis machine was around seven years and that could have been the reason for giving the contract for seven years.

The dialysis coordinator at RGSSH had been working since December 2014 and employed by the DHS on contract, which is renewed every six months. His job was to approve the papers of the patient for dialysis at the dialysis centre, ensure that all the papers were there, maintain records of the patients, guide them, coordinate with the DHS, etc. According to him there were in all 250 patients registered for dialysis, all of them sponsored; the number of paying patients was negligible (less than 10 per cent). There was a waiting list of 135 patients for dialysis. Patients needed to show the EWS certificate, or income certificate to be eligible for the sponsored patient category.

2.6 Accessibility, affordability and quality of services under the PPP

In RGSSH,Sponsored Patients (those who do not have to pay for their dialysis) have to go through a three-step procedure to avail of dialysis treatment at the dialysis centres operating in PPP mode at the two government hospitals.These steps are as follows:

i) Pre-authorization: The patient has to first consult the Senior Nephrologist in the OPD at Guru Tegh Bahadur Hospital (GTB), which is about 3 kms away from RGSSH.

ii) Authorization: Once the senior nephrologist prescribes the dialysis, the patient then consults another doctor at RGSSH (the Nodal Officer) for the authorization of his/her dialysis without paying charges.

iii) Following this authorization, the patient submits the papers to the dialysis coordinator (appointed by the Directorate of Health Services, Delhi government), stationed at RGSSH for this purpose. The dialysis coordinator scrutinizes the papers and approves the procedure for cashless service, for a period of three months.

Towards the end of three months, the patient has to go through the above three steps and get the pre-authorization and authorization renewed from the nephrologists for the next three months. On the other hand, patients who undergo dialysis at Lok Nayak Hospital (LNH) consult the nephrologist within the hospital itself and do not have to go to another hospital for getting this pre-authorization and authorization from senior nephrologists for dialysis. Once the in-house nephrologist authorizes the dialysis, the patients submit the papers to the dialysis coordinator stationed at LNH, who then processes and scrutinizes it and approves it for the three-month period.

The patients availing services at RGSSH have to go through the inconvenience of consulting the nephrologist in a different hospital because RGSSH is still not fully functioning tertiary hospital with only some skeletal OPD services for cardiology and gastro-intestinal diseases. While space has been given to the private company to start and operate the dialysis facility as per the PPP agreement, however the hospital itself does not have any nephrology services. At the time of the study (March 2016) there was no nephrologist or other doctor functioning as nodal officer at RGSSH for the authorization, as his contract had got over. The dialysis coordinator was performing this task of authorization.

The surgery for creation of the fistula for performing dialysis is not done at these dialysis centres located at RGSSH or LNH, and the patients have to get it done at their own cost at any hospital of their choice. For the sponsored patients the cost of this procedure is paid by the government if it is performed at another dialysis centre run by the company in another part of the city; the government does not pay for the procedure if done at any other hospital.

Availability and cost of medicines: The drug Erythropoietin is required during every session. One of the patients showed the injection that he had bought - the MRP on the packing was Rs. 1543; however, he had got it at Rs. 250from a pharmacy in Yusuf Sarai. It was learnt from the patients that there was one shop called HELPLINE (in Yusuf Sarai) where the medicines were available at a highly subsidized cost. For instance: this injection was available for Rs. 200/-, which works out to Rs. 1600 for eight sessions in a month. Besides this they had to take two other injections – carnitine, which cost Rs. 100 per session (Rs. 800 for eight sessions in a month)and iron injection for Rs. 100 each, twice a month (Rs. 200 per month). Thus the total cost of these injections in a month came to a minimum of Rs. 2600 for two sessions of dialysis per week, excluding cost of vitamins and calcium tablets.

One of the grievances that came out in the group discussion with patients at RGSSH was the problem in getting medicines free of cost from Guru Tegh Bahadur Hospital (GTB) due to the very long waiting time. The patients felt that medicines should be made available at RGSSH itself, as the pharmacy there was open and the pharmacist did not have much work to do (as the hospital was not functioning fully). Some patients felt extremely inconvenienced in running between the two hospitals. For any emergency care they were sent from RGSSH to GTB; even tests were not performed at RGSSH. This situation could not be discussed with the patients at LNH, however, according to the nephrologist interviewed at LNH the patients do not face any such problems as the medicines can be bought from the hospital itself.

Travel costs: Nearly all the patients in the group discussion had travelled long distances to reach RGSSH, about 25-50 kms. The minimum cost worked out to Rs. 80 per day, and to Rs. 640 a month.

Thus, total expenses incurred by the patients on travel and medicines came to around Rs. 3200 a month. This does not include the loss in earnings, if any. An entire day has to be spent as each session lasts for 4 hours; to this was added the time spent on travel (1-2 hours one way, 4 hours per session) and on waiting for an hour each before and after the dialysis. This high cost could be reduced if medicines were available free, without too much waiting time.

Quality of workforce involved: The patients in the group discussion at RGSSH were of the opinion that the technicians were not trained and could not insert the needles properly into the fistula; due to which their fistula

and veins got blocked. Five of them (one of them a woman) showed swollen and injured arms. They felt that the company was hiring untrained technicians and that there was a high turn-over of the junior technicians, as they were not being paid properly. According to them, the company seemed to be getting untrained people, who left for greener pastures, after getting trained on the job at these centres where largely sponsored patients came. One of the patients said that he had written about this problem in the complaint register several times, but received no response. He opined that the technicians did not treat patients like him properly as they were not paying for their dialysis. In December 2015 nearly 75 patients from RGSSH had submitted a petition to the Health Minister, pointing out these problems and seeking relief. A copy of the petition submitted was provided to the researcher by one of the patients. They informed that no action had been taken on the grievances.

Other services for patients: Patients at RGSSH said that there was no separate waiting area at RGSSH for the patients and their attendants. They had to sit in the hospital waiting area near the registration counters. There was a waiting room next to the dialysis rooms for the dialysis patients and their attendants, however it is currently locked up and access denied to them. According to the patients when this waiting room used to open, their attendants/relatives would sit there and come to their bedside at frequent intervals during their dialysis. They would call the technicians or the doctor if there was any problem or discomfort during dialysis. The patients feel that the waiting room has been locked to prevent their relatives from being next to them and pointing out the problems during dialysis. The relatives now have to sit elsewhere (on the ground floor of the hospital) and could not go often to the second floor, where the dialysis rooms were located. However, according to the dialysis coordinator the waiting room had been locked up for 'security reasons' – to prevent relatives from wandering around the floors during the night sessions of dialysis, when the hospital was deserted. This does not explain why it has to be shut during the daytime hours.

2.7 Expansion of dialysis services

In February 2016, in the Central government's budget for 2016-17, the Union Finance Minister announced the National Dialysis Services Programme under the National Health Mission, in PPP mode, in all district hospitals. According to news reports, by mid-2016 the health ministry had received close to 400 proposals for district hospitals to start dialysis units in PPP mode, of which 275 had already been approved; further the central government has also circulated model tender documents for this programme (Ghosh 2016). Incidentally, the same company that was operating the service in Delhi, DCDC Health Services, had got the contract for Jharkhand and for MP too (even before the announcement of this national programme, as told during interview with the CEO of the company in February 2016).

Limitations of the study

The main limitation of the study was lack of access to data and information from the government. Limited information is available in the public domain. Hence efforts were made to collect information through primary interviews and observation. The access to the LNH dialysis unit was a problem. At the time of data collection, a lot of renovation and construction work was going on and locating the dialysis unit was a problem. After reaching the LNH dialysis unit, the absence of a waiting area outside the unit made it difficult to locate the patients who were waiting and not currently undergoing dialysis. Therefore, only one patient could be interviewed at LNH.

We could not interview the member(s) of monitoring/expert committee or the grievance redressal committee that were reportedly set up by the government for this PPP. Neither the hospital officials, nor the Health Department official, or the CEO of the private company could give us any concrete information about who these members were and so this could not be done. This also reflects the lack of transparency in the implementation of the PPP.

IV. DISCUSSION

What is the benefit to the patients from this PPP arrangement?

The cost of dialysis in the private sector in Delhi is reported to be in the range of Rs. 4000-5000; and for fistula/ shunt is around Rs. 12,000. At the dialysis centres operating in these hospitals in PPP mode, paying patients can get dialysis and related services at discounted rates: such as Rs. 1073/- (or Rs. 1302/- for sero positive cases) per dialysis session. Related services such as fistula/shunt, cannulization, catheterization, permacath insertion, etc. also are provided at similarly discounted rates, which range from Rs. 2043 to Rs. 787. However, these are not provided by the company at the dialysis centre in these government hospitals, but at the dialysis centre run by the company at its own premises in another place in Delhi. The sponsored patients – residents of Delhi who possess a certificate of EWS or the green card (under the National Food Security Act)– need not pay this amount, as the government reimburses their costs to the company.

In practice, at present it is largely the sponsored patients who are getting some relief from this project, and there is a waiting list even for such patients at RGSSH. Even these patients incur minimum costs of around Rs. 3000 on medicines and travel. As of March 2016 the project was operational only in two hospitals in one cluster, LNH and RGSSH, which together were catering to around (100+250 respectively) 350 patients only. As preference has to be given to sponsored patients, the majority of these are sponsored. This means that most paying patients arenot getting dialysis at the discounted rate of Rs. 1073; and are possibly availing of it at the market rates in other hospitals, or in the other centres in Delhi run by this private company.

Patients can get the medicines that have to be taken while on dialysis free of cost from the respective hospital. In case of LNH all the patients on maintenance dialysis get the medicines free of cost from the hospital pharmacy (according to the technician and resident doctor we spoke to). Whereas, patients at RGSSH have to obtain them from GTB Hospital. However, the patients there complained that this was very time-consuming and often took 3-4 hours to get the medicines due to the long queue for medicines. Due to this they often ended up purchasing the medicines from outside the hospital. Thus, even the sponsored patients end up spending money on medicines and transport.

Thus, even after four years of initiating the process of this PPP, and two years of it being in operation, this dialysis PPP seems nowhere near its objectives of improving the haemodialysis facilities in hospitals, and providing access to high quality haemodialysis at affordable pricing. Of the objective of setting up 120 machines across six hospitals, less than half the number are functional. There seems to be no move to assess the performance of the PPP and make any mid-term corrections. The private company's interest seems to be largely that of access to a number of patients, which it feels is the main advantage of partnering with the government.

Is this PPP the best or the only option to provide dialysis at affordable rates?

Experiences from other places indicate that haemodialysis could be made more accessible and affordable by locating it in the smaller free standing units or nephrologists-owned units, in the private sector rather than in a corporate hospital set up. According to estimates of Mumbai Kidney Foundation (MKF) haemodialysis could be provided at less than Rs. 1000 per session, at as low as Rs. 350 (Khanna 2009). The Mumbai Kidney Foundation (MKF) conducted a data collection exercise with the help of industry sources, personal discussion with nephrologists and telephonic confirmation of dialysis centres (Khanna 2009). According to their findings, of the about 5000 dialysis patients in Mumbai city then, 1250 were getting dialysis at less than Rs. 350 per dialysis; and the average price of dialysis was Rs. 700 - 750 per session, which was the cheapest in the country (national average cost then was Rs. 1100). Some patients paid less than Rs. 100 per dialysis (in charitable dialysis units).

MKF conducted a survey of actual costing of dialysis in few private hospitals in different cities of India and came up with the following findings (Khanna 2009):

a. The cost differed from a nephrologist owned facility versus a corporate hospital

b. The administration greatly exaggerated the cost

c. Even in large corporate hospitals the recurrent cost dialysis worked out to be between Rs. 700-900.

The average cost to the patient across the country came to Rs. 1100 per session, which was beyond the reach of most people in the country (Khanna 2009).

Table 3: Costing of dialysis services (Khanna 2009)

City	No. of dialysis centres	No. of dialysis machines	No. of dialysis per month	Cost of dialysis per session
Delhi	79	490	28,500	1600
Mumbai	112	600	40,000	750
Chennai	44	146	10,220	1200
Calcutta	36	250	20,000	1100

According to the author, the cost of dialysis in Mumbai was the lowest because of the presence of two kinds of models in the city: the nephrologist owned free standing dialysis centres and of charitable dialysis centres. Mumbai had 112 dialysis centres, of which 17 were free standing units. Of the 600 dialysis machines in Mumbai, 150 were in charitable units.

This exercise shows that it is possible to provide dialysis at low rates even in the private sector; it could also be done in the government sector, with proper planning, provided it is organised appropriately, with the interests of the patient at the centre. The Delhi government could have undertaken a planning exercise, conducted such background studies of the number of dialysis centres across Delhi, their ownership pattern and rates at which they provided dialysis, could have worked out costs and ways by which they could be reduced, could have contacted nephrologists and other doctors, and dialysis could have been provided at a lower cost, whether in the private sector or through government subsidy, through other partners. The present system of PPP by the Delhi government need not be the best or the only option to provide dialysis at affordable rates.

V. CONCLUSION

There is adequate evidence to show that nearly all the PPPs of the Delhi government in health services have either not taken off at all or have been abandoned, or private partners have backed out or asked for re-negotiation, or are only partially functional, pointing towards the reluctance and/or unreliability of private partners. Studies and reports evaluating PPPs in health sector in other states have shown that PPPs seem to be fraught with problems and may not be very efficient or effective(Roy & Gupta 2011; NRHM 2012; Karpagam et al 2013; Gupta & Pachauli 2015).

Among the partially functioning ones is the dialysis PPP, the implementation of which suffers from several problems described above. As the planning/feasibility studies were not made available to us, nor are they available in the public domain, it is not clear how they were conducted and by whom, and whether studies such as the ones by Mumbai Kidney Foundation and epidemiological considerations were taken into account. There has been no involvement of public health personnel with experience of health systems planning in the process of operationalizing these PPPs. On the contrary, the process has relied on feasibility studies prepared by business consultants/advisors, and this report is not available in the public domain. In the name of PPP, the government has engaged only with the business enterprises involved in dialysis provision, and not looked into the feasibility and potential of either engaging with not-for profit providers or of providing the services itself.

There does not seem to be any monitoring of the on-going PPP to ensure its proper implementation and moreover it has not even started in one cluster of hospitals. There is no increase in budgets or in human resources for this PPP and there is a lack of monitoring and grievance redressal,all of which could further affect the quality of care. There are issues in transparency and critical documents and information like the MoU and other programmatic data are not available in the public domain.

The recent developments in the National Dialysis Service Programme indicate that there is a move to replicate the Delhi model of PPP in dialysis services across the country, including partnering with the same company in some states. This is a major area of concern. This study documents some of the problems that the programme is currently facing: the major one being that it is not effective in reaching all the people who need dialysis; those having access to it are also incurring out-of- pocket expenses and are not necessarily getting good quality care; private companies cannot always be relied upon to abide by the terms of the contract; and the government is not increasing the financial resources, or setting up mechanisms for monitoring and is unable to make the private party fulfil the terms of the contract.

Given the manner in which this national dialysis programme has been announced, it reinforces the observations that PPP policies are more a piece-meal, arbitrary measure by the government, an attempt to provide patient volume to the large private sector, and less the outcome of a well-designed, well-planned component of a larger policy measure to improve and strengthen the health system.

Evaluations of PPPs in health in developed and developing countries indicate that to get the benefits of public-private partnerships, governments need to invest significant financial and human resources in addressing the myriad problems (Hellowel 2012). While such partnerships have strong proponents among academia, policy-makers, western governments and international donors, however, "there is no existing empirical evidence in relation to their performance in low and middle-income countries (LMICs), while they are clearly associated with substantial implementation challenges. Their economic value in high-income contexts is heavily contested by scholars and it will be some time before their appropriateness for the health systems of developing countries can be intelligently assessed" (Hellowel 2012 p 72).

The poor performance of PPPs in healthcare is often attributed to lack of technical capacity among the government to work with the private sector, and moves are on therefore for capacity building of government

staff in this direction (Harding 2009). However,regardless of these operational issues, there are certain larger problems in PPPs. Firstly, the current approach to PPPs to provide services for a specific disease could well end up reinforcing the vertical approach and further fragment the already ramshackle public health system.

Secondly, considering that PPPs have been originally adopted in sectors such as infrastructure – construction-roads-water, etc., and is being sought to be implemented in healthcare sector, the larger and more important question is: can PPPs address the deep-rooted, multi-faceted problems of the health sector in India today? Are they appropriate for provision of medical care services, which requires integrated curative, rehabilitative, preventive care, at various levels of the health system? What kind of partnerships, with whom, for which services of the health system, and for what purposes, would strengthen the health system for universal access? It has been repeatedly pointed out that healthcare cannot be treated as another commodity and provided through market mechanisms. In the discourse on partnering with the private sector why is no distinction made between the non-profit and for-profit sectors? Is it possible to align the goals of equity and universal care through a comprehensive healthcare service, with the commercial, profit motive of an expanding for-profit and corporate sector in the country? Engaging with these issues and taking cognizance of the wealth of facts accumulating on poor performance of PPPs in healthcare would constitute rational and evidence–based policy making, rather than ignoring and dismissing them as ideology-driven.

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VI. ANNEXURES

Annexure 1

The shortlisted bidders were as follows

1. M/s Fresenius Medical Care Pvt. Ltd.

2. M/s B. Braun Medical India Pvt. Ltd.

3. M/s Nipro India Corporation Pvt. Ltd.

4. M/s Nephrine Renal Care Pvt. Ltd.

5. M/s Deep Health Care and Metalite Properties Pvt. Ltd. (Consortium)

6. M/s Apollo Hospital Enterprise Ltd.

7. M/s Narayana Hrudayalaya Pvt. Ltd.

8. M/s Max Healthcare Institute Ltd. and Nephrocare Health Services Pvt. Ltd. (Consortium)

9. M/s Maharaja Agarsen Hospital

PUBLIC HEALTH RESOURCE NETWORK

Public Health Resource Network (PHRN) is a network of individuals and organizations with the perspective of strengthening technical and management capacities to take action towards the common goal of 'Health for All'. Its main objective is to contribute and strengthen all efforts directed towards the goal of 'Health for All' through promotion of public health, social justice and human rights related to the provision and distribution of health services, especially for those who are generally left underserved.

JAN SWASTHYA ABHIYAN

Jan Swasthya Abhiyan is the Indian circle of the People's Health Movement, a worldwide movement to establish health and equitable development as top priorities through comprehensive primary health care and action on the social determinants of health. The Jan Swasthya Abhiyan coalition consists of over 20 networks and 1000 organisations as well as a large number of individuals that endorse the Indian People's Health Charter.

OXFAM INDIA

Oxfam is marking its 67th year in India this year. In 1951, Oxfam Great Britain came to India during the Bihar famine to launch its first full-scale humanitarian response in a developing country. Over the past 66 years, Oxfam has supported civil society organisations across the length and breadth of the country. In 2008, all Oxfams working in India came together to form Oxfam India, a fully independent Indian organisation (with Indian staff and an Indian Board), which is a member of the global confederation of 18 Oxfams.

PHRN

Jan Swasthya Abhiyan
People's Health Movement-India

ऑक्सफैम इंडिया
OXFAM
India