Role of Public-Private Partnerships in addressing inequities in access to health services: Case studies from Rajasthan

Thesis submitted to the Jawaharlal Nehru University in fulfillment of the requirements for the award of the degree of

DOCTOR OF PHILOSOPHY

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2021

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Dedicated to

my father, (Late) Sekhar Kumar Neogi and all my teachers,

who encouraged me to pursue my goal until I have achieved it.

Acknowledgments

Ever since I have started working on my thesis, I have maintained a small diary to write the names of those who have helped me start, pursue and complete my Ph.D. I did this to ensure that when I finally write the acknowledgments, I do not miss out on anyone who supported me in this journey. Having a relook at them I think they fall into three categories – drivers, active supporters, and passive supporters. At the onset, I want to extend my heartfelt gratitude to all of them.

While I ought to be in the driver's seat as it is my thesis, but in my case, I was pathetic at driving it. If left to my driving, this Ph.D. would have never reached its destination and I would have never written this section. The first and foremost driver was my dad. Although he is no more with me in person, he is the strongest force that kept me going. At times after long hours of writing also I did not feel tired, I knew it was him who was providing me with the extra and positive energy. Closely following him would be my two guides, Prof. Rama V. Baru and Prof. Rajib Dasgupta. It is impossible to put in words what and how they nurtured me and my thesis. Of course, their in-depth knowledge on the topic and their expertise in guiding students were of invaluable advantage; but what I admire most is their extreme patience and perseverance, sometimes more than what I deserved. I also feel that in the course of this Ph.D. they have taught me the two biggest lessons of life – *do not complicate your life* and *stay calm.* At last but not least is my core family – my husband Sourav and my eight-year-old son Sachit. They were my backbone, my comfort zone, and my strictest monitors.

The next category comprises those people who have helped me to successfully gather information on a topic that is opaque and guarded by professional and personal interests. The first name on this list is Dr. M. L. Jain, retired Director RCH, Department of Health, Government of Rajasthan. I have known and worked under him when I was working as a consultant in that department between 2010 -12. I was sure that he was an encyclopedia as far as the working of the health department was concerned, but I was pleasantly surprised when he candidly shared his experiences which helped me a lot in understanding the changes in the health sector in Rajasthan. The other active

supporters are my (ex)colleagues in the state health department and in NGOs where I have worked. While only a few of them also became my respondents. Many of them went out of their way to help me get the required data when all roads seemed to have reached a dead end. I am not taking their names in the interest of their privacy.

The third category is that of passive supporters. I must admit that the important word here is 'support' and not 'passive'. My mother and my sister are the first two people on this list followed by my in-laws. Among friends, Poonam, Kapil, Gunjan, Jeet, Farhad, Sangeeta, Kumud, Seemi, Eshita, Chandan, Ranvir, and Lakshmi merit special mention. I am also thankful to Dinesh (documentation unit), and all the staff in the administrative office of the Centre. Finally, there is one person whose support I cannot undermine, my house-help Mithilesh.

I owe all of them sincere thanks and also apologies for my erratic behaviour in the past years. However, I take the sole responsibility for any mistakes in this thesis or any objections to it.

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Abbreviations

ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
CHC	Community Health Centre
CM&HO	Chief Medical and Health Officer
CRM	Common Review Mission
CSR	Corporate Social Responsibility
Dy. CM&HO	Deputy Chief Medical and Health Officer
EoI	Expression of Interest
FW	Family Welfare
GoI	Government of India
GoR	Government of Rajasthan
HFA	Health for all
IMR	Infant Mortality Rate
JSY	Janani Suraksha Yojana
MDSD	Most Different System Design
MH	Multi-speciality Hospital
MMR	Maternal Mortality Ratio
MMS	Mobile Medical Service
MOIC	Medical Officer In Charge
MOU	Memorandum of Understanding
MSSD	Most Similar System Design
NACP	National AIDS Control Programme
NBCP	National Blindness Control Programme
NFHS	National Family Health Survey
NGO	Non-governmental Organization
NH	Nursing Homes
NHM	National Health Mission
NNGO	National NGO
NRHM	National Rural Health Mission
OOP	Out-of-pocket

PHC	Primary Health Care
PHC	Primary Health Centre
PPP	Public Private Partnership
QCA	Qualitative Comparative Analysis
RCH	Reproductive and Child Health
RFP	Request for Proposal
RHSDP	Rajasthan Health System Development Project
RHSDP	Rajasthan Health System Development Project
RNTCP	Revised National Tuberculosis Control Programme
SC	Sub-centre
SNGO	State NGO
TFR	Total Fertility Rate

Chapter I: Introduction

"Of all the forms of inequality, injustice in healthcare is the most shocking and inhumane." [Martin Luther King Jr.]

A healthy population is an essential constituent for a well-functioning society. But, the stratification in our society, based on power hierarchy, influences the equitable distribution of the resources in general and health-related resources in particular. This leads to differential exposure and vulnerabilities to ill-health resulting in inequity in health status. This then causes differential consequences of ill-health which reinforces and perpetuates social gradient (Gilson et al 2007).[1] Thus, inequity in health is not merely a public health problem, it is a developmental concern (Bambas and Casas, 2001). Persistent inequities, one of the main challenges in achieving Millennium Development Goals, ought to be realized to meet the Sustainable Development Goals (Hosseinpoor et al., 2018).

The health system of a country has a vital role in reducing the inequities in access by addressing its determinants. For that, it has to perform four functions, service delivery, financing, resource generation, and stewardship, in a manner so that the healthcare needs of all sections of the population are satisfied, irrespective of their socio-economic status and geographical location. Besides, the design of the system should integrate all three levels of care – primary, secondary, and tertiary.

Three types of actors – the public sector, the private for-profit, and the private not-for-profit/ non-profit sector perform the functions of the

[1] The Priority Public Health Knowledge Network under the aegis of the Commission of Social Determinants of Health presented five levels of factors associated with inequity health outcomes. These were socio-economic context and position, differential exposure, differential vulnerability, differential access to healthcare and differential consequences. Social class, gender, ethnicity, education, occupation and income comprised the social position which in turn affected the exposure to risk factors. Clustering of risk factors in some population groups along with co-existence of other health problems increased their vulnerability. People in lower social position also suffered from low access to health services. Finally, all these factors contributed to the health outcomes. This often triggered the vicious cycle and reduced the social position of the individuals.

health system. Besides, the people or the users of the system are also important. However, the roles performed by them vary according to the design of the health system of the country. It, in turn, is shaped by the institutional, historical, and ideological context that varies from one country to another (Hunter, 2016). Besides, the health system is also impacted by the changes in the global political-economic landscape.

Like most countries, India has been grappling with the problem of inequities in health status since its independence. To address it, the architects of India's public health system proposed a publicly financed and provided model integrating primary, secondary, and tertiary levels of care, which would be available to all irrespective of their ability to pay. However, this model got lost in translation due to factors like shortage of human resources, especially at the primary level, poor infrastructure, and insufficient budgetary allocations. This adversely affected the health of the populations residing in rural areas and low-income urban settlements.

The opportunity was seized by the private sector provider to flourish, most of them were for-profit. Thus a mixed economy emerged in the health system which defeated equity (Nishtar, 2010). This is explicit from the poorer health status of people from lower socio-economic categories. The condition further deteriorated during health sector reform (Bali and Ramesh, 2015). With neoliberalism as the dominant paradigm of the reform, the welfare model was replaced by the commercialization of the health system. The term 'commercialization', coined by Koivusalo and Mackintosh (2004), is a wider concept than privatization. It refers to the provisioning of health services through market relationships. It includes private contracting and supply to a publicly financed health system. This led to structural and functional transformations in the way health services were financed and delivered in the country.

One of the key reform strategies was to engage the private sector in the public health system. Two avenues were proposed for this – (i) facilitate private financing through insurance and (ii) encourage private sector

delivery of clinical services, through public financing (Basch, 1999). These new institutional arrangements were commonly known as the Public-Private Partnership (henceforth PPP). Thus PPP neatly qualifies as a vehicle for the commercialization of health services.

In India, PPP was adopted for non-clinical and diagnostic services at the secondary and tertiary care level as well as in national health programmes delivering primary level care since 1990. Even after the reforms era was officially completed this remained as the core as well as supplementary strategies in the National Rural Health Mission launched in 2005, to improve the state of primary health services, especially in rural areas.

While studies on the ill-effects of changes in the health systems, espoused by the reforms, on inequities in access are abundant, most of these studies have attributed inequities to the weakening of the public health system along with the rising commercialization of health services at the tertiary and secondary levels, but there is limited research on the PPP strategy at the primary level.

Dovetailing these two gaps, this thesis aims to examine how the PPP arrangement implicated inequities in access to primary level care, especially in rural areas. The rural-urban divide in health outcomes is a valid concern in a country like India with the majority of the population residing in the villages. This introduction chapter aims to link the two core themes – inequities in access to healthcare and PPP in the health system in India to develop a conceptual framework for the primary research.

Section 1: Inequity in access to health services: the role of the health system

1.1 Meaning of the term inequity

The term inequity is the linguistic opposite of the term equity. One of the common definitions of equity is the "absence of systematic differences in one or more aspects of health status across socially,

demographically or geographically defined populations or population subgroups" (Starfield 2001; pg. 546). Although inequity in health has been defined and conceptualized by different disciplines, there are some common features in all the definitions. These are unfair and avoidable, attributable to a responsible agent and not due to free choice (Whitehead, 1991; Marmot, 2007; Fee and Gonzales, 2017).

Whitehead (1991) provided a working definition of equity encompassing three principles. The first principle refers to equal access to health services based on need; the second is equal utilization of health care for equal need and the third is the equal quality of health care for all. In the first two definitions, need is an important determinant of distribution. Recognizing the difficulty to ascertain the epidemiological need for the whole country, estimating need based on overall deprivation was considered a suitable alternative (Barker, 1996). Moreover, there is a significant overlap between the epidemiological need and the felt needs of the vulnerable population. There are different dimensions for overall deprivation; one of which is the geographical location of the population. Premised on this dimension, the population can be broadly divided into rural and urban regions.

Several conceptual frameworks delineate the factors causing inequity in health outcomes. While it is not possible to cover all those, some of them merit special mention in the context of health. Globally the idea of inequity was reiterated in the Alma Ata Declaration in 1978 by launching the Health For All (HFA) campaign. According to that declaration, health was linked to all social sectors, hence achieving equity in health was defined as equal access to clean water and sanitation system, housing, adequate nutrition, and food intake as well as addressing the factors causing poverty. It also challenged the unequal distribution of wealth between developed and developing nations (Rifkin, 2018).

This *comprehens*ive approach to health was bargained for specific diseases under *selective primary health care,* which resonated in the supply of public health services in most of the low and middle-income countries (Baum et al, 2017). The primary health care approach came to the limelight again in 2008 after the World Health Report titled *Primary Health Care: Now More Than Ever* was published. In this report, a diluted version of the HFA framework was proposed based on the recommendation of the Commission on Social Determinants (CSDH). This framework, like its predecessor, was an ideal statement, with little clarity about how to translate it into action. The other lacuna in this framework was that it assumed that poverty is the only axis of inequity and hence suggested interventions targeting those below a certain economic level (Fee and Gonzale, 2017). In the WHO's report, the PHC approach heralded four reforms necessary to refocus on health for all agenda[2]. Universal coverage was one of the reforms and equity was a part of it.

This brief historical account of the concept (in)equity in health reveals that since the neoliberal era, there was a shift in focus from the production to the distribution of disparities (Qadeer, 2006). As the structural factors associated with the idea got replaced by only health system-related factors catering to a deprived section, measures to improve access to health services became the mainstay of the government programmes and policies. With that, it became important to define the need. The policymakers, instead of choosing the epidemiological approach, settled for an economic criterion. Based on that, health services were targeted towards the poor while other axes of inequity were often neglected.

[2] The World Health Report (2008), supported this revival of PHC approach and extended it to four reform necessary to refocus the health system towards health for all: (1)universal coverage that ensure health systems contribute to health equity, social justice and the end of exclusion , (2) service delivery that reorganize health services around people's needs and expectations, (3) public policy that secure healthier communities, by integrating public health actions with primary care and by pursuing healthy public policies across sectors; and (4) leadership that replace disproportionate reliance on command and control on one hand, and laissez-faire disengagement of the state on the inclusive, participatory, negotiation-based leadership required by the complexity of contemporary health systems.

1.2 Defining inequities in access to health services

Equity is a normative concept that cannot be measured directly. However, inequities in access can be assessed by measuring the differential access between more and less advantaged social groups (Braveman, 2014). Hence, it is important to first define access. This is a challenging task as the term 'access' seemed to be an elusive concept given the plurality of definitions, (Khan and Bhardwaj 1994). At this juncture it is important to demarcate access from utilization; both these terms are often interchangeably but they are not identical. Access denotes the possibility of using services when required while utilization, on the other hand, refers to gaining access (Aday and Anderson, 1981).

The idea of inequity in access was succinctly articulated in the Inverse Care Law propounded by J.T Hart in 1971 based on a study of National Health Services of the United Kingdom of Great Britain and Northern Ireland (Nambiar and Mander, 2016; pp 356). The law stated:

> *"The availability of good medical care or social care tends to vary inversely with the need of the population served."*

A comprehensive definition of access to healthcare services is (Levesques, Harris and Russel, 2013; pg 233):

> *"Within healthcare, access to a service, a provider or an institution, thus defined as the opportunity or ease with which consumers or communities are able to use appropriate services in proportion to their need."*

One of the ways to operationalize inequities is through barriers to access across socio-economic categories. Broadly, there are two categories of barriers – supply-side and demand-side. These are also referred to as service delivery characteristics and characteristics of the population at risk respectively (Aday, Quill and Reyes-Gibby, 2001; Oliver and Mossialos, 2004; Aday and Anderson, 1981).

Supply-side factors consisted of resources and organization. These factors include healthcare personnel and their training, physical infrastructure, equipment, and material used in healthcare delivery. It also includes financial investment for these. The organization refers to the process of providing preventive and curative medical services. There are two interdependent processes – (i) entry, which refers to how the resources are coordinated, and (ii) structure, which indicates how those are controlled. Predisposing, enabling, and need are components of characteristics of the population at risk. These operate at the individual, household, community, and population levels. Based on these determinants, access can be either potential or realized access. When only the service delivery characteristics are addressed it improves potential access while both types of factors need to be addressed for realized access (Khan and Bhardwaj, 1994).

What complicates access further is its different dimensions. Levesque, Harris, and Russell, (2013) divided it into five dimensions:

(i) Approachability –Elements such as transparency, information regarding available treatments and services, and outreach activities contribute to making the services more or less approachable

(ii) Acceptability – Cultural and social factors determining the possibility for people to accept the aspects of the service and the judged appropriateness for the persons to seek care.

(iii) Availability and Accommodation – Results from characteristics of facilities (e.g. location), of health personnel (regularity, qualification), and modes of provision of service (e.g. contact procedure and waiting time).

(iv) Affordability – Related to direct prices of services and related expenses in addition to opportunity costs related to loss of income. Furthermore, it can vary by type of services and depends on the capacity to generate the resources to pay for care.

(v) Appropriateness – Refers to fit between services and clients need, its timeliness, the amount of care spent in assessing health problems and determining the correct treatment, and the technical and interpersonal quality of the services provided

An analytical framework that dovetailed dimensions of access to its barriers was given by Jacob et al. (2012). It included four dimensions of access – geographical accessibility, availability, affordability, and acceptability. The supply-side barrier for the first dimension was service location. Waiting time, wages, quality of staff, availability of drugs and consumables were determinants of the second dimension while the direct and indirect cost of services were related to the third dimension. Management and staff efficiency along with technology were attributed to the last dimension.

1.3 Role of the health system in reducing barriers to access

Focus on barriers to access health services warrants a strong health system. The World Health Organization (WHO) defined the health system as "all organizations, institutions, and resources that are devoted to producing actions principally aimed at improving, maintaining or restoring health" (Hunter 2016). There has been an array of models and frameworks that have evolved that called for the strengthening of the health system as a prerequisite for improving the health status of the population. These frameworks were rooted in the dominant political and economic paradigms of their time and hence were based on diverse assumptions with specific agenda (Olmen et al., 2012).

The importance of focusing on the health systems was highlighted in the World Health Report 2000, titled *Health Systems: Improving Performance*. According to the report, the health system should perform four key functions to achieve the desired goal of improved health outcomes. These are service delivery, financing, resource generation, and stewardship (WHO, 2000). Service delivery includes issues like access to

care among all social groups to reduce inequality, maximum population coverage, patient safety, and understanding the different types of service delivery strategies. Financing includes the mechanism of collecting and pooling revenue and then distributing it among the providers to improve health. Resource generation pertains to creating human resources and innovating new technologies. Stewardship implies the ability to formulate strategic policy directions, ensure good regulation and tools for implementing them. It also maintains a vigil on the health system's performance to ensure accountability and transparency (Hunter, 2016).

An operational framework was published by Roberts et al (2003) to assess the health system performance as well as to guide measures to strengthen it. Known as the Control Knobs Framework, it linked five factors (referred to as the control knobs) to three intermediate performance measures, namely cost-effectiveness, quality and access, and three performance goals – health status, risk protection and customer satisfaction. The five control knobs were drawn from the functions of the health system. The first knob was financing which was related to funding mobilization and allocation. Linked to this was the second knob, payment, indicating how the service delivery organizations were paid as well as incentives and disincentives which influenced their performance. The third knob was the organization which refers to the overall structure of the health care delivery system. This knob focuses on four characteristics of the system – (i) who are the health care providers; (ii) what are their respective activities in the sector; (iii) how do they interact with each other; and (iv) what are internal administrative structures. Regulation, the fourth knob, was related to the measures adopted by the state or other parastatal bodies to influence the practices of the individuals and organizations in the health sector. The fifth and final knob is communication. This includes methods influencing behaviour change at the population level. This frame

has been used in health systems programmes and health policy reforms, funded by the World Bank, in many LIC (Ergo et al, 2011).

Directed towards improving the health system, policies govern the roles of different actors performing the above-mentioned functions. Primarily three types of institutions comprise the health service system of a country – (i) public, (ii) for-profit private, (iii) not-for-profit private. They are supported by a fourth type – transnational and multinational organizations. All these actors are engaged in different functions across three levels of care – primary, secondary, and tertiary. Barriers to access are present at all these levels, hence the health system must be designed accordingly. However, a system that enables comprehensive primary health care is considered to be the most equity-promoting (Gilson et al, 2007).

The development and design of the health system vary across countries, but some common features have emerged which imply that in the current scenario, health systems are not only failing to reduce the inequities in health outcomes, they are also exacerbating the barriers to access. These features are as follows (Hunter, 2016):

- focus on financing of healthcare to ensure equity in access
- role of the state is reducing while that of markets is expanding in the provision of healthcare
- provision of curative services at the secondary and tertiary care institutions is prioritized over the primary level care

Dovetailing some of these features, a study examining the role of a health system in addressing inequities in access should deal with two aspects –the primary level of care and relative roles of state and markets in the provisioning of care.

Section 2: Problem of inequity in access to health service in India

The rapid economic growth of India does not commensurate with the health status of the people. On the other hand, it ranks 145th on the global healthcare access and quality (HAQ) index (Yadavar, 2018). Although the country has been able to register improvement in maternal and child health indicators as well as in reducing the prevalence of diseases, the population averages mask the difference across caste, class, gender, education, and geographical location (Baru et al, 2010, Rao, 2017). One of the most pervasive determinants of inequities in health outcomes and as well as access to healthcare is geographic location. Different rounds of national surveys on health have revealed that health indicators in rural areas were worse than their urban counterparts. This is a cause of concern in India because the majority of the population resides in the hinterlands. Hence to reduce the inequities in health status between the rural and urban the government has to pay more attention to the former.

2.1 Inequity in health outcome and utilization

The rural-urban divide in health outcomes can be illustrated using Infant Mortality Ratio (IMR). Although the country's total IMR has reduced from 79 (NFHS1; 1992-93) to 40.7(NFHS 4; 2015-16), there is a significant difference between the rural and urban areas (IIPS, 2017). In the rural areas, the IMR between NFHS 1 and NFHS4 is 85 and 45.5 respectively while in urban areas it has declined from 56.1 to 28.5. The IMR across education, caste, and wealth index in rural areas is significantly higher than its urban counterparts.

The rural disadvantage has been attributed to socioeconomic and community-level factors (Saikia et al., 2013). Some of these, like access to safe sanitary practices and no access to tapped water, were lesser in rural areas (Goli, 2012). While all factors are not under the purview of the health department sector, it justifies the need for better health services to offset these vulnerabilities.

2.2 Inequities in Utilization

Urban-rural differentials in utilization can be described using utilization statistics from NFHS 4 of three services related to IMR – vaccination, treatment of Acute Respiratory Infection (ARI), and treatment of Diarrhoeal Diseases (Table 1.1). The NFHS 4 (2015-16) shows that in all these indicators the percentages were higher in urban areas than in rural areas.

Table 1.1: Urban-rural differentials in the utilization of services (in%)

Type of service	Total	Rural	Urban
All basic vaccination received	62.0	61.3	63.8
Treatment of ARI from a health facility	78.1	75.5	86.2
Treatment of Diarrhoea sought from a facility	67.9	65.8	74.1

Date Source: IIPS, 2017

2.3 Inequities in supply-side determinants of access

The health system in India, comprising both public and private sectors, failed to adequately address the supply-side barriers to access in rural areas. This can be explained through the three functions of the health system.

- Service delivery

The availability of trained human resources in the public health system in rural areas is deficient. According to the recent Rural Health Statistics 2018-19, out of the total number of functional sub-health centers (158417) about one-third do not have either a female or male health worker. Similarly, out of the 25000 primary health centers, only 36.9% have a medical doctor. There is also a shortage of doctors at the community health centers (867 out of 3304 sanctioned posts are filled) which is the first referral unit for primary level care (GoI, 2019). Besides, the public health workforce mostly belongs to the upper socio-economic group who prefer to distance themselves from the marginalized groups based on their caste

(Qadeer, 2011; Rao, 2017). As a result, even when there are public sector services, they do not reach the marginalized sections of the rural society.

There is also a marked variation in the availability of public health facilities between rural and urban areas (Baru et al, 2010). The number of government hospital beds in urban areas is more than twice the number in rural areas (Balrajan, Selvaraj, and Subramanian, 2011). Even where the public facilities were available they were in poor conditions. It was revealed in a study of six states that primary health centers in rural areas lacked toilets, drinking water facilities, clean labour rooms and regular electricity (Kasthuri, 2018). The geographical location of the health facilities is also a key concern. Only 37% and 68% of rural people, residing within 5 km distance, were able to access inpatient and outpatient care respectively (*Ibid).*

This gap is often filled by the private sector, but more than half were untrained practitioners providing only outpatient care. In a comparative study in rural Madhya Pradesh (MP) and urban Delhi, Das et al (2012) revealed that out of the total (MP-241 and Delhi-64) 67% and 16% had no medical qualification in MP and Delhi respectively. Out of them, only 11% were working in the public sector in the rural study area (Das et al. 2012). The formal medical professionals trained in allopathic medicine are mostly located in urban areas and deliver secondary and tertiary level care (Baru et al, 2010; Das et al., 2020). This could be because the new generation of doctors trained in private medical colleges belongs to the upper and upper-middle class/caste who are less willing to join the public services, especially in rural areas; instead, they are keener to work in the bigger hospitals located in the urban areas (Diwate, 2019).

There is also evidence of the high prevalence of undesirable practice by the private sector at all levels, of which irrational prescriptions of drugs was the foremost in both rural and urban areas (Bhat, 1999). However,

the frequency of non-evidence-based antibiotics was found to be higher among private providers at the primary level, especially those in a rural area where many of the providers were not trained in allopathic medicine (Farooqui, Mehta and Selvaraj, 2019; Das et al, 2020).

The aforementioned evidence suggests that neither the public nor the private sector in rural areas is appropriate to overcome barriers associated with the availability of services. Instead, it often exacerbates inequities. The rural-urban variation exists across all states, but in states with a higher rate of urbanization, the differences are more (Dilip, 2005). Studies in other transitional economies also show that the distribution of health services varies between rural and urban areas (Das et al, 2020).

- Financing

The service delivery function is closely linked to financing. It is also linked to the affordability of services. It is well established that the public sector financing for primary level care has not been sufficient since its inception. First, the required 12% of GDP for building a robust public health system, proposed by the Bhore Committee, was never allocated. In the first five-year plan, only 3.3% was reserved for the health sector (Prabhu, 1994). This figure has been reducing since then. It was less than 1% during the reform period and currently, is 1.18% of the Total Health Expenditure (NHSRC, 2019).

Out of the total allocated budget, preference was given to the medicalized health system at secondary and tertiary care. The budget for primary level care was spent in implementing vertical health programmes, for disease control and family planning services. All these factors led to the deterioration of the primary health centers. As the public health system was not meeting the needs of the people, they sought services from the private sector. This led to increased out-pocket expenditure.

According to the NSSO 71st round, the expenditure incurred is less in rural areas as compared to urban areas for all ailments in the last 15 days, per episode of hospitalization and for institutional childbirth (Sundaraman and Muraleedharan, 2015). While in absolute terms this is favourable to rural areas, the disadvantage is revealed when juxtaposed with the per capita income of these two areas. The ratio of cost of care and per capita income in rural and urban is 0.42 and 0.26 respectively[3]. The expenditure on medicine, which is the largest component of OOP expenditure for health care, is more in rural (77%) than urban (70%) areas (Baru et al., 2010). Overall the expenditure burden of day-to-day morbidities is very high in rural areas when the indirect cost and loss of wages are included (*Ibid*).

The other option for financing is health insurance. There are three health insurance options available in India. These are government-sponsored schemes, group-business and individual business. The total health insurance penetration is only 35% as of 2018. The majority of the population is covered under the first category(359.3 million), followed by group business(89.4million) and very few by individual business(33.3 million) (Keelery, 2020). There are also models of Community Health Insurance schemes managed by Non-Government Organizations. Although these are dedicated to the vulnerable section the coverage is dependent on the availability of external resources for their sustainability (Safi, 2015). Studies have revealed that the rural population lacked the required information about insurance options and hence are not adequately benefitted from these different schemes (Pandve and Parulekar, 2013).

[3] Per capita income in rural and urban areas in 2011-12 was 40772 and 101313 respectively (See ToI, 2016). The cost of care per hospitalization episode is 16956 and 26455 for rural and urban areas (Sundaraman and Muraleedharan, 2015).

- Regulation

The health system has failed to regulate the performance of public sector staff as well as the private sector; which has benefitted the provider of services, rather than its users. This is an important component of its stewardship function, which is the responsibility of the government and some parastatal bodies. Problems emerging from poor regulation of public staff were explicit and acknowledged in different health policies, like private practice by public doctors, but it could not be stopped. Active efforts from the administration met with resistance from the professional lobbies (Das Gupta and Muraleedharan, 2014).

Similar attempts were made to regulate the private sector through promulgating the Clinical Establishment Act in 2007. This Act is only focused on secondary and tertiary care private providers while the primary level private providers, most of whom are untrained, are not included (Baru et al, 2010). The enforcement of this Act was also not possible because appropriate guidelines or rules were not drafted by the state as well as the conflict of interest between the government and the professional bodies (Das Gupta and Muraleedharan, 2014). The situation is the same for other legislation regarding drugs and medical devices (Madhavan and Kala, 2015). Thus these service providers continue their inappropriate and sometimes harmful practices unabated as well as charge the user as per their wish.

The other aspect of stewardship that is closely linked to the failure of health service delivery is the failure of accountability (Hammer, Aiyar and Samji, 2007). Accountability is fundamental in the context of health care because of the asymmetry of information between the user and the provider which in turn promotes supply-induced demand. To ensure that the service providers are accountable to the users, the policymakers need to capture the experiences of the community and convey them to the

providers. It is possible to achieve accountability either directly through the design and execution of appropriate programmes (long route) or by empowering the people (short route) (*Ibid*).[4]

While the absence of a proper accountability framework is also an urban issue, its manifestation in rural areas is affected by the poor educational level in the latter as compared to the former[5]. The avenues to gather health information are also limited in rural areas. The need is more in the case of preventive services at the primary level, with limited short-term health benefits.

Section 3: Role of Public-Private Partnership strategy in health service

With a growing overall trend in the utilization of private healthcare facilities combined with an overburdened and crumbling public health system, there was a move from a publicly funded and publicly delivered to a publicly funded and privately delivered health system. This marked the genesis of the Public-Private Partnership (PPP) strategy, which was a compulsion to avail the World Bank loan under the aegis of the Structural Adjustment Programme launched during the 1990s. This was also endorsed by leaders from academia and a civil society organization (Baru and Mohan, 2018). While the context and content of PPP are dealt with in greater detail in the following chapter, some key features of this institutional arrangement are worth mentioning.

The strategy was adopted initially to deliver non-clinical services at primary, secondary and tertiary level care. For instance, private

[4] The government has to act as an intermediary between the buyer (read user) and the seller (read provider) to ensure that the provider understands the users' health need and has incentive to satisfy it. This includes two approaches – long route and short route. In the long route, the policy makers take cognizance of the users' needs while designing health policies and programmes and then transmit it to the provider by creating incentives such that the providers are inclined to implement the goals of the programme. In the short route, the government takes measures to empower the community by awareness generation about health problems and their possible solutions. The other approach is to engage elected representatives as watch dogs. See Hammer, Aiyar and Samji, 2007

[5] According to NFHS 4, the median schooling in rural areas is 3.1 years, while that in urban areas is 7 years. The Net Attendance Ratio (NAR), of rural and urban areas, for primary school is comparable, but for middle and higher levels, it is higher in urban (71.7) than in rural (66.1).

organizations, most of which belonged to the private non-profit (PNP) category, were involved in awareness generation about vertical disease control programmes at the primary level. In secondary and tertiary levels they were assigned the task of delivering services like diet, security, sanitation and laundry. Later, the scope of PPP expanded to the delivery of clinical services. The strategy continues to be an integral part of the public health system, under the current National Health Mission. A form of PPP – strategic purchasing was also recommended by the High-Level Expert Group for achieving the goal of Universal Health Coverage.

While the PPP strategy does not explicitly claim to address the problem of inequities in access, its justification alludes that it will improve the performance of the health system, especially those concerning service delivery. Moreover, it was introduced as a strategy under the health sector reforms. One of the stated purposes of the reform was to ensure equity (Berman, 1995[6]). On the other hand, it is an instrument for the commercialization of health services, which is associated with greater inequity in accessing treatment (Mackintosh and Koivusalo, 2005). Hence, it is important to examine this paradox. The focus of the review is mostly on primary level care in the Indian context.

3.1 Service Delivery

In PPP arrangement service delivery function has been delegated to the private sector; the capacity of the different actors is an important consideration. In the PPP under the Revised National Tuberculosis Control Programme (RNTCP), it was found that most of the private providers engaged, in rural areas and slums, were those who did not have any formal training (Malmborg, Mann and Squire, 2011). The preference for these providers was justified by the fact that the poorer population resorted to these providers. It also improved case detection rates. However, this did

[6] Breman (1995) defined as a sustained, purposeful change to improve efficiency, equity and effectiveness of the health sector (Berman, 1995)

not address the lacunae of the public health system which was responsible for the referral and treatment aspects of service delivery. As a result, the PPP strategy could not improve recovery rates. This fragmentation of the service delivery function also had a deleterious effect on both the comprehensiveness and effectiveness of the programme (Baru and Nundy, 2008). Besides, the PPP strategy was not able to engage the trained medical professionals, who had the technical capacity. The PPP strategy worked better in only those cases where referral care was being provided by a third PNP partner, like the case of Mahavir Trust Hospital in Hyderabad (*Ibid*).

There is also evidence from the PPPs for managing the primary health centers that even PNP organizations that may claim to have the capacity, are not able to meet the requirements of the contract. This was evident in the study of partnership with Karuna Trust for the management of Primary Health Centres (PHC). The study revealed that the Trust deployed lesser staff and distributed expired medicines in their PHCs. There were complaints about its inability to control the spread of dengue fever, irregularity in attendance of staff, misuse of funds, lack of accountability and also charging user fees when the services were supposed to be delivered free of cost (Karpagam et al., 2019).

Another study assessed the nature and extent of primary health care services provided in PHCs managed by NGOs (PHC-NGO) and Corporates (PHC-COR), as compared to the government (PHC-GOV) in Odisha. It was found that none of the partners offered comprehensive care. While the provision of some services like institutional childbirth was better in the PHCs managed by the PNP, appropriate resources were not deployed. The NGO managed by the PHC was found to employ AYUSH doctors and medicines were being prescribed by the pharmacist. The patients had to pay for buying medicines. In the PHC-COR, no doctor was present and the laboratory was not providing free-of-cost services (Baig et al., 2014).

3.2 Financing

In most of the PPP arrangements for primary level care, the public sector was responsible for financing functions. This was because most of these services were not lucrative for the private sector to invest their resources. But, the insufficient budgetary allocation for health continued to affect the service delivery in a PPP arrangement like it did when the services were delivered by the public sector cadres. Besides, the paucity of funds and delay in the disbursal of funds were common features of the public sector (Rao, 2017).

For some services, there was joint financing. In this, also commonly known as strategic purchasing, the accredited private sector received some financial assistance for providing healthcare under the scheme for a certain section of the population. This approach was adopted mostly for publicly funded insurance schemes for secondary and tertiary care as well as for promoting institutional deliveries under the National Health Mission. In this form of partnership, the private sectors identified were mostly in bigger cities which meant that to avail those services the people from the hinterland have to incur out-pocket expenditure. Overcharging, unnecessary surgical procedures, and denying healthcare to patients with medical complications are a few of the other common problems in this type of financing (Neogi, 2020).[7]

3.3 Regulation

The fact that the private sector in India is unregulated cannot be overemphasized. The reasons for the inability of the public sector to regulate the private providers have been described in detail in Section 2.3 of this chapter. While those conditions prevailed, additional factors

[7] The problems in this type of financing are not unique to India. The experience of strategic purchasing of health services from the private sector adopted in the NHS revealed that it did not ensure patient centric care or reduction in prescription cost. On the contrary it meant differential treatment to the beneficiaries under this scheme and also provoked private partners to employ lesser numbers or quality of staff. See Neogi 2020

obstructed the function of regulation in the case of the PPP model of service delivery.

The regulation, in this case, refers to primarily two things. First is the selection of an appropriate partner and the way the partnership is managed. The selection of private partners is subject to the availability of an adequate number of partners that meet the criteria in a given area (Baru and Nundy, 2008). Ambiguity in the terms of the contract regarding performance parameters obstructed the regulation process (Mills, Bennette and Russell, 2001). Besides, the asymmetry of power between the private and public sectors has a serious consequence for governance and accountability (Baru and Nundy, 2008).

There was little engagement of district-level staff in the design and limited efforts to build their capacity to monitor (Venkatraman, 2014). Under health sector reforms a new contractual cadre was introduced in the public sector and the autonomous structure was established at the district level which directly interacted with the private sector. This led to the diffusion of authority and power which altered the way private partners were selected and monitored (Qadeer, 2011). There is evidence that political patronage was a deciding factor in the choice of partners which made monitoring even more challenging (Baru and Nundy, 2008). All these factors hindered the regulation of the PPPs.

Section 4: Conceptualization

India is a country with a majority of the population residing in rural areas. There are marked differences between the health outcomes in rural and urban areas. There are many supply-side factors for inequities in access to healthcare in rural areas like unavailability of human resources and infrastructure as well as management of these resources. The public health system in India has failed to address these determinants adequately. Although this has led to increased utilization of private health

services, a majority of the providers are untrained and from the informal sector. Moreover, these providers also charge for the services and indulge in unnecessary procedures that raise the cost of care. Some services were also delivered by the formal private sector which includes both for-profit and nonprofit organizations. All these actors have their limitations to deliver services equitably. Besides, the inadequate budgetary allocation by the government for the health sector, as well as gaps in regulatory mechanisms and institutions for regulation, persists. These have affected the service delivery of both the public and private sectors.

The inability of the public sector to meet healthcare needs was exploited to commercialize the public health system. PPP as an institutional arrangement for commercialization at the primary, secondary and tertiary levels during the health sector reforms era. Studies related to the implementation of PPP in many health programmes during this period have alluded to the limited success of this strategy in providing healthcare. Besides, studies have also identified other factors that impede the proper functioning of the health system in this institutional arrangement.

Recognizing the persistent inequities in access between the urban and rural areas, the Government of India launched the National Rural Health Mission in 2005. Its vision was to “improve the access to rural people, especially women and children to equitable, affordable, accountable and effective primary health care” (GOI, 2005). Despite the evidence questioning the performance of the PPP strategy in the delivery of health services, the Mission adopted it. Besides, the Mission introduced other architectural changes in the public health system of the country.

The purpose of this research is to examine some of those services under the aegis of NRHM, that are being implemented through a PPP model. After more than a decade of implementation of NRHM, the question

that needs to be asked is how has PPP performed with respect to addressing the vision of the Mission.

This study aims to enrich the existing body of literature on PPP by addressing three vital gaps. First, the lens of inequities in access has not been explicitly applied in most earlier studies. For that, in this study, only PPPs delivering primary level care in rural areas are included. Also, the study is based in Rajasthan, a state which has marked differences in health outcomes across rural and urban areas. Second, most studies look at the outcomes of the process of PPP. To address this gap, the study captures all aspects of PPPs starting from design to implementation and from process to outcomes. It also reviews the existing theories on PPPs to arrive at a framework that links the architecture of PPPs to their role in addressing inequities in access. Third, in most PPP studies, the private and public sector is treated as a monolith, while there is a plurality of actors across these sectors. The present study, therefore, captures the views of categories of actors engaged in the PPP. It also chooses two models of PPPs based on the financing modality.

4.1: Objective of the study

Overall Objective:

To study the role of PPP in addressing inequities in access to healthcare in Rajasthan, through select cases

Specific Objectives:

1. To trace the history of Public-Private Partnership in Health in Rajasthan
2. To understand the architecture of PPPs for select cases with respect to the capacity and motivation of the actors.
3. To explore the perception of different actors of PPPs about their roles in addressing the inequities in access.

4.2 Conceptual and analytical framework

To achieve the study's objectives, three conceptual frameworks have been synthesized. The starting point is inequity in access to health care. For that, the conceptual framework provided by Levesque, Harris and Russell (2013) was found to be the most appropriate. This framework delineates the different dimensions of access and their respective supply and demand-side determinants. The supply-side factors associated with three dimensions of access – availability, affordability and approachability are included in this thesis. The focus on supply-side factors is justified because these come directly under the purview of the health system. Moreover, the PPP arrangement claimed to bridge the service delivery deficiencies of the public health sector. The supply-side factors were categorized according to the Control Knob's Framework – organization, financing and regulation. This is the second framework. With this framework, the relationship between access and the health system was established. Each of the dimensions of access will be studied across the three control knobs of the health system (Table 1.2).

Table 1.2: Dimensions of access with corresponding functions of health systems

Definition	Availability	Affordability	Approachability
According to Levesque, Harris and Russell (2013)	The physical existence of health resources with sufficient capacity to deliver prompt services	Direct and indirect price of services for the user	Information regarding available services and outreach activities that could contribute to making the services more or less approachable
Operational definition for this study according to the Control Knob of the health system: Organization	Human resources and infrastructure, Waiting time, timings of service, location	Sources of funding of the private provider and conditions associated with it	Information dissemination about the services – content, coverage, mode of delivery, frequency

Definition	Availability	Affordability	Approachability
Financing	Fund allocation for the scheme Disbursement of payment	Cost is borne by the patient Incentives to users (if any)	Cost of information dissemination
Regulation	Selection of providers and location for delivering care	Regulate the user charges for services and cost of drugs	Transparency related to services

In the two models of PPP chosen for the study, the organization concerns the private sector and regulation is by the public sector. There is variation in the type of actors responsible for the financing function (Table 1.3). The characteristics of the actors influence their roles. The study focuses on two dimensions of the characteristics. First, the architecture which includes the capacity and motivation of these actors to perform their respective functions. These dimensions have been adopted from Resource Dependency Institutional Cooperation (RDIC) model developed by Rijk, Raak and Made (2007)[8]. To strengthen the connection with inequity, the researcher added the second dimension of the perception of the actors about the role of the PPP model in addressing inequity.

Table: 1.3: Functions of different actors in a PPP model

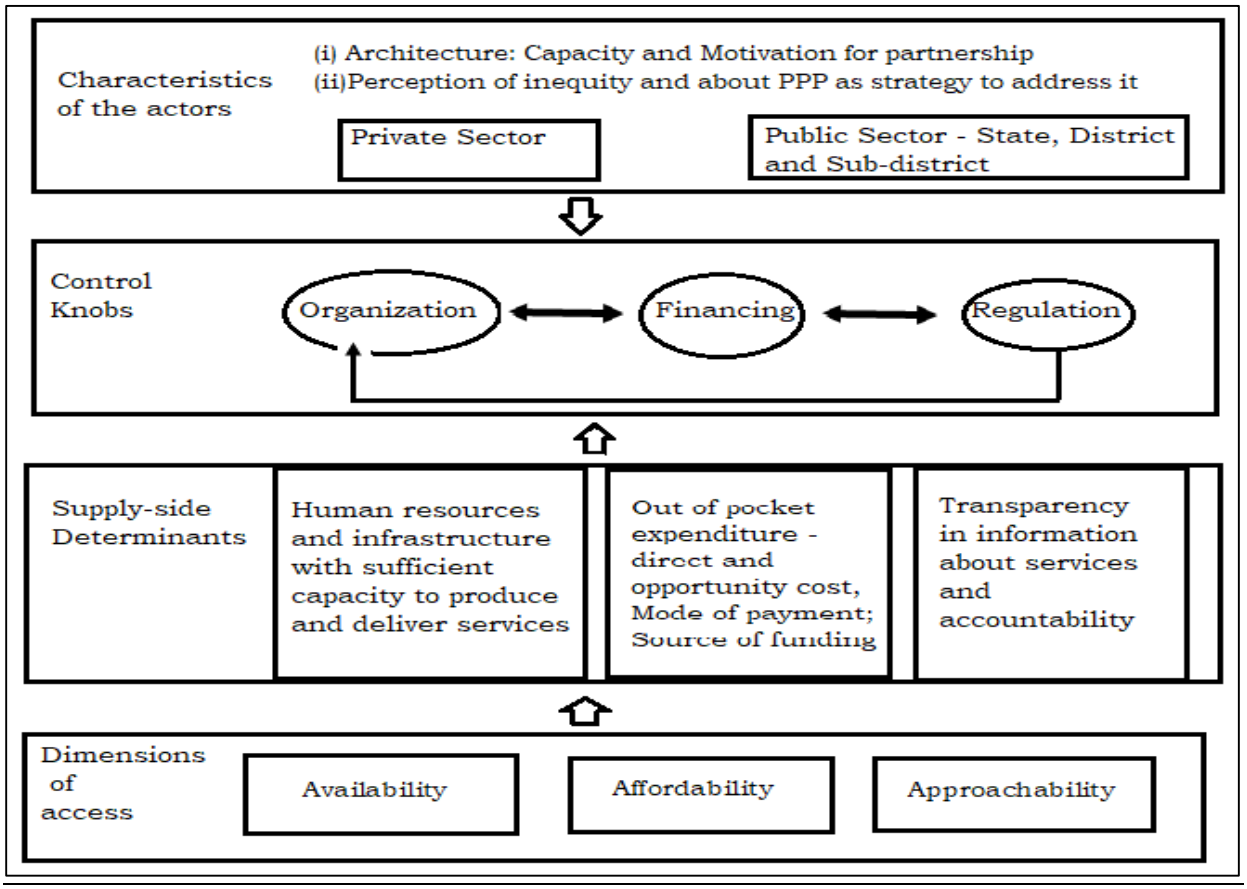
Functions	Responsible Actors
Service Delivery	Private for-profit organizations Private non-profit organizations
Financing	Ministry of Health – approving and disbursing of funds to states State Health Department – allocating budget for PPP and regularity in the disbursement of funds to the districts District Health Office – payment of the private sector Private sector – additional cost
Regulation	Ministry of Health – designing the schemes

[8] The RDIC model is based on four sociological therories – network theory, resource dependence, organizational behaviour and new institutional theory. This has been used to evaluate the level of cooperation between different group of actors. The model comprosies of three level of factors – (i) sooperation, (ii) willingness and ability to cooperate and (iii) goals resources perceptions and institutions.

Functions	Responsible Actors
	State Health Department – selecting the private partners and monitor the performance of the district District level –supervision of the private partners and support wherever necessary; some role in selecting private partners; redressal of community's grievances.

The proposed conceptual model for the study, therefore, had four elements – (i)dimensions of access, (ii) supply-side determinants of access, (iii) control knobs of the health system that are responsible for addressing access, and (iv)the characteristics of actors in a PPP arrangement (Diagram1). Through the case studies an attempt was made to establish a relationship between these four elements. While the first two frameworks match perfectly, the research attempts to map the dimensions of the third with them. For that, a synthetic conceptual framework is proposed in the study (Fig 1).

Figure 1: Conceptual framework for the study



Section 5: Methodology

5.1 Research Design

A case study design provides the scope to understand and describe a complex phenomenon as experienced by different informants to build a holistic picture (Bryman, 2012). This design is preferred in health systems research because of three reasons. First, in the health policy and systems research, there are multiple interpretations of the same phenomenon with different people bringing their context to bear on its interpretation. Second, it helps to study complex behaviour and relationships among actors and how these relationships influence their roles. Third, it can be used to both describe and analyze the design and implementation of the policies (Crowe

et al., 2011). To meet the objectives of the study, the case study design is adopted.

Within the broader canvas of case study designs, the Qualitative Comparative Analysis (QCA) was found to be particularly applicable. QCA is a method in comparative case-oriented research for studying a small-to-moderate number of cases that are mandated for a specific outcome (Sydney et al., 2005). QCA adds to the work of Przeworksi and Teune (1970) most different and most similar systems designs (MDSD and MSSD) by emphasizing the need for variation in cases as well as in outcomes. The variation of cases was in terms of certain constituting properties that describe each case, the outcomes, and also the critical pathway to reach the outcome (Wagemann, 2014; Sydney 2005).

Although all PPP cases usually adopt contracting as a tool for partnership and are being examined for their role in addressing inequities, variation is expected in the process that is adopted owing to the differences in models of PPPs – (i) facility-based care and (ii) outreach services. The former was for institutional childbirth and sterilization while Mobile Medical Services was studied for the latter. These two services also differ in terms of the financing model[9]. Besides, there are different types of private partners in each of these cases.

As a research design QCA requires double knowledge, about the concept and about the case, which can be gained through a variety of research methods viz. content analysis, standardized questionnaire, expert interviews and document analysis (Wagemann, 2014). In this thesis, three different methods were used to gather information – (i) narrative review of literature, (ii)document analysis of relevant government

[9] For the first, the private sector is contracted to deliver services in their facilities and only the cost per patient is reimbursed by the government. In the second case, the capital expenditure is made by the government, while the operational expenditure is transferred to the private sector for the delivery of service.

policy documents and reports and (iii) key informant interview of selected cases and (iv) participant observation and non-formal interview (Table 1.4).

Table 1.4: Objective-wise research methods used in this study

Specific Objectives	Research Methods
Trace the history of Public-Private Partnership in Rajasthan	Document analysis Key informants interview official working in the State Government and International Organizations, Civil Society and Media
Understand the architecture of PPP for select cases with respect to the capacity and motivation of the actors.	Document analysis of schemes and contract In-depth Interview with Key informants at the State and selected districts In-depth Interview with Key informants from the private sector in the selected districts Participant observation and non-formal interviews
Explore the perception of different actors of PPPs about their roles in addressing the inequities in access.	In-depth Interview with Key informants at the State and selected districts In-depth Interview with Key informants from the private sector in the selected districts

5.2 Description of the research process

The stepwise process of building theory from a case study developed by Eisenhardt (1989) has been adapted for this study to arrive at a theory explaining the factors in PPPs design and implementation that enable it to address inequities to access to healthcare.

5.2.1 Step 1: Defining the research question and a priori specification of constructs

As suggested by Eisenhardt, "[A] an initial definition of the research question, in at least broad terms, is important in building theory from case studies." This helps the researcher to stay focused on the objective of the research, specify the type of organization to be approached, and, once there, the kind of data to be gathered. The kind of data to be gathered is shaped by the identification of *a priori* constructs based on existing theories.

As described in the conceptualization *a priori* constructs are derived by dovetailing aspects – the dimensions of access, supply-side determinants of access, the control knobs of the health system and the architecture of PPP. An additional dimension regarding the perception of partners about the role of PPP in addressing inequity (See Table 1.2 and 1.3).

5.2.2 Step 2: Defining Cases

To build a theory from case studies, the study population is crucial because it defines the entities from which the research sample is to be drawn. The process of selection can be theoretical sampling or random. Most of the studies using the case study design adopt theoretical selection as compared to random sampling because such cases may be selected to replicate previous cases to extend emergent theory, or they may be chosen to fill theoretical categories (Eisenhardt, 1989).

- Selection of State

Located in the northern part of India, Rajasthan is the largest state spread over 342239 sq. Km across 33 districts and the ninth based on population (68.55 million) (GoI, 2018). The state performs poorly in all the development indices (Table 1.5). Rajasthan was selected for the study because of two other reasons –

(i) One of the 18 High Focus States of NRHM is based on the low public health indicators as well as inadequate infrastructure (Table 1.5). All the national health programmes funded by the Central government, like RCH, RNTCP, NACP in which the PPP strategy was adopted, were implemented in the state. The state also implemented the World Bank-funded Health System Development Project – Rajasthan Health System Development Project (RHSDP) that fostered and shaped the PPPs in the health sector in Rajasthan; although the focus was mainly secondary and tertiary level care.

Table 1.5: Development Indices of India and Rajasthan

Development Index	**India**	**Rajasthan**
Human Development Index (HDI) value	0.434	0.466; HDI rank 17 out of 23 states
Gender related Development Index (GDI) value	0.590	0.526; GDI rank 31 out of 35 states
Inequality Adjusted Human Development Index (IHDI) value	0.343	0.308; IHDI rank 13 out of 19 states
Loss of HDI due to Inequality (%)	32	34.02

Source: Singh and Keshari, 2016

(ii) Researcher's work experience in the state for more than 10 years with the non-government organization and government health system. She is familiar with the district and the block officials as well as key respondents working in the area of public health in the selected districts.

- Selection of Cases

QCA offers a specific view on the social world which is focused on diversity, on the comparison, on case orientation, and, most importantly, on set-theoretic relations (Wagemann, 2014). For selecting the cases for this study, first, all vertical programmes under NRHM were listed, based on the desk review, which adopted the PPP strategy. To validate this list meetings were held with state government officials under the respective departments to collect the status of PPPs (Table1.6).[10]

[10] The main focus was on partnership with the private sector under different programmes, so contracting in technical and managerial staff in NRHM was not included in the list.

Table 1.6: List of national government programmes with PPP

Name of the National Health Programme	Scheme for involving private partners	Type of partners
Reproductive Child Health (RCH)	Sterilization	Multi-speciality Hospital Private Nursing Homes Non-government organization
	Institutional Childbirth	Private Nursing Homes Non-government organization
	Urban RCH Centres	Non-government organization
Revised National Tuberculosis Control Programme (RNTCP)	TB treatment clinic	Individual Private Providers Non-government organization
National AIDS Control Programme (NACP)	Targeted Intervention Private Blood Bank	Non-government organization Private Hospitals
Blindness Control Programme (NBCP)	Cataract Treatment	Non-government organization Private Hospital
System Strengthening	Mobile Medical Services	Non-government organization Pvt. Nursing Homes Trust CSR Foundation

Data Source: Government of Rajasthan, Annual Reports of Health Department, published from 2011-18.

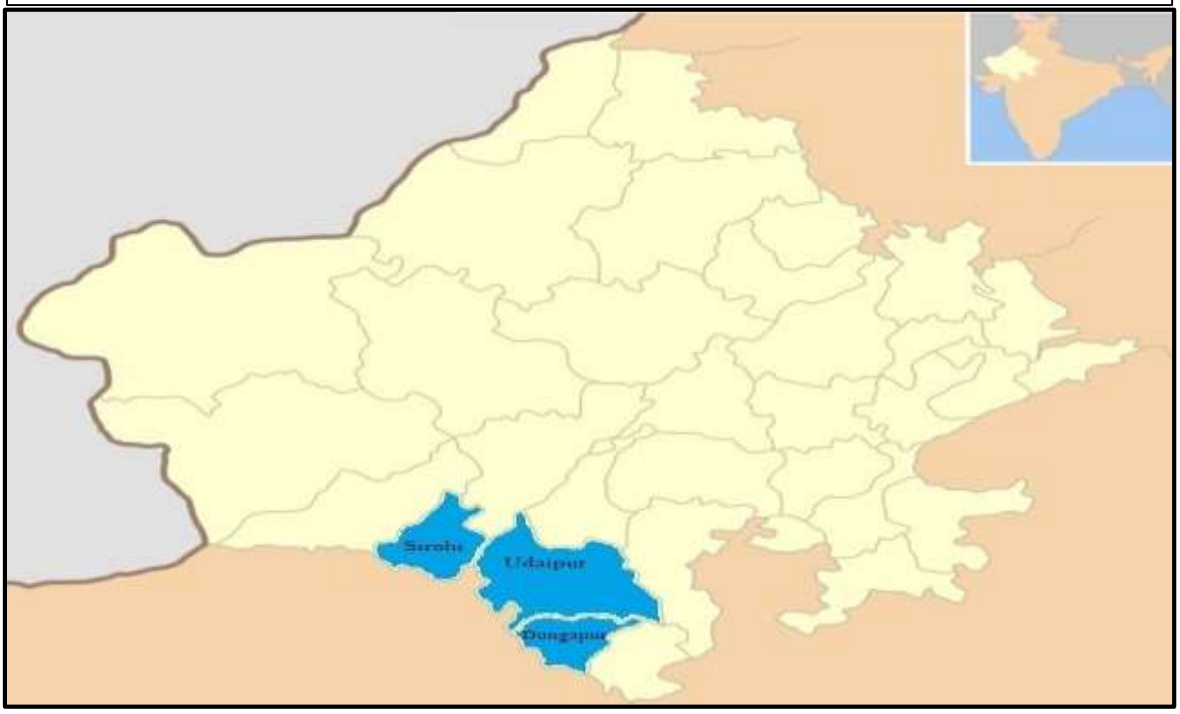
Following this, programmes were classified into two categories – (i)facility-based service and (ii) outreach service. This classification also overlapped with the two financing models. In the first category, the government paid the private provider on a per case basis, while they utilized their resources for service delivery. In the next category, the government bore the operational and capital cost for the service, while the private partner was responsible for managing the infrastructure and also the delivery of services. In the first category, the private sector owned the facility, while ownership was with the public sector in the second case. The two services identified under the first category were institutional childbirth and sterilization. The second category was the Mobile Medical

Services (MMS).[11] The selection of these three types of services was relevant because reproductive services were one of the focus areas of NRHM and MMS was an innovation under the Mission.

- Selection of Study Districts

Southern Rajasthan is a tribal belt that is marked by a low standard of living and poor access to healthcare. Based on the Standard of Living Index (SLI) mentioned in District Level Health Survey 3 (2007-08) and Human Development parameters from Rajasthan Human Development Report (2008) Udaipur, Sirohi and Dungarpur were selected as three study districts from southern Rajasthan (Table 1.6).

Fig 2: Map of Rajasthan with selected study districts (in blue)



[11] Rajasthan also has a PPP model for management of primary health centres. It was not included in the sample because during the data collection, the process had just started. It was also a state's initiative with no support from the central government.

Table 1.7: Demographic and health indicators of the study districts

Indicators	Udaipur	Sirohi	Dungarpur
Population (in lac)*	30.68	10.36	13.89
% of rural population*	80.2	79.9	93.6
% of tribal population*	60.3	58.8	74.4
Rural population service per PHC◉	29356	31828	27021
Under-five Mortality Rateα	98	90	84
Life Expectancy at Birth (in years) α	60.18	60.01	62.57
Human Development Index α	0.595	0.645	0.409
HDI Rank in the state (out of 33 districts) α	20	14	32
Source of data: * Census of Rajasthan, 2011; ◉ District Level Health Survey, 2007-08; α Rajasthan Human Development Report, 2008			

5.2.3 Step 3: Crafting Instruments and Protocols

Interviews, observations, and archival sources are common data collection methods for building theory from the case study. A plurality of methods is used for triangulation purposes which helps to substantiate the findings (Eisenhardt, 1989). In this thesis, three methods were used – (i) document analysis, (ii) in-depth interview and key informant interview, (iii) observation and non-formal interviews. The details are as follows.

- Document Analysis

According to Bowen (2009; pg 23), "documents of all types can help the researcher to uncover meaning, develop understanding and discover insights relevant to the research problem." Analysis of government documents may be an important starting point to capture the design and the status of the programme. The Annual Report of the health department, Government of Rajasthan, from 2010 to 2018, the Memorandum of Understanding for the three cases were reviewed and the central

government guidelines for the selected cases and the reports of the Common Review Mission (CRM) for the period between 2015 and 2018 were also referred. A thematic analysis of these documents was done to understand the design of the PPP schemes around four themes – the role of the private and public sector, interaction between the public and private sector and approach to services delivered.

- In-depth Interviews and Key informant interview

The interview is the most widely employed method in qualitative research. There are two main types of interviews – unstructured and semi-structured interviews (Bryman, 2012). In this thesis, both these methods were adopted. The in-depth interview conducted with private providers and public officials at the state and district officials were semi-structured in nature (Annexure 1). On the other hand, an unstructured approach was adopted for the key-informant interviews with the experts in the health sector of Rajasthan who could explain phenomena related to the operation of PPPs in the state. The tools for block and district level as well that of the private sector were piloted in Jaipur. The data collection was conducted in two stages – (i) July 2015- November 2016 and (ii) March 2018- August 2019.

- Non-participant observation and non-formal interview

The researcher also engaged in non-participant observation and non-formal interviews. Non-participant interviews were mostly collected when the researcher visited the clinics or accompanied the field team to the camps. The purpose of these visits was to observe the actual process of service delivery, the participation of the users and also the interaction between the providers and users.

To further substantiate the observation, the researcher also conducted informal interviews with the users. Such interviews were difficult to be recorded as there were no pre-decided tools. The researcher

took verbal consent from the users as most of them were illiterate. The data collected through this process was only used for informing the in-depth interview tools.

5.2.4 Step 4: Selection of respondents

Based on the objective, there are two categories of respondents who were purposely selected for the in-depth interview, from public and private partners. The public sector respondents comprised two levels – (i) those who were part of the governance structure like senior government officials in the administration at the state and district; and (ii) those who were responsible for the implementation of the selected PPPs at the state, district and block (Table 1.8).

Table 1.8: Number of public sector respondents: category-wise

State		District and below	
Designation	No.	Designation	Nos.
Level: Governance			
Mission Director	1	Chief Medical and Health Officer – 1 for each study district	3
Director Reproductive and Child Health	1		
Retired high-level government officials	5	Chief Medical and Health Officer (retired)from non-study districts	6
Level: Implementation			
Project Directors		Additional Chief and Medical and Health Officer for Sterilization 1/ study district	2
Maternal Health	1		
Family Welfare	1	Reproductive and Child Health Officer for Institutional Childbirth 1/ study district	2
National Health Mission (for MMS)	1		
State Demographer cell for sterilization	2	District Programme Managers 1 – for MMS	1
Consultant Janani Suraksha Yojana	1	District Accounts Manager – 1/ district - for MMS	6
Consultant Mobile Medical Unit	1	Block Chief Medical Officer/ CHC Medical Officer – 2/district	6
Retired government doctors from the selected blocks who were earlier responsible for the implementation of the P	4	Block Programme Manager - 2/each district	9
		PHC Medical Officer:2/ district	
		ASHA, ANM and AWW(for MMS) – 3/ district	12
Total	**13**		**49**

The private sector was represented by the head of the institutions. The staff of the organizations was also included as respondents where the head of the organization agreed. In most of the private for-profit hospitals, the researcher was not allowed to speak to the staff (Table 1.9a and b).

Table 1.9a: Number of private sector respondent for Reproductive Health Services: category-wise

Udaipur		Sirohi	
Designation	Number	Designation	Number
Type of service: Sterilization			
Not for profit organization -1 Project Manager Doctors in the Camp Nurse in the Camp Counselor Small Nursing Home Owners-3 Multi-speciality Hospital-1	 1 2 2 3 1	1.. Small Nursing Home – 1 in the district Gynaecologist & Owner Owner Gynecologist	1 1 1
Type of service: Institutional Childbirth			
1. Not for profit organization Executive Director Programme Coordinator Staff Nurses in the Clinic	 1 1 2	1. Small Nursing Home – 2 in the district Gynecologist Owner	 2 2
Total	**14**		**7**

Table 1.9b: Number of private sector respondents for Mobile Medical Services: category-wise

CSR Foundation – Udaipur		Trust – Sirohi		Not for profit Organization – Dungarpur	
Designation	Nos.	Designation	Nos.	Designation	Nos.
State Representative	1	Trustee	1	Executive Director	1
District Manager	1	District Manager	1	District Manager	0
Camp team (3members per camp) in 2 blocks	6	Camp team (3members per camp) in 2 blocks	6	Camp team (3 members per camp) in 2 blocks	6
Total	**8**		**8**		**7**

The respondents for key-informant interviews for the history of PPP in Rajasthan were selected through snow bowling based on the researcher's prior contacts in the field of public health in Rajasthan. This included retired government officials, representatives of renowned NGOs in the state. Few interviews were conducted with journalists and academics who are associated with the health care system in Rajasthan. A total of eight key informant interviews were conducted in Rajasthan and four in Delhi.

Before the data collection, the researcher informed the respondents about the purpose of the study and also sought written consent. Consent was also sought for recording the interview. Most of the private and public sector respondents agreed to take part in the interview but did not allow recording. So the researcher took extensive notes during the interview, which included quotes and also keywords, - which denoted themes. Once the interview was over, the researcher wrote detailed accounts of the information that was collected. The same process was followed for key respondents; however, they were more open to the recording of the interview. These were then transcribed into text.

5.3 Data Analysis

The process of data analysis began during the data collection phase itself which helped to shape the ongoing process. This sequential analysis or interim analysis was done to refine questions and pursue emerging avenues of inquiry in further depth. It also helped in identifying new respondents.

The data analysis was done in a stepwise manner for each objective. For the first objective, the documents were analyzed concerning the three functions of the health service system. Then the data collected from the key informant interviews were analyzed to build a complete picture. In the case of the second object, the MOU and other scheme-related documents

were analyzed. The data gathered from in-depth interviews were later added to that analysis. This was done separately for the two categories of respondents. Finally, it was triangulated using observational data. Based on these similarities and differences between the cases were identified.

5.4 Ethical Issues

When a social scientist embarks on a study of medical institutions there are tensions between the researcher and the subject; which invariably has a bearing on a gathering of data. This phenomenon is rooted in the professional identities of the two parties. There are three ways to approach this problem (Hoeyer, Dahlager and Lynoe, 2005). In this research two of these were used.[12]

1. To build a social relationship with the subjects: The researcher had experience of working with various state and national non-government organizations in the state of Rajasthan. So she already had a good rapport with the heads of these institutions. After the university approved the researcher's study, she also took up the job of a consultant, with the state government's health department, which allowed her to build contacts with government officials at the state and districts. By the virtue of working with the government, many of the private providers were also acquainted with her. These relationships were useful during data collection. Working with the public sector, the researcher was privy to several meetings with the national government in which many of the decisions about PPPs were being made.
2. To discuss the purpose of research and its benefits: Before every interview, the researcher informed the respondents about the objectives of the study. She also explained that it was academic research; and that the data collected would not be shared with any other respondents. Some respondents asked questions about the benefits of this research while

[12] The third way was to have a medical staff as a co-applicant. This was not possible in this research because it is a doctoral thesis; hence to be conducted by a single researcher.

others were critical. The researcher responded to all the queries to the best of her ability.

5.5 Limitation of the study

1. User perspective not included: This aspect was consciously avoided in this study because the focus was on the supply-side determinants of access. However, to capture the field realities the researcher used non-participant observation as well as non-formal interviews with some users during the fieldwork.
2. Non-cooperation by the respondents: In many instances, the researcher was not given the required information and many respondents were not willing to participate. For instance, some of the high-level government officials did not give an appointment to the researcher despite repeated attempts. Similarly, many private hospital owners did not permit the researcher to interview their staff. A total of 12 respondents across the different categories did not participate in the study.
3. Not allowed recording: Most of the respondents did only permit recording. This affected the richness of the quotes because it was not possible to write every word spoken by the respondents by a single researcher.
4. Lack of documented evidence: There was very little literature on the history of the health sector or the emergence of the PPP model in Rajasthan. The only way to bridge the gap was by conducting interviews.
5. Logistic challenges in the field: This limitation applied to the data collection of the Mobile Medical Services scheme. The scheme covered almost all blocks of the districts, but the researcher could not visit the remote ones because they were far from the district headquarters and also there were no boarding and lodging facilities available in those locations.

Section 6: Chapterization

This thesis has the following chapters :

- Chapter I: Introduction
- Chapter II: Content and Context of Public-Private Partnership in the Health Sector of India
- Chapter III: Overview of Public-Private Partnership for healthcare in Rajasthan
- Chapter IV: Public-Private Partnership for Reproductive Health Services in Rajasthan
- Chapter V: Public-Private Partnership for Mobile Medical Services in Rajasthan
- Chapter VI: Discussion and Conclusion

Chapter II: Content and Context of Public-Private Partnership in the Health sector of India

"*Public-private partnerships should generally be viewed as social experiments that are attempting to learn how to tackle intractable health problems in better ways."* [Roy Widdus, 2001, pp.718]

Healthcare, unlike other goods and services, is susceptible to market failures which qualify it as a public good. Conforming to this principle, the design of an organized health system post World War II in most countries was publicly financed and provided; which integrated primary, secondary and tertiary levels of care. During health sector reform, as the neo-liberal principles challenged the notion of the welfare state, structural and functional transformation took place in the public health system. The process of commercialization played a key role in shaping the initiatives under the rubric of health sector reforms. Public-Private Partnership (PPP) was an important strategy of reforms globally as well as in India.

According to the World Development Report 1993, which is unequivocally accepted as the first blueprint for health sector reforms across the globe, facilitating the involvement of the private sector was one of the reform strategies (Basch, 1999). Two avenues were proposed for this – (i) encourage private financing and provision of insurance and (ii) encourage private sector delivery of clinical services, including those that are publicly financed. While both these qualify as a Public-Private Partnership model of healthcare, this thesis focuses on the latter. Rooted in the neo-liberal principles, this meant, limiting the role of the state to that of a purchaser and enabler of health services, while delivery was to be done by the private sector.

Indian policymakers, during independence, had envisaged a public health system that will provide *no-cost* care to all sections of people. This

vision got lost in translation. Instead what emerged was a health system with a dysfunctional public sector and a wide private for-profit sector ranging from formal to informal providers as well as private non-profit organizations. When India embarked on the reform process, the then policymakers uncritically accepted the role of these non-state actors and engaged them in the delivery of health services at all levels of care throughout the country. Different models of PPP were adopted which varied in the nature and roles of the two sectors, as well as, in their intended outcomes. Since then PPP strategy has been a part of various national health sector policy documents.

Although the reform process is officially complete, the relevance of PPP continues. This is evident in the current National Health Policy, 2017 (GoI, 2017; para 3.3):

> *"Free primary care provision by the public sector, supplemented by the strategic purchase of secondary care hospitalization and tertiary care services from both public and from the non-government sector to fill critical gaps would be the main strategy of assuring healthcare services".*

Aimed at understanding the role of PPPs in the delivery of health services two aspects – content and context are covered in this chapter. The first section unpacks the content of PPP. The second section describes the context of PPPs in healthcare in India. For that, the evolution of India's health system through the lens of changing roles of the three categories of actors – state or public, private for-profit (PFP), and private non-profit (PNP), has been traced. The discussion is divided into three time periods starting from independence till date. The third and final section critically analyses the different theories that explain the PPP model of service delivery.

Section 1: Unpacking the content of PPP in the health services

1.1 Meaning of the term PPP

At the onset, it is important to declare that there is no authoritative definition of the term 'Public-Private Partnership' (PPP) resulting in a 'terminological quagmire' (Kapilashrami, 2010; pp 17). There are multiple interpretations of the term because of the varied context in which PPPs emerge, their purpose, the models, and the nature of partners as well as their respective roles in this arrangement (Weihe, 2006). The desired starting point is, therefore, to proceed from a generic understanding of partnership in the health sector to one which is specific to India's public health system.

- Public Sector

In the term PPP, 'public' refers to all organizations financed and controlled by the government (Reich, 2000). Generally, the public sector performs all three functions of the health system – service delivery, financing and regulation. But, this thesis will include those governmental organizations responsible for financing and stewardship functions, provided those in service delivery have some additional role in the other two functions.

The public sector in India encompasses a broad range of actors from legislative and executive pillars of the government performing a different function of the health system. Broadly, there are two levels of organizations – central and state. Although as per the Indian constitution health is a state subject, it has some components which come under the central government's control. The overall planning of the health system has been led by the Ministry of Health at the center. Besides, it also partly finances different national health programmes that are implemented across the country. Three types of projects/schemes are funded by the Ministry – central sector projects, additional central assistance, and centrally

sponsored schemes (Duggal and Gangoli, 2005). Thus the central government has a key role in stewardship and financing functions. For this there is a two-winged administrative structure – secretariat comprising of officers from the administrative cadre while the directorate has professional experts mostly trained in allopathic medicine[13]; the latter is subordinate.

A similar structure of the public sector prevails at the state level. There is a Directorate of Health Services (DHS) which is headed by bureaucrats and technical officers under the overall leadership of the Health Minister. The DHS performs dual responsibility of planning state-specific intervention as well as spearheading the implementation of national health programmes designed and financed by the central government. The officials at the state headquarters perform the task of planning and oversight, while there are agencies at the district and sub-district level that have a dual role in both regulation and partly in financing. However, the actual scope of involvement of each of these bodies in the planning and execution of PPPs dependent on the scheme-specific guidelines as well the overall policies guiding the sector[14]. The role of state and district bodies increased under the National Rural Health Mission because there was an explicit push for decentralized planning; although the practical devolution of power is yet to be ascertained.[15] Besides, the 14th Finance Commission promised devolution of tax revenues to the state which enables states to

[13] In India, there is a separate ministry for indigenous systems of medicine, known as the Ministry of AYUSH. This is not a part of this study.

[14] Health sector reforms, driven by the principles of New Public Management, promoted agencies for specific health programmes like State Tuberculosis Control Society was formed under the State Tuberculosis Control Society was formed under the Revised National Tuberculosis Control Programme (RNTCP), State AIDS Control Society (SACS) for National AIDS Control Programme (NACP). Similar district level agencies were also formed under different programmes. These bodies were constituted with government staff. Although these were under the health department, were given functional autonomy to take decisions regarding the programmes, in their specific context. This process, known as agencification, is to disassociate the function of policy formulation to that of policy implementation. See Singh, 2007.

[15] With the launch of the National Rural Health Mission (NRHM) in 2005, the state government was given space for creating state specific plans which were to be based on plans prepared at the village, block and district level. This decentralization of the planning process intended to address the state specific needs of health service (Mavalankar, 2008).

allocate resources as per their requirement (Mukhopadhyay, 2019). Thus the state governments also had a role in the financing of the central sector and centrally sponsored scheme.

For primary level care in the rural area, Panchayati Raj Institution at the village, block and district is also important. Although these bodies came into existence after the 73rd Amendment of the Constitution, in 1992, the elected representative did not have much role in health services. With NRHM, the elected representative got a platform to engage with the health department through the Village Health, Sanitation and Nutrition Committee.

Last but not the least, there are parastatal bodies that are engaged in policy formulation. From 1950 till 2014, policymaking was directed by the Planning Commission of India. Those plans along with the budgetary allocations were the basis for the schemes designed by the Ministry of Health (Rao, 2017). In 2015, the ruling political party decided to abolish the Commission. A new body was established, National Institution for Transforming India (NITI) Ayog, to advise the government about development policies. However, the relevance of NITI Ayog in the context of planning is relatively less because, unlike the Planning Commission, it is not a constitutional body and does not have the power to allocate funds (Maira, 2019).

This elaborate description of public sector actors may not be exhaustive but it is sufficient to conclude that the public sector is not a monolith. It consists of several tiers of cadres and officials who have and can play some role in the process of designing and executing PPPs. Hence, the perceptions and experiences at all tiers of the health system hierarchy need to be captured to understand the characteristics and working of this strategy. Another purpose of this description is to question one of the assumptions of New Public Management (NPM) from which the concept of

PPP emanates. The NPM paradigm criticized the bureau-professional nature of the traditional public system and buttressed a techno-managerial model. But the given description explicates how the control of the bureau-professional approach continues to prevail and perpetuate. [16]

- Private Sector

All organizations and individuals working outside the direct control of the state are clubbed under the category of the private sector. The WHO divided the private sector into two categories (i) for–profit (henceforth PFP) institutions and individuals whose explicit motive is to seek profit and (ii) not for profit/ non-profit (henceforth PNP) commonly known as Non-Government Organizations (WHO, 2000).

In India, the PFP ranges from individual healthcare providers, across different systems of medicine, paramedics, private hospitals and nursing homes (run by a single doctor or a group) and corporate hospitals. There are also subcategories within the PFP sector – formal and informal. While the latter is especially relevant in the context of the rural area, most programmes, except RNTCP, do not consider them eligible for partnership.[17] The PNP (commonly referred to as NGOs) are those organizations registered as not for profit/ non-profit entities under Societies Registration Act/ Indian Trust Act/ Companies Act/ Income Tax Act.

This classification is also used by Indian policymakers. For instance, the Working Group, constituted by the erstwhile Planning Commission, on PPP to improve health care delivery for the 11th FYP Plan period (2007-2012). Two types of partnerships were recommended:

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[16] All the organizations formed, namely district and state health societies, still maintain that characteristics with bureaucrats followed by the medical professionals playing a lead role.

[17] Under the RNTCP, many informal private providers were engaged in identification of cases as well as to provide DOTS (Directly Observed Treatment Short Course) at the doorstep. See Uplekar, 2003.

- Between government and for-profit sector: Services included in this category were drug stores, operation and maintenance of MRI and CT Scan machines, mobile hospitals for health care and diagnostics, disease-specific Information Education and Communication (IEC) services, non-clinical services in tertiary and secondary level public health facilities, insurance.
- Between government and non–profit sector: Awareness generation under vertical programme (mainly RCH), provision of clinical and non-clinical care, managing health centers in the rural and urban area and emergency ambulance service were some of the services under this category.

The above categorization of the private sector was based on the source of funding. Organizations that generate funds from user charges are considered to be PFP while those which offer free-of-cost services to the users or charge very nominal fees, but access other sources of funding, are the PNP. As per recent data, the majority of the health services are provided by single doctors (73%) in the for-profit category (Hooda, 2015). The contribution of the PNP sector in the delivery of health services was insignificant. Only one and nine percent of such institutions run hospitals and outpatient services respectively (Das and Kumar, 2016).

The binary classification of the private sector as for-profit and nonprofit has come under scrutiny because there are no definitive criteria for for-profit and non-profit organizations. On one hand, there are many tertiary private hospitals registered as non-profit entities but its cost structure, management style salaries and incentives are as per the corporate hospitals (Baru and Kapilashrami, 2019). On the other hand, the corporate firms and big industrial houses are starting their PNP units, referred to as Foundations, to transfer the entire Corporate Social Responsibility budget that they are legally mandated to spend (Kumar, 2016). Also, there are examples of PNP organizations who have jettisoned their earlier approach

towards community empowerment and started to work as 'brokers' for the private sector (Hunter, 2016).[18]

This classification of private based on profit also masks the differences in the characteristics of organizations within the category. For instance, clinics managed by individual doctors in a slum location are classified as PFP because they generate revenue from user charges, but unlike the other organizations in this category, the cost of care is much less than the cost of out-patient care available in corporate hospitals. They are more similar to the charitable hospitals which levy nominal user charges but are considered to be PNP. Moreover, different types of organizations are also subsumed under the category of PNP. While some are working directly with the community while others are working through these smaller organizations, fostering an inherent hierarchy within this sector.

This description of the private sector in the Indian context has two implications for the present study. First, *a priori* classification of the private sector as PFP and PNP cannot be used. Instead, all types of private sector engaged in the PPP scheme, within the study districts, are included. Second, the study attempts to arrive at a more nuanced categorization of the private sector organization based on their capacities and motivations to address the supply-side barriers to access as well as their perception of inequities in access.

- International Donor Organizations

Besides the two main parties in a PPP arrangement, i.e. the public and private sector, the international/ multi-lateral/transnational organizations also played a crucial role in promoting and brokering partnerships. Health sector reforms were undertaken as part of the Structural Adjustment Programme funded by the WB and IMF for the

[18] In the Sambhav Scheme (voucher scheme for institutional childbirth and other reproductive health services) funded by USAID in Uttar Pradesh, NGOs were given the task of motivating women from the lower income settlements to utilize private facilities empaneled under the scheme. These NGOs were also incentivized with additional resources if they could increase the utilization of the private facilities.

developing countries. The World Bank also directly fostered changes in India's public health system during this era through state-specific health sector development projects catering to secondary and tertiary care and revising different national health programmes for primary level care. PPPs were a common feature in all the projects supported by these agencies.

The World Health Organizations' role in the process of reform became evident from the year 2000 with the establishment of the Commission on Macroeconomics and Health which also explicitly encouraged the role of the private sector in different spheres. A similar commission was also formed in India, funded by the WHO, which also heralded the views of the global predecessor. The organizations under the United Nations and the donor agencies from the developed western nations also aligned their efforts to facilitate the reform process. The role of these organizations is in strategic planning, facilitation, resource mobilization to support implementation and in research for advocacy (Kishore, 2017). Donors, like the Department for International Development (DFID), United Nations Population Fund (UNFPA) and Bill & Melinda Gates Foundation (BMGF) supported the National Aids Control Programme which was supported by (Rao, 2017). External funding, by UNICEF and other United Nations agencies, for some components of Reproductive Child Health Programme like immunization, management of childhood diseases, was also visible. DFID has also supported the National Polio Eradication Programme and the Revised National Tuberculosis Programme (Kishore, 2017). Many other international donor groups offered grants to PNPs to design and implement projects in line with neoliberal reforms.

It merits mention that these organizations contributed less than two percent of the total health spending. Moreover, their projects are often not grounded in Indian reality. Despite that, these international agencies wielded power over Indian policymakers (Rao, 2017).

- Defining partnership

The term partnership has been defined in myriad ways in literature, so it is difficult to choose a single definition. First, those definitions are presented that are not specific to health sectors to understand the features of a PPP. UNDP (2003) defines it as "voluntary and collaborative relationships between various parties, both state and non-state, in which all participants agree to work together to achieve a common purpose, or to undertake a specific task and to share risk, responsibilities, resources and competencies and benefits" (Weihe, 2006; pp 8814). According to the World Economic Forum (WEF), PPP is "…a form of agreement [that] entails reciprocal obligations and mutual accountability, voluntary or contractual relationships, the sharing of investment and reputational risks, and joint responsibility for design and execution" (Venkat Raman and Bjorkman, 2009). Paoletto defined it as "collaborative efforts among interested groups based on mutual recognition of respective strengths and weakness, working towards commonly agreed objectives developed through effective and timely communication" (Paoletto, 2000; pp 725) According to Dickinson and Glasby, a partnership is "negotiation between people from different agencies committed to working together over more than the short term; aims to secure the delivery of benefits or added value which could not have been provided by any single agency acting alone or through the employment of others; and included a formal articulation of a purpose and a plan to bind partners together" (Hunter and Perkins, 2013; pp 53).

WHO views PPP as a "means to bring together a set of actors for the common goal of improving the health of a population based on the mutually agreed roles and principles" (WHO, 2000; pg 12). As defined by Asian Development Bank (2010) "partnerships are useful ways of engaging a wide range of stakeholders and non-government organizations in achieving the complex set of objectives in health (Mehta, Bhatia and Chatterjee, 2010).

From a review of these definitions, two features of partnership need to be highlighted. These are core to the problem of inequities in access. First, all literature alludes to a common goal, but none of them clearly defines the goal. Second, there is a notion one partner is to compensate for the other partners' lacunae. Thus there is an implicit assumption that both partners lack something as well as have something to offer in the partnership which will help to bridge their internal gaps. But, there is hardly any mention of what characteristics comprise strengths and weaknesses. Third, values like trust, transparency, and accountability are prerequisites of a PPP approach, but these terms have not been specified either. It can be argued that the definitions are purposely kept loose so that they can be customized for a given geographic region as well as for a specific thematic area.

The Indian government's stand on PPP for the health sector can be understood based on different government documents. The Planning Commission Subgroup for PPP in Social Sectors (henceforth Subgroup) first defined the term partnership in their report in 2004. According to the Sub Group, PPP is "a mode of implementing government programmes/ schemes in partnership with the private sector (corporate sector/ voluntary organization/ community-based organizations/ individual institutions) while the responsibility for providing the services rests with the government" (GoI, 2004, pg 4).

Yet another definition of PPP, specific to the health sector, issued by the Ministry of Health & Family Welfare described PPP as 'collaborative efforts between public and private sectors, with clearly identified partnership structures, shared objectives, and specified performance indicators for delivery of a set of services in a stipulated period' (GoI, 2005). While the Task Force on PPP for the 11th Five Year Plan (2007-12) upheld this definition, it added the following specific objectives (GoI, 2006; pg 10-16):

- *Universal coverage and equity for primary health*
- *Improving quality, accessibility, availability, acceptability, and efficiency*
- *Exchange of skills and expertise between the public and private sector*
- *Mobilization of additional resources.*
- *Improve the efficiency in the allocation of resources and additional resource generation*
- *Strengthening the existing health system by improving the management of health within the government infrastructure*
- *Widening the range of services and number of service providers.*
- *Clearly defined sharing of risks*
- *Community ownership*

These objectives were narrowed down to two key objectives by the Reconstituted Task Group on PPP under National Rural Health Mission (GoI, 2006). These were strengthening the public sector and expanding the pool of health professionals. The group clearly stated that partnership with the private sector should be considered as a strategy in addition to the efforts for improving the public health system like the expansion of healthcare providers at all levels.

> "*While not ruling out meaningful partnerships with non-governmental providers for meeting public health goals, there is no getting away from a well-funded, well-functioning, effective and efficient public sector in health care at all levels – from the village, the sub-center, the PHC, the CHC to the district level.*" (GoI, 2006, pg 12)

This Task Group contemplated various approaches to ensure minimum service guarantee in partnership to deliver healthcare in remote areas where public services were hardly existent. For engaging the PFP sector, accreditation of the already existing providers based on cost and protocol as well as giving them some cash incentives, while for the PNP sector would require 100% grant-in-aid were suggested.

Besides allocating a portion (at least 5%) of the budget (for fostering PPP, the Task Group also emphasized the need for a dedicated regulatory body at the state level to ensure transparency, trust, standards, and

regulation. Gathering evidence of PPPs across the country it strongly opined that this body was not only to oversee the private sector's role but also pursue the problems within the public sector that shape the partnership arrangements; which have adverse implications on the delivery of services.

The Mission Document of the National Rural Health Mission (GoI,2005; pg 9) also mentioned the PPP strategy for achieving public health goals. The features were as follows:

- Refine regulation mechanisms and reform regulatory bodies
- Representation of private sector in the District Programme Management units
- Develop guidelines for PPP in the health sector for identifying areas of partnership, which are need-based, thematic and geographic
- The Public sector has to play a lead role in defining and sustaining partnerships.
- Design management plans for PPP initiatives at the district/ state and national levels.

A critical reading of these definitions from the global to the national and overtime is required to understand the form of partnership that exists in the health sector in India. Features like collaboration, shared objectives and value addition were common to the definitions of partnership globally and in India, but the aspect of regulation was seen only in Indian documents. However, a key gap in both the global nor the national document was the lack of clear outputs. From the definition, it appears that forming and sustaining the partnerships were the only desired output.

There has also been a discernible change in the perspective vis-à-vis the role of each partner as well as the overall goal of the partnership. In India, PPP, initially, was merely a mode of implementing government programmes. Later aspects of collaborative efforts, clearly identified partnership structures, shared objectives, and specified performance indicators were also included. Besides, budgetary allocation and regulation were also included. Notwithstanding these modifications, the clarity of the definition of the term continues which allows for multiple interpretations. These interpretations vary across as well as within the different categories of partners.

1.2 Contracting as a form of Public-Private Partnership

PPPs can be defined operationally based on the forms of relationships between the partners. The most common form of partnership in the delivery of health services under the New Public Management paradigm is contracting, so it is discussed in detail. Also, for primary level care, this is the preferred form. Contracting can be defined as a normal market exchange of services in which a written agreement specifying the terms of the exchange, also known as the contract, is signed by the buyer and the seller (McPake and Banda, 1994). This is required to institutionalize the inter-relationship and also legitimize the roles of the partners.

The Planning Commission Sub Group and later the Task Group recognized that contracting is the predominant tool for PPP in the delivery of health services in India across different levels of care as well as the nature of services. The draft National PPP Policy, prepared by the Ministry of Finance, GoI (2011) also mentions contractual arrangements between the public and private sector for social sectors, which include health, under the Annuity Model (GoI, 2011; pg 6).

> In sectors/projects not amenable to sizable cost recovery through user charges, owing to socio-political-affordability considerations, such as in rural, urban, health and education sectors, the government harnesses private sector efficiencies through contracts based on availability/performance payments.

1.2.1 Types of contracting in India

Broadly contracting can be divided into two types – contracting out and contracting in. There is another type of contracting which is used in the case of strategic purchasing of services. This is a means for forging partnership when the public facilities have low utilization rates, are difficult to manage due to systemic deficiencies, are in remote and inaccessible areas, and need to increase community involvement (Venkatraman and Bjorkman, 2006).

There are different options for contracting out of services (*ibid; pp. 56-58*):

- *Option 1:* The government hands over the physical infrastructure, equipment, budget, and personnel of a health unit to a service provider. Here, the terms of a partnership are fixed by the government.
- *Option 2:* The government hands over the physical infrastructure, equipment, and budget, but the staff is recruited by the selected agency. Here, the terms of the contract are fixed by the government.
- *Option 3:* Government hands over the physical infrastructure, equipment and budget. The selected agency has the freedom to decide on the personnel and service delivery model, but the overall principles of public services apply.
- *Option 4:* Government hands over the physical infrastructure, equipment and budget. The selected agency has the freedom to

decide on the personnel and service delivery model. It is also permitted to expand the types of services provided and charge user fees to recover some proportion of the cost.

In India, different states have experimented with the second option of contracting out to strengthen primary care institutions. This includes handing over Primary Health Centers and Mobile Medical Units to the private sector. Emergency Referral Services come under this category. For some secondary and tertiary care institutions, the fourth option is preferred. Rajiv Gandhi Super Specialty Hospital in Raichur, Karnataka is one such example. Although the latter is outside the remit of this thesis, the autonomy accorded to a private player delivering primary care is less than their counterparts in secondary and tertiary care.[19]

The opposite of 'contracting-out' is 'contracting-in'. This method has been used for non-clinical services like cleaning, diet and security as well as for support services like diagnostics in secondary and tertiary care public institutions. It is important in the context of the Indian health sector because this type of contracting was the first to be introduced in almost all states. Yet another form of contracting is when the private sector uses its infrastructure and human resources to deliver health services mandated under the government programmes/ schemes and receives a fixed amount for each user. This form of partnership referred to as strategic purchasing, is being used in some national health programmes like Chiranjeevi Yojana and mainly for government-sponsored health insurance schemes (Saha, Panda and Gaurav, 2018). Despite the challenges in executing this form of partnership, the same was suggested by the High-Level Expert Group for Universal Health Coverage.

[19] For the PPP at primary level care, the government plays the role of a financier and exercises more control over the private partners engaged for delivery of services. The private sector works according to design prescribed by the government PPPs in which the secondary and tertiary facilities are handed over to the private sector, there is joint financing, so both partners have some control over the functioning of the institutions. In other words, these private partners enjoy relatively more autonomy than those who are delivering services at the primary level.

1.2.2 Features of Contracting

While there is plurality in the forms of contracting, there are some features, common for all, which is necessary to ensure that the PPP strategy meets the objectives it is intended to. Advocates of PPP used contracting as a means to establish an inter-organization relationship with the premise that it could stimulate focus on quantity, quality and cost of care, instill competition which in turn will increase the operational efficiency, increase the consumer choice by expanding the service base (Ashton, Cumming and Mclean, 2004). However, to achieve these benefits some key features need to be taken into account (Venkatraman and Bjorkman, 2006; Mills, Bennett and Russel, 2001; Mills and Broomberg, 1998).

The decision to contract is an important starting point of all contractual relationships which encompasses key issues like the nature of services that are contracted, factors that influence such a decision, availability of potential contractors for the task, decentralized decision making. There are broadly two types of services – clinical and non-clinical.

Contract design is important to specify the terms of the contract, pricing, duration, and compliance. For contract specification, there is a need for clarity on inputs like staff, building, types of equipment, staffing; the process of delivering services, also known as the throughputs; and finally, the output indicates the tangible information about the services provided. There are also quality parameters but due to difficulty in measurement, it is generally avoided.

Contract pricing is based on the volume of services and the preferred approach for paying for the service. It is either based on outcomes or the process. It also delineates the mode of payment like block contract, fee-for-service, or cost and volume. All these have their share of drawbacks which are discussed in the next sections.

The duration of a contract can be either short-term (one to two years), which has greater chances of generating competition, or it could be a long-term contract. Finally, compliance is either based on sanctions which means that the contractor abides due to the fear of penalty, or trust-based which happens when both the contractor and the purchaser have shared value. In short, the design of a contract is a complicated process, especially in the case of health services.

The process of implementation starts with an invitation for bidding. The selection of the contractor may be based on competitive or non-competitive bidding. This depends on the type of service being contracted, its volume, the number of contractors required. Once selected the payment to the contractor as per the agreed terms is important for the contractor to deliver services accordingly.

Monitoring and accountability measures are important features to understand the partnership model. The contractor is bound by certain monitoring standards. When these are not very specific, it is difficult to assess the contractor's performance. Besides, it is linked to the regularity of the process of monitoring which is based on information shared by the contractor as well as periodically by the government staff.

Regulation involves three key functions, accreditation, enforcement of protocols and quality assurance (Ejaz, Shaikh and Rizvi, 2011). Some regulations are specifically for the selected contractor like the wages of the staff and other facilities. The nature of regulation is one of the deciding factors for the willingness of the private sector to partake, which is necessary to ensure competition. However, the extent of regulation by the state is premised on its ideological moorings.

Trust between the partners, which is based on, shared values and culture is another key factor for the success of contracting. There are three types of trust – (i) contractual, (ii) goodwill and (iii) competence. While it

requires a long-term relationship to build trust, it is more effective in short-term relationships. Trust in long-term relationships risks becoming cozy and collusive affairs giving rise to problems that may adversely affect the joint working and innovations (Glasby and Dickinson, 2008).

1.2. 3 Challenges with Contracting

Based on the above themes some challenges emerge from studies related to contracting from different countries; most of these are also evident in the Indian context.

- Authority in decision making:

According to proponents of contracting, one of the limitations of the public sector is that the over-centralized bureaucracy was not responsive to the needs of the people. As the private sector was considered to be more responsive, engaging them was recommended as a solution to deliver public services. While this approach to deliver services was accepted, the decisions regarding the contract were taken at the national or state level (Hunter and Perkins, 2013). It was further influenced by international donors (Palmer, 2000). Thus, the top-down approach of traditional public management prevailed in this model as well.

The PPP arrangement in India, especially under the national health programmes for primary level care, was mostly prepared by the government, at the national and state level. There was hardly any scope for negotiations by the private sector on different aspects of services. Studies have shown that when the private partners initiated the contract it was disregarded by the public sector and finally the private sector had to sign the contract that the public sector had designed (Baru and Nundy, 2008).

When the power in partnerships is biased towards the purchaser, which is a government in the case of PPP, the provider's autonomy is

restricted (Mathur, 2013). This phenomenon – known as institutional isomorphism, was put forward by DiMaggio and Powell (1983). It is defined as 'a constraining process that forces one unit of the population to resemble other units that face the same set of environmental conditions' (*ibid*). The obvious effect is that professional decision-making was once again overtaken by bureaucratic mechanisms (Hunter and Perkins, 2013).

As argued by Mc Donald(cited in Hunter and Perkins, 2013; pp 28);

> *"Partnerships are nothing more than a mechanism for nullifying dissent thorough incorporation and used by elites to keep power and reinforce existing power relation. Partnerships do little to empower users and divert resources away from welfare delivery."*

- Competition

One of the justifications for replacing the direct provision by the public sector was premised on Property Rights theory. The theory argued that the public sector is dysfunctional because it is sheltered from competition. So, contracting was the preferred tool, as it fostered competition. While competition is also possible within public sector institutions as seen in Nordic countries, the importance accorded to competition and choice in the neo-liberal paradigm is largely to drive pro-market policies (Hunter, 2011). Moreover, effective competition also required an adequate number of potential bidders. It is difficult to ensure it among healthcare providers because of a plurality of reasons. One of the reasons was that the private sector generally tends to settle in a particular area and was reluctant to move (Palmer, Strong and Wali, 2006). It is also not desirable to move the contractors because there is a need for local knowledge.

In India, this strategy was being implemented in all districts with no consideration of the availability of potential private providers. Referred to as the '*cookie-cutter'* approach, is especially a challenge for the remote blocks (Gupta, 2011). The officials also did not account for the condition of the public sector institutions already delivering services. For instance, in certain states, the strategy was adopted for the delivery of diagnostic services in all public hospital facilities; even the ones where the human resources were already in place.

The competition in the case of health service PPP is difficult also because benchmarking services in terms of cost and quality is not always possible. The government uses characteristics based on entry-level conditions, which are minimum requirements with more emphasis on the financial bid. In India, the government tends to select the lowest bidder to fulfill the audit requirements, rather than service delivery objectives (Venkatraman, 2014). So, many private players purposely maintained a low price to win the contract (Palmer, Strong and Wali, 2006). Once selected, these providers also compromised on the services by deploying less than committed resources (Venkatraman, 2014). Dees (1995) observed that organizations that have a deep sense of values and social mission do not take part in the bidding process unless the goals of the partnership are clear and compatible with the organization's mission (Palmer, Strong and Wali, 2006).

Most of the private sector organizations were motivated to join the bidding process to gain sustainability and legitimacy by working for the government (Hunter and Perkins, 2013). The PFP sector took part only when they could gain legitimacy without compromising on their professional autonomy (Zurbrigg, 1984). It also made it easy for them to access different subsidies that would help to increase their profit margins. For the PNP sector, the motivation to partner was derived from the fact by aligning with the public health goals they were able to mobilize resources

from both the government and international organizations (Sundar, 2010). This, in turn, could help them to expand in size and emerge as a 'visible' entity (Anand and Sinha, 2013).

In 2003, the Government of India established the Competition Commission. This body is mandated to eliminate those practices that adversely affect competition and to promote and sustain competition so that the interests of consumers are protected and freedom of trade in the markets of India is ensured. According to the policy note titled *Making Markets Work for Affordable Health Care,* the Commission has focused on four issues. While three of these are related to the pharmaceutical industry, one is about the vertical arrangement in healthcare services. Notwithstanding the narrow recommendations by the Commission on the issue, there is an explicit acceptance that competition among private healthcare providers is non-existent in India due to appropriate regulatory mechanisms (Competition Commission of India, 2018).

- Regulation of the private sector

A competition-based model that delivers the best possible healthcare is notional and does not apply to the health sector unless there is appropriate regulation of the market. Regulation is the health system function which the government is expected to perform, but has been considerably neglected in countries across the globe (Das Gupta and Muraleedharan, 2011). This has been observed in the case of National Health Services in the United Kingdom that the government's growing reliance on the private sector has led to weakening the capacity of the former to regulate the latter (Hunter, 2016).

It was also assumed that transferring the service delivery function to the private sector would reduce expenditure on that account and more resources will be available for strengthening the regulation. However, practically the contracting increased the transaction cost for the public

sector (Mills, Bennett and Russell, 2001). Besides, the Structural Adjustment Programme led to a budget cut for the public health system; which meant that the amount allocated for conducting regulation was less. With no new recruitment in the public sector taking place, the staff overburdened, with their existing tasks, had little opportunity to conduct any regulatory activities.

Earlier efforts to regulate the private sector, in India, was not very effective because a significant proportion of doctors in the public sector had stakes in the private sector and resistance from para-statal regulatory bodies that supported the commercial sector (Das Gupta and Muraleedharan, 2014).

- Capacity to design and manage contracts

Designing and managing contracts are complicated processes that often suppress the benefits of the contracting process. The studies on PPP in the Indian health sector by Venkatraman and Bjorkman (2006) found that the public sector officials did not have the required capacity to design contracts so transaction consultants were engaged. These consultants had limited understanding of equity, access, clinical standards and technical complexities related to public services. Thus the contracts designed by these consultants did not address the needs of the health sector. There were other challenges like lack of verifiable performance indicators and bottlenecks that exist in the public system that delayed the release of payment (Rao, 2017). Thus, the public sector was lacking in its preparedness to create, govern and sustain these partnerships.

From the review of literature, it is clear that the model of contracting, with the public sector as purchaser and private as the providers, may not be able to address the problems that exist in the working of the public and the private sectors. On the contrary, it bred newer challenges, which adversely affected the problem of inequitable access to health services. On

one hand, there was a further fragmentation of the health system and on the other hand, accountability of the providers diminished.

Section 2: Context of PPPs in the Indian Health System

The process of inculcating market-oriented changes in the public sector began with the World Bank's Structural Adjustment Programme (SAP) in the 1980s in most developing countries, premised on three principles of deregulation, liberalization and privatization (Birdsall, 2000). Since the report titled 'Structural Adjustment with a Human Face' was published in 1987 it became evident that to achieve the goals of SAP targeted social programmes and safety nets for the vulnerable were necessary (Greshman and Irwin, 2000). Thus health sector reform was conceived to improve the functioning of the public health system.

The reform was a global phenomenon defined by the World Health Organization (WHO) as a sustained process of fundamental change in policy and institutional arrangements of the health sector, usually guided by the government (WHO, 2000). Driven by neoliberal ideologies, there were two underlying agenda for these reforms in developing countries – to reduce public spending on health and to facilitate the expansion of markets for medical technologies developed in the industrialized nations (Qadeer, 2008). For that, it proposed that the government should be focusing on two functions – financing and regulation, while the task of delivering curative services at the tertiary and secondary level to be transferred to the private sector.

Therefore, to understand the context of the PPPs it is important to take a historical view of the changes in the public sector as well as in both types of private sectors – PFP and PNP in India since independence. The evolution is divided into three phases associated with the reforms – the pre-reform era from independence until 1990, the reforms era between 1990 and 2005, and the post-reform era from 2005 till date.

2.1 Pre reforms era: from independence till 1990

The era started with a grand vision to build a comprehensive public health system that was publicly financed and provided, but the policymakers permitted the private doctors to continue their practice with the assumption that once the public health system was established, these private providers would automatically recede (Baru, 2019). Till the mid-1970s, the public health system focused on secondary and tertiary care along with national health programmes directed towards a few communicable diseases and population control. As a result, primary-level care was neglected.

The private sector that existed during independence seized this opportunity to emerge as an important provider of curative primary level care through outpatient services. These providers, representing the PFP sector, included both registered practitioners of allopathic medicine as well as those who did not receive any formal training. The Mudaliar Committee (1959) proposed to encourage private practitioners to admit their patients in public hospitals (Qadeer and Baru, 2016). This was the first attempt to formally allow the private sector involvement in the public health system.

By the 1970s, the importance of PFP institutions in providing healthcare increased. Not only did the PFP sector grow in absolute numbers, but some primary providers also started small nursing homes to provide in-patient services (Baru, 2002). This phenomenon can be attributed to deteriorating public health services at all levels of care due to sustained underfunding by the government for the public health system, emerging demand for better health services from the elite and middle classes in rural as well as urban areas, subsidies to the private sector from the government through medical education and monetary concessions (Qadeer, 2011). The growth was however not uniform; most of them were

in the urban areas and also in the western and southern parts of India which had experienced the Green Revolution (Baru, 2002).

Values, like super-specialization, profit and power became entrenched in the PFP sector, also transferred to the public sector through social links making it difficult for the government to regulate the sector. This was evident from the unsuccessful efforts made by different state governments to ban the private sector during that period (Qadeer, 2011). A dearth of any regulatory framework led many of these institutions to adopt unethical practices for earning more profit. A lack of any standard protocol meant that the private practitioners were permitted to prescribe drugs that they deemed fit. Persistent asymmetry of information between provider and user and the absence of a legal framework made it difficult to hold these providers accountable (Qadeer and Baru, 2016).

The other type of private sector, PNP institutions, included two kinds – charitable institutions providing medical care and organizations working directly with the community. The government, although acknowledging the role of these charitable institutions, reduced support for the charitable medical care institutions (Nundy, 2009). Some of those organizations working with the community took part in national health programmes receiving funds from the government since the First Five Year Plan period, mostly for the promotion of family planning services (Qadeer, 2011; Baru and Nundy, 2008). There were also other national bodies established to promote PNP like the Central Social Welfare Board was set up as early as 1953.

In the 1960s and 70s, another type of community-oriented organization emerged that criticized the government's role. These institutions, unlike the pro-government PNP organizations, favored a rights-based discourse to development rather than that based on welfare governance. They shared good working relationships with international

and national donor agencies, which enabled them to demonstrate alternative paradigms for human development in general and health services in particular (Sundar, 2010; Pachauri, 1994; Seth and Sethi, 1991). Success stories of few PNP organizations were projected as the model, which gave rise to optimism about the role of the sector (Mukhopadhyay,2011). Consequently, international funding for all PNP organizations increased which encouraged the spawning of such organizations (Sarkar, 2005). To facilitate the process of leveraging international funds the Foreign Contribution Regulation Act was promulgated in 1974.

Based on the limited information about PNPs, it was assumed that they were more responsive and accountable than the state. This interpretation did not take into account the aspect of distribution and coverage of the PNPs. Most of the PNP organizations were found in better-developed districts and even those who were delivering innovative approaches had limited coverage (*Ibid*). Moreover, these organizations were largely dependent on external funding which influenced their priorities and challenged their autonomy to take decisions (*Ibid*).

Some of these organizations morphed from a simple and austere form into bigger and complex structures with sophisticated operations and management structures as per the requirement of the donors. The staffing pattern of these organizations also changed with more professionals joining the sector as the salary was reasonably good. Therefore, voluntarism was replaced by professionalism. They also shifted offices away from rural areas to urban metropolitan cities. Some of these organizations expanded their reach across states; hence they started to resemble the government and corporate organizations (Sundar, 2010; Sheth and Sethi, 1991).

By the end of the 70s, after becoming a signatory to the Alma Ata declaration, the government was once again trying to focus on public health services. In the 6th Five Year Plan, the Minimum Needs Programme was launched with that intention. In that too, medical care was opened up to PNP organizations (Qadeer, 2011). Following this trend, the first National Health Policy (1983) called for expansion of the private curative sector which would help reduce the government's burden (Duggal, 2005).

By the end of the 1980s, India's public health system, across all levels of care, had become dysfunctional but there was a growing demand for better health services. The private sector, predominantly a for-profit enterprise, emerged with a range of providers from small and medium nursing homes, providing mostly outpatient care and some in-patient facilities, to big corporate hospitals with new and advanced technologies (Hooda, 2015). These providers were given additional support from the government, but with hardly any regulation.

The PNP sector also got attention from the government. The National Fund for Rural Development and Council for Advancement People's Advancement and Rural Technology (CAPART) was set up in the 1980s, for mobilizing resources for promoting PNP agencies' work in rural development programmes. Besides, there were grants from international development organizations for enabling partnership between this sector and national health programmes. One example is the grant received from the United States Agency for Development (USAID) for enabling PNP organizations in the Family Welfare Programme of the government (Rao, 2017).

By the late 1980s, two kinds of private sector organizations, for the delivery of health services, emerged – (i) those who delivered primary level care and (ii)providing secondary and tertiary care. These organizations can also be classified based on their primary source of funds – (i) from user fees, (ii) from government and (iii) from national and international donors.

Yet another classification was based on their management structure and location – (i) managed by individual professionals and located in a poorer rural area, (ii) managed by a group of professionals and located in peri-urban areas and (iii) managed by corporates located in the big urban cities. While there are overlaps between these categories, it questions the widely used typology of private for-profit and non-profit.

2.2 Reforms era: between 1990 and 2005

With this backdrop, in the 1990s, India embarked on reforming its public health system as per the global policy prescriptions mentioned in the World Development Report, 1993; but thorough cutting down public expenditure and introducing market-oriented reforms (Baru, 1994). These were conditionalities for availing the loans under the World Bank's Structural Adjustment Programme (SAP) which was necessary to tide over the fiscal crisis that the country was facing (Rao, 2017). Building partnerships with the private sector emerged as a key strategy in this programme.

Initially, PPP implied engaging PNP organizations for implementing government schemes. The practice of engaging NGOs for the delivery of national health programmes was there since the first five-year plan and had gained momentum in the 1980s with international grants. PPP became a popular strategy in all the national health programmes launched between 1990 and 2000. Some of these were a revised version of already existing ones while some were new. All these centrally sponsored schemes were formulated, designed as well as funded by the Ministry of Health, while the state government was in charge of implementing it. But, with declining public expenditure, there was a steep reduction in central grants for disease control programmes, which were restored by soft loans from the World Bank (Rao, 2017).

Consequently, the Bank exercised its policy control on the public health services along three principles based on the dominant neo-liberal

paradigm: (i) concept of an essential health package, which delinked the preventive from curative services, as opposed to comprehensive care linking all the levels of care, (ii) confining the role of government to implementing disease control programmes and (iii) allowing the market to provide hospital and medical care with government engagement (*Ibid*). These principles ushered in a new array of problems that were inherent in the tools of partnership.

The essential package of services was narrowly defined based on technologies promoted by Global PPP, vertically managed, and lacked epidemiological rationale and feasibility across India (Qadeer, 2011). Moreover, with the new programmes, some of the services were now provided by the PNP sector. As a result, the limited government resources (including the World Bank's loans) were getting diverted to either purchasing products developed by the global PPPs or services from the PNPs.

Like the earlier version of vertical programmes, they did not offer any curative services at the primary level. Users were compelled to choose between three options; all of which had their problems. First, they could purchase healthcare from the private providers at the village level who were readily available but with no formal training and accreditations. The second alternative was to seek medical care from private institutions at the block and district level, which was costly and unregulated with very little accountability. The third option was to use the services of the public sector but it was mostly inaccessible due to poor physical and human resource conditions arising from inadequate budgetary allocations. Also, due to health sector reforms, medical care at this level was no longer free of cost. Although the poor were exempted from user charges, like in most targeted interventions, it also suffered from administrative issues and hence the poor too ended up paying for these services in addition to the cost of medicines.

Recognizing the need to revive the block and district public health facilities, the government of India requested the World Bank for a loan under the State Health System Development Projects during the mid-1980s (Rao, 2017). These loans were described as "investment loans for policy reforms in the area of resource allocation for the health sector, capacity development for sector analysis and management strengthening, enhancing the participation of the private and voluntary sector in the delivery of health services and implementation of user charges for those who can afford to pay. Contracting out to the private sector was one of the strategies for improving efficiency and patient satisfaction (Baru, 2003).

These programmes were implemented directly at the state level, but the state department did not have much control in the designing of the project and there was hardly any involvement of the doctors and other staff in these hospitals, regarding the direction of reform. These were projects with set goals and strategies which were not always as per the requirement of the facilities; instead, it was wasteful (Baru, 2002). Thus these loans were not successful in reviving the appalling state of public secondary and tertiary facilities.

In addition to the partnerships with organizations, there were also partnerships with individual private practitioners who were encouraged to deliver clinical services at the public institutions. Human resources were also contracted for governance-related tasks. Casualization of the workforce was one of the measures to reduce public spending, but it can also be construed as a means to usher private interest in public facilities. It also affected the regulation and monitoring functions of the government. This became evident by early 2000 (Qadeer, 2011).

A detailed account of all these issues regarding engaging the private sector has been presented in the Report of the National Commission of Macroeconomic and Health (NCMH), but its optimism about private sector

engagement in providing healthcare persisted. As stated in the Report (GoI, 2005; pg 90):

> "Efforts of the Government to collaborate with the private sector have been programme-based, sporadic, disjointed and tentative, and not the result of a well-thought-out strategy aimed at achieving national health goals. Despite the mixed and varied experience, it is clear that collaboration with the private sector could enable expansion of access."

This was in line with the prescription of the Commission on Macroeconomics and Health constituted by the WHO in 2000 which, upholding the views about techno-centric interventions to achieve public health goals, strongly advocated for harnessing the private sector in the form of global PPPs (Banerji, 2002). The pressure to achieve the Millennium Development Goals in a specified time was another reason that national policymakers continued to support the private sector (Mukhopadhyay, 2005).

Adhering to the two approaches recommended by NCMH viz. shift the role of the government from producer to the purchaser of care and ensure accountability of the system by appropriate institutional structures, subsequent plans (9th and 10th FYP) and policies (National Population Policy 2000 and National Health Policy 2002) continued to support the private sector engagement in the public health system in myriad ways.

Initially, proposals were floated to rent out PHC and CHC premises to private qualified doctors mostly for out-patient care, especially for providing Reproductive and Child Health Services in rural areas (Duggal, 2005). The urban slum component was added after the India Population Project funded by the World Bank was launched in 1993 but in select cities. This was according to the global thrust for reproductive health after the Cairo Conference in 1990.

Until 2000, the programmatic support for promoting inpatient care in private hospitals was only limited to the Central Government Health Scheme. The public sector despite its poor condition was the preferred choice for the lower quintile of the population for inpatient care. This meant that despite the concession received by the private sector, it did not reach all sections of the population equally. Cost and locations were the two important reasons for that (Hooda, 2015). The government intervened to inflate the demand by launching the Universal Health Insurance Scheme in 2001. Although this scheme was a non-starter, it was enough to elicit the interest of policymakers to adopt this approach later (Rao, 2017).

Despite the support to the private sector for delivering healthcare, the government could not ensure an expansion of coverage, especially to the poorer sections. This became explicit in the assessment of the PFP sector, mostly corporate hospitals, which received subsidies for importing high technology medical equipment and also landed in prime locations at a token price. These hospitals, registered as Trust to avail tax exemptions, were supposed to conduct research and also earmark a certain percentage of their beds for poorer sections. Studies conducted in Delhi showed that they seldom complied with these conditions (Qadeer and Reddy, 2006; Qadeer and Baru, 2016).

A review of some studies conducted between 1990 and 2000, presented in the Report of the NCMH provided evidence against the PFP sector, especially those in the rural areas (GoI, 2005). This included poor infrastructure, hazardous waste management practices, inadequate capacity of paramedical staff and in some cases doctors were also not trained in allopathic medicine. Patients seeking healthcare from the private sector were discharged earlier than was medically advisable for a quick turnover of patients and they were also subjected to more diagnostic tests along with unnecessary surgical procedures.

These problems were not heeded because there was no systematic accreditation and registration process of these institutions. The accountability of private providers was also much lower than their public counterparts. One of the reasons for low accountability emanates from the hierarchical relationship between the health care provider and the user due to the asymmetry of information. While this is true for both the private and public providers, private providers become less accountable because they are not part of the public health system, hence exempted from the democratic pressures that the public health system is subjected to (Ritu Priya, 2005).

Post-1990s, the PNP sector also changed considerably with respect to the structure of the organizations, its staffing pattern as well as the type of issues that they addressed. They were influenced by the ideology as well as the political context of the donor. After 1990, the implicit agenda was to offset the adverse effects of globalization and structural adjustment. There was a move towards legitimizing the role of the PNP sector in the name of pro-poor development (Sundar, 2010). In the case of the health sector, they were given an important role in strengthening primary level care. The majority of these organizations began to engage in outreach activities under the national health programmes. Their role was largely limited to demand generation through Information Education Communication (IEC) and Behaviour Change Communication) (BCC) components (Das and Kumar, 2016).

The Trust Hospitals[20], a category of PNP institutions that provided inpatient services, also underwent drastic changes. (Nundy, 2009; Qadeer and Reddy, 2006). In the period of reforms, many of the Church managed hospitals had to shut down because of staff shortages as they could not

[20] The Trust hospitals were charitable institutions, set up in the latter part of the 19th century, by faith based organization and traders or industrialist. Hence the user charges in these facilities was relatively lower. See Nundy, 2009.

compete with the fees paid by nursing homes and other PFP health care facilities. There was also a dearth of funds because religious charity from developed nations, the main source of funding, had reduced during the economic recession (Qadeer and Baru, 2016). Some of them, however, shed their altruistic beliefs and started to behave like for-profit institutions but retained their legal status to avail the tax subsidies from the government (Nundy, 2009; Qadeer and Reddy, 2006).

The 2000s also saw the emergence of the global civil society movement, of which India's PNP sector became a part. Such movements were highly instrumental in the framing of Millennium Development Goals as well as in monitoring their progress in the field (Sundar, 2010). Some PNP organizations that allied with this movement started to act like an extended arm of their international lobby. As a result, they became critical of the government policies, but seldom criticized the policies of the donor agencies (Das and Kumar, 2016).

In 2003, the government declared that it would accept funds only from select bi-lateral agencies. As a result, some funding agencies stopped their operations in India while those who continued had much lesser funds. This resulted in a twin grid of problems (Sundar, 2010). First, it resulted in the stratification of PNP organizations into big, intermediary and local in terms of their size and location. Only the bigger organizations continued to receive funding from the donors. Second, most of the smaller organizations that were more anchored in the community did not have adequate funds; most of them did not have FCRA registration which was a prerequisite for receiving a foreign donation.

While it was expected that these bigger organizations would engage the local ones, it was found that they were too distant, logistically, from the site of action, hence another layer of organizations was added to

manage the local NGOs.[21] A clear demarcation of roles, as well as fund allocation, was inherent in these levels. The big organizations received the largest share of funds for design and monitoring the implementation while the entire onus of project deliverables was with the local counterparts, but the latter received the smaller share of funds. Such arrangements, also referred to as consortiums, were considered necessary to cover diverse locations and develop community-specific interventions. However, this was less likely the case because the design of the project was done by the big NGOs without much consultation with the local ones.[22] Also as the fund flow was from the national to the local, the project approaches seldom changed based on field realities, although there was scope for slight tweaking, but only after the permission from the donors.

By the end of 2004, there was growing recognition among Indian policymakers that the policies inspired by the international financial institutions and other donors, embedded in neo-liberal ideology were not able to stimulate the weakened public health system towards achieving public health goals (Rao, 2017). The then coalition government at the center launched the National Common Minimum Programme (NCMP). This programme emphasized economic growth and pro-poor investment in all social sectors, especially in rural areas. Addressing the problems of inadequate coverage of the primary level care in rural areas as well as underutilization of the existing primary health centers due to shortage of drugs and equipment were included in the goals of the programmes (Bajpai and Goyal, 2004).

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[21] This classification also mirrored the arrangement of public systems with big NGOs at the national, intermediary NGOs at the state and local ones at the district level. There was hierarchy between these NGOs, similar to that of the public system.

[22] Most often the big NGOs prepare the project proposal and leveraged funds. Once the project was sanctioned these NGOs started looking for desirable partners. This process of identification of partners at the local level was based on prior experience; sometimes new partners were also engaged but only after a thorough background check and field visit, unlike the lowest bidder approach. The issue of lack of transparency as well as corruption, however, could not be ruled out.

2.3. Post reform era: 2005 onwards

Triggered by the recognition of market failures in the provision of healthcare, the aim to strengthen the public health system started to resurrect in global policies in early 2000 (Rice, 2013 cited in Ritu Priya, 2018). In India, the coalition government, through advocacy by Civil Society Organizations (CSO) and the academia, launched the National Rural Health Mission in 2005, to bring about 'architectural corrections' in the public health system. Under the Mission, five approaches adopted were – communitization, improved management, flexible financing, monitor progress against standards and human resource management. It also promised to increase the budgetary allocations from 0.9% to 2-3% of the GDP (Dasgupta and Qadeer, 2005). A decentralized planning process was also envisaged in the Mission, to enable States to design their implementation plan according to their requirement (Mavalankar, 2008).

The design of the Mission has been criticized on certain grounds. First, all these measures were appropriated according to the neo-liberal paradigm (Dasgupta and Qadeer, 2005). The Mission document did not capture the problems in earlier policies related to the Primary Health Care approach and continued to focus on Reproductive and Child Health services (Duggal, 2005). In the context of PPP it was noted (Shukla, 2005, pg 130):

> *"…while declaring public-private partnership as an important strategy of the Mission, there seems to be no analysis of the glaring issues related to decades of non-regulation of the private medical sector."*

The private sector, under NRHM, has been engaged in the delivery of clinical services, clinical support services, non-clinical services, referral transport and community processes. Besides, the partnership is also envisaged for capacity building of different cadres, hiring human resources

and demand generation activities (GoI, 2004). Financing of these PPPs is mostly by directly purchasing the services through public funds. The suggestion to engage the private sector through strategic purchasing along with strong institutional arrangements for regulation was also given by the High-Level Expert Group (HLEG) for Universal Health Coverage constituted by the Planning Commission along (Planning Commission, 2011). While the strategic purchase option was adopted, the rest of the suggestion given by the HLEG was not institutionalized (Reddy and Mathur, 2018[23]).

Finally, the Mission also envisaged the role of NGOs in working with the Panchayati Raj Institutions and community-based organizations to monitor the right to healthcare and service guarantees from the public health institutions. For this, bodies like the Rogi Kalyan Samiti are formed at the public health facilities. The experience with these institutions is that they promoted privatization and became tools for engaging public-private partnerships (Dasgupta and Qadeer, 2005). These bodies were also dependent on the level of engagement of district collectors with the health sector (Kumar, 2003).

After the first phase of NRHM, the Planning Commission's Working Group reviewed the ongoing PPP schemes (Go1, 2011). It found that financing and monitoring of these PPPs have been a challenge, which has been attributed to the lack of capacity of the state and district level officials. Acknowledging the drawbacks, the Group recommended the capacity building of the staff and forming independent teams to monitor the PPPs. It also highlighted the need to prioritize partnerships with PNP organizations where ever possible. The PPP cell was also established under the Ministry of Finance to design institutional mechanisms and

[23] While the Group proposed various addenda in institutional mechanisms for correcting the accountability and governance lacunae of all providers; it also claimed to establish a system in which the private sector will be compelled to forgo its personal interest and deliver as per the UHC framework. This euphemism seems ahistoric in the Indian context. See Reddy and Mathur, 2018.

legislations that encourage the private sector partners, but no such body exists in the public health machinery (Roy, 2019).

During this period, the PFP sector had diversified ranging from small nursing homes in towns to bigger super-specialty hospitals in cities. They were also located mostly in urban and peri-urban areas. Continued lack of regulatory framework led to different problems with the PFP sector. The cost of care in these facilities had become very high, which only the rich could afford (Sengupta and Nundy, 2005). Besides, the private sector continued to indulge in irrational practices in the provision of primary level care for diseases like malaria and tuberculosis (Qadeer and Baru, 2016).

As far as the PNP sector is concerned, with a significant reduction of funding from the international development partners, the public sector has become one of the important donors; but the relationship between the PNP sector and government was strained, especially at the implementation level. This is because the presence of the PNP sector reduced the state's control over resources, service and patronage. Moreover, it challenged the local power structures (Sundar, 2010). This led to stricter restrictions on the NGO to receive foreign funding. In 2007 the government formulated the National Policy on Voluntary Action that aimed to create an enabling environment to mobilize necessary financial resources and to enable the sector to collaborate with the government effectively in terms of mutual respect and trust.

There is also a growing trend of philathro-capitalism in the PNP sector with American philanthropic foundations as well as national corporate firms. This model of funding is driven by the self-interest of the capitalists who are donating. Besides how these funds are generated and who does it benefit in the long run, one of the central discourse on this phenomenon is that this form of philanthropy has further entrenched the

merits of market principles on welfare rather than questioning it (McGoey,2012; Ramdas, 2011).

The above description of the changing pattern of nature of PNP and their funding patterns was to establish that this sector is not a monolith. Variations emerge from the dilemmas that this sector is subjected to both due to internal and external factors. The first one is the choice between depth versus the breadth of their role. While some organizations cover a whole range of issues, very few are only focused on health. This also entails the extent of geographic coverage; while few continue to do good quality work in a limited area, most are interested in expanding the coverage. Second, there is a dilemma regarding the stance of these organizations whether pro-people or pro-donor. Professionalism versus voluntarism is the third aspect that delineates the different approaches that these organizations adopt. Those organizations that were more professional were favoured by international donors as well as the government.

Section 3: Theoretical frameworks for understanding PPP

Most of the PPP studies have been done from four disciplinary perspectives. A review of these is justified at this stage, to arrive at a theory that explains the PPPs in India as well as their relevance for addressing inequities in access

3.1 Sociological perspectives

PPPs have been analyzed using functionalism and general systems (Ahmed and Ali, 2004). According to the functionalism theory, for institutions to survive, they have to adapt to the changing circumstances through interdependence on their partners. The general systems theory analyses systems from three different viewpoints: (1) system relations to determine the nature of the relationship between various components of a system; (2) system effectiveness to judge how satisfactory are relationships among various components of a system for the whole system to survive or

make optimum use of resources; and (3) system dynamics to investigate what forces a system to change and the direction in which the change occurs *(Ibid)*. Indeed it is a prerequisite to have a clear role demarcation and defined relationship to make PPP work. It is necessary to give the private sector a role in which they have the maximum potential to excel. Conversely, financial and management inputs may be beyond their capacity, and it may be better to leave this activity to the public sector. It is also important to assess how comfortable the partners are in a PPP arrangement. Adjustments in the way each sector works may be necessary to nurture and sustain the partnership so that optimum resource utilization is ensured. The partnership arrangement should be considered dynamic because it is affected by factors like population growth, new regulations and the acquisition of new skills. The force and direction of change in the work performed by the private and the public sector should be carefully weighed to maintain the optimum balance.

3.2 Economic Theories

A diminishing distinction between the public and the private sectors was noticed by Dahl and Lindblom as early as 1953 (Larkin, 1994). As the combination of the two sectors was becoming more widespread, a new term of "mixed economy" was coined to describe such arrangements. Bozeman (cited in Larkin, 1994) examined some characteristics of the mixed economy in detail. He argued that business firms are becoming more independent of government agencies and many government agencies are becoming more like business firms. He observed that both public and private sector agencies behave traditionally for certain issues and display the behavior of their counterpart in other matters.

Bozeman also found the formation of hybrid organizations making the dichotomy of the public and private sector even less distinctive. Etzioni (in Larkin, 1994) argued that these hybrid or 'third sector organizations'

hold a great deal of promise for many of our domestic problems. These third sector organizations provide a means to combine the 'efficiency and expertise' from the business world with a public interest, accountability and broader planning of the government. According to Etzioni, the new organization is important as alternatives, not replacing the existing order, but balancing roles played by public and private sector agencies (Larkin, 1994).

3.3 Management Theories

Aickenhead (1999) has investigated various theories of management to reflect upon public/private partnership. Resource dependency theory posits "alliances and networks operate as alternative mechanisms to markets or hierarchies for addressing specific strategic needs" (Saxton, 1997 in Aickenhead 1999). The 'co-opetition' framework offers a new way to view the interaction of organizations. It adds a player to the traditional value net of customers, suppliers and competitors. This new element is called 'complementor'. "A player is your complementor if customers value your product more when they have the other player's product than when they have your product alone" (Brandenhurger & Nalebuf, 1996 in Aickenhead, 1999).

At the onset, an organization must emerge out of two traditional mindsets: the 'business-as-war' and the 'either-or'. Second, it should allow the exploration of alternative relationships between organizations. To help in avoiding these biased, detrimental approaches an organization must learn to use the power of its perspective as of other players. Finally, the theory of co-opetition is about cooperating with others to best exploit the comparative advantage of each organization. The core precept of co-opetition theory is that it does not matter if others win—or lose—it matters if the organization itself benefits (Aickenhead, 1999).

3.4 Governance theories

At the core of governance is multi-organizational action where both the state and non-state actors work together to create, execute and implement programmes that respond to the people's needs (Asaduzzaman and Virtanen, 2016). This paradigm was generated during the 1990s with the entry of the New Public Management discourse which critiqued the traditional management approach adopted by the government (Yamamoto, 2007). The concept of governance is applicable in distinct zones – global, national, organizational, service and community (Asaduzzaman and Virtanen, 2016). The PPPs included in this study fall in the fourth zone which concerns the governance of national, regional and local service spaces composed of various providers – public, private and non-government organizations.

While there are many frameworks, Onibokun and Kumuyi (1999) suggest that policy frameworks and implementation strategies must be accompanied by new forms of governance to increase efficiency and effectiveness, as well as to maximize popular participation in service provision. An increasing interest in public, private and community partnerships is evident in the sector. But this is often related to technical or financial issues, rather than with political, sociological and environmental relationships. It is further noted that techno-financial approaches have failed to develop an institutional set-up necessary to empower citizens to participate effectively.

Most of the PPP studies have analyzed the content, but the emphasis on the context remains underplayed. The historical overview of the PPP strategy in the Indian health system described in this chapter argues that both these are critical to explaining the functioning of PPPs as well as the outcomes. The governance theory is the best fit for this. Besides the fact that the theory originated during the 1990s, it also provides the scope for

discussing the changes brought about in the public sector during this period. Alongside, it also examines how the state has involved the different non-state actors in the provisioning of public services.

The other pillar that determines the functioning of the PPP strategy is the role of private sector institutions. The plurality of these institutions and their dynamic nature has a bearing on how the PPP models are operationalized. These aspects have been neglected in the discourse on PPPs. For this, the sociological theories for institutions provide suitable explanations. Hence the study uses both governance theories and sociological theories to examine the role of the PPP in addressing inequities in access to health care.

Chapter III: Overview of Public-Private Partnership for Healthcare in Rajasthan

"PPP in Rajasthan were promoted for attracting additional resources, but with very little consideration regarding how these will improve the services." [Interview of a retired government official, August 2019]

In the seventh schedule of the Indian Constitution, Article 246, health components included in the state list are public health and sanitation, hospitals and dispensaries while the concurrent list includes prevention of infectious or contagious diseases (Kruthika, 2020). This arrangement allows the states to design their respective public health system based on the requirements of the people while the central government is mandated to design programmes that address the needs of the population in the entire country. In reality, the national government policies, about health, seem to govern the state government's plan to a large extent. This can be attributed to the budgetary allocations from the Centre to the state, as well as the bureaucratic and political connections between the two levels of government.

The control of the center in matters of the state becomes more prominent especially in states with poor economic and development parameters. In many of the national policies and programmes, there is a special emphasis on such states. They also draw the attention of international donor agencies. Rajasthan is one of the eight Empowered Action Group states and is also one of the 18 high-focus states identified in the National Rural Health Mission. It is marred by inequities across different axes emanating from its feudal legacy and geographical disadvantages. Despite the government's investments, by both state and central, the health status of certain sections of the people of the state

continues to be poor. With three-fourth of the population residing in rural areas, this thesis focuses on those areas.

Both the public and the private sector play an important role in the provisioning of health services in Rajasthan. Like the rest of India, the proportion of the population seeking healthcare from the private sector is significant. This propelled the state government to launch schemes to engage the private sector in the delivery of health services. Besides, the state is also implementing the central government scheme with the same strategy.

Though the purpose of this chapter is to understand the PPP in the health sector in Rajasthan, it is important to first elucidate the context of Rajasthan with respect to the dimensions of inequities in health and describe the role of the public and private sector independently in health service delivery. Accordingly, the chapter is divided into four sections. The first section examines inequities in Rajasthan, in general as well as in health outcomes as well as utilization of health services in rural areas. The second section describes the health system in Rajasthan including both the public and private sectors. The third section undertakes a review of earlier programmes, especially related to health, in which the private sector was engaged. It also reviews the PPP policy for health. The fourth and final section analyzes the scope of PPP in addressing the inequities in access to health services by juxtaposing the capacity of the public and private sectors.

Different sources of information were used to create the chapter. While data on health status was based on published literature, there was insufficient secondary literature about the characteristics of private for-profit (PFP) as well as non-profit (PNP) health sectors in Rajasthan. This first set of gaps was filled through five key informant interviews with members of the Rajasthan Chapter of Indian Medical Association (IMA)

and Federation of Obstetric and Gynaecological Society of India (FOGSI) while six interviews were conducted with key informants from the private non-profit sector in the state to provide an evolutionary perspective about these sectors in the state. For the evolution of PPP in the state, studies of different social sector programmes were referred and for the health sector, this was complemented with interviews of retired senior government officials in the health department who were closely involved in the process of designing and implementing PPP policies, grey literature accessed from the officials when the researcher was employed in the state health department as a consultant.

Section 1: Patterns of Inequity in Health in Rajasthan

Rajasthan is the largest state in India in terms of area with the harsh climatic and geographical condition, which affects the life of people. After independence, the state was created by merging different princely states without challenging feudal relationships. The feudal rulers in these erstwhile independent principalities were least concerned to improve the social and economic conditions of the citizens (Vyas, 2008). These factors together adversely affected the health of the population. During the post-independence period, it became one of the agenda of the democratically elected government of the state as well as the centre to change this scenario.

While the state has been able to register economic growth in the last 20 years[24], this has not been well reflected in the extent of poverty in the state. According to an analysis based on a Multi-dimensional Poverty Index (MPI)[25] computed based on current national sample survey data, the rural

[24] The per-capita GSDP of the state has risen from INR 12379 in 1998-99 to INR 121581 in the year 2018-19. See Guruswamy, Mazumdar and Mazumdar, 2008 for 1998-99 and GoR, 2019 for 2019 figures. These figures are not inflation adjusted. Inflation adjusted amount of 1998-99 is INR 40070.

[25] The Multidimensional Poverty Index is computed using ten indicators across three factors – health, education and standard of living. For health the two indicators are under five mortality and underweight children below three years. See Cowling, Dandona and Dandona, 2014

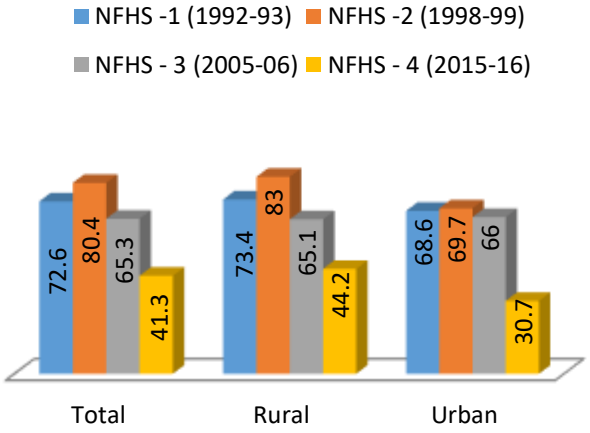
areas in the state are more impoverished than urban and among them, Scheduled Caste (SC) and Scheduled Tribe (ST) populations are more deprived than the other castes (Cowling, Dandona and Dandona, 2014). This is especially important considering that 75% of the state's population resides in the rural area; out of the 18.5% and 16.9% belong to SC and ST categories respectively (Census, 2011).

To understand the extent of inequities in health, three dimensions are examined: (i) health outcome (ii) health service utilization and (iii) characteristics of health service. For the health outcome, two indicators are selected, Infant Mortality Rate (IMR) and Maternal Mortality Ratio, mentioned in the goal of the National Rural Health Mission (NRHM). Indicators for the other two aspects were based on the factors associated with these two health outcomes.

1.1 Inequity in health outcome

It is well accepted that Infant Mortality Rate (IMR) is one of the most sensitive indicators not only for assessing health outcomes but also a measure for the socio-economic development of the country. The total IMR of Rajasthan decreased 31.3 between 1992-93 and 2915-16 but the IMR figures continue to be higher in rural areas (Graph3.1). Moreover the annual rates of decline in these areas, since the 1980s, have been lower compared to both state's urban as well as national rural average. This trend is seen in almost all districts of Rajasthan (Choudhary, 2018).

Graph3.1: Urban -Rural Variation in Infant Mortality Rate

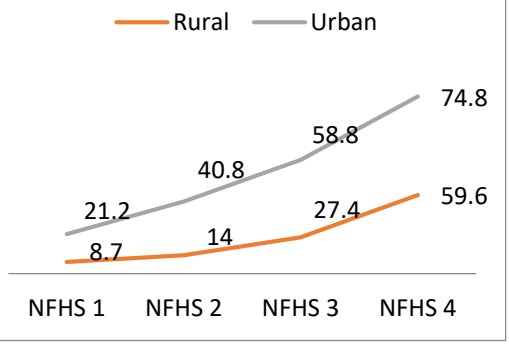


As far as Maternal Mortality Ratio (MMR) is concerned, Rajasthan has the second-highest ratio after Uttar Pradesh. According to the latest SRS (2014-15), the MMR of the state is 199. Although there has been a decline since 2004-06 from 388, it is the third highest in the category of EAG states and Assam (NITI Aayog, n.d.). While it is difficult to estimate MMR for rural and urban areas separately, a study conducted in rural regions of four desert districts in Rajasthan in 2004-05 estimated the MMR of 517 (Gupta, Khanna and Gupta, 2010). This figure is higher than the state average in 2004-06. Data on IMR and MMR indicate the unfavourable conditions of health services in rural areas.

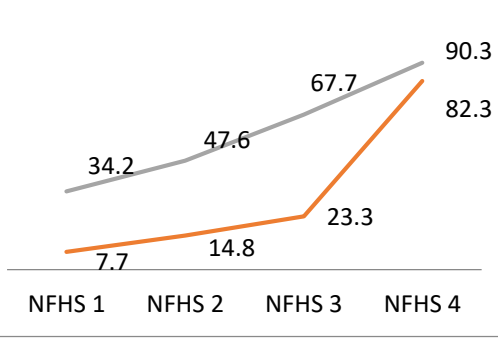
1.2 Inequity in the utilization of health services

Services required to reduce IMR and MMR are antenatal care (ANC) and skilled childbirth. Other important services are immunization for IMR and postpartum care, contraception and abortion service for MMR. Therefore, the utilization of these services in rural areas needs to be compared to that of urban areas to capture the extent of inequity. There is a steady improvement in all these indicators in both rural and urban areas, but the former continues to be more than the latter. Graphs 2 and 3 illustrate this for the two indicators related to services, which are common for reducing IMR and MMR.

Graph 3.2:
Women who received ANC within the first trimester



Graph 3.3:
Births in health facility



Similar variations were explicit for postpartum care, contraception and abortion services (Iyengar, Iyengar and Gupta, 2009). In the case of immunization-related services, according to NFHS 4 (2015-16), the difference in the percentage of children who are fully immunized in rural and urban areas is 7.8 (Urban 60.9; Rural 53.1). There is an improvement from the previous round of the survey, where the difference was more than 20 points (Urban 44.3; Rural 22.1). While this indicates a huge improvement in immunization coverage, it has not been uniform. A study conducted in rural areas of a tribal district of Rajasthan showed that not only the better-off families were significantly more likely than the poorer families to have received all the vaccines, but there was also social gradient (complete immunization coverage=19%, 29%, 46%, and 68% for groups 1–4[26], respectively; P =.001). This was higher for all the vaccines except for the oral polio vaccine (Mohan, 2005).

1.3 Characteristics of the health services

For a comprehensive understanding of trends in the utilization of the above-mentioned services, it is important to review the characteristics of health service providers in rural areas. In Rajasthan, the public sector has been the dominant provider, but the increasing role of the private sector also merits attention. According to NFHS 4 data, women who sought healthcare from private providers are more in case of selected ANC services namely blood pressure measurement like blood and urine sample testing as well as abdomen examination. While the NFHS 4 report does not disaggregate the source of providers across rural and urban areas, there is an indication that rural areas are also using the private sector for ANC services[27].

[26] Four groups were created, in the ascending order of socio-economic status, based on the assets and amenities. Weights were assigned to different assets as per the National Family Health Survey. See Mohan 2005.

[27] Number of women in rural and urban areas is 7771 and 2491 respectively, while those seeking public and private providers are 7860 and 3437 respectively. See Table 38, NFHS 4

The source of providers across rural and urban is better manifested in the case of childbirth services. In NFHS 4, women in rural areas are more likely to use public health services; there is also the option of NGO/ Trust as a healthcare provider in both areas. When compared to NFHS 3 data, it shows a trend in the increase in public as well as private providers in both rural and urban areas (Table 3.1)

Table 3.1 Percentage of women giving birth in institutions

Place of Delivery	NFHS 3 (2004-05)			NFHS 4 (2015-16)		
	Rural	Urban	Total	Rural	Urban	Total
Public	11.3	34	15.9	65.1	57.6	63.5
Private	3.4	12.9	5.4	17.2	32.5	20.4
NGO/ Trust	0.1	0.7	0.2	0.1	0.2	0.1
Total	14.8	47.6	21.5	82.4	90.3	84.0

When this data is juxtaposed with the data on the cost of seeking childbirth service, it eludes to the fact that despite the cost of care being four times higher in private (INR 12509) than the public sector (INR 2969) in a rural area, there is an increasing trend of choosing private over public provider for childbirth. This is in a context when a nationwide scheme to promote institutional childbirth (Janani Suraksha Yojana) has been able to reduce the social gradient in accessing public services (Joe et al., 2018). For other services like immunization and female sterilization, the majority of the rural population continues to use the public sector, while the private sector is utilized more for abortion services (Sharma et al., 2016; Mohanty et al., 2020).

These aforementioned data highlights that health outcome and utilization of service continues to be unequal between rural and urban areas. It also points towards the increasing role of the private sector for many of the services required; which is indirectly linked to the unequal health outcomes as services in the private sector are mostly located in the urban areas. All these together raise the question about the capacity of public and private sector institutions in addressing it.

Section 2: Status of Health System in Rajasthan

Recognizing the role of the health system in reducing the barriers to access, this section attempts to capture the role of the public and the private sector in service delivery. In the context of Rajasthan, the international organizations in the health sector need to be given due importance owing to their close working relationship with both sectors.

2.1 Public Health System

2.1.1 Organizations

The government of Rajasthan has developed an extensive network of three-tier public health infrastructure for service delivery, as recommended in the Bhore Committee, comprising sub-health centres (SHC), primary health centres (PHC) – rural and urban, community health centres (CHC), and hospitals. There are also mother and child welfare centres and dispensaries in the urban areas and these institutions are managed by the Department of Medical, Health and Family Welfare (DMHFW), Government of Rajasthan (Table 3.2).

The average number of villages covered by these institutions in Rajasthan is less than the national average and also comparable to good performing states like Maharashtra and Andhra Pradesh, except Kerala[28] (Table 3.3).

[28] As per the Niti Aayog's Ranking (2019) Kerala, Andhra Pradesh and Maharashtra are the top three, in the larger states category, in terms of overall performance. See Health States, Progressive India: Report on the Ranks of States and Union Territories. Niti Ayog, 2019.

Table 3.2: Public Health Infrastructure in Rajasthan

Type of facility	Numbers
Hospital	103
Community Health Centre	606
First Referral Unit	153
Dispensary	190
Mother and Child Welfare Centre	118
Primary Health Centre (Rural)	2090
Primary Health Centre (Urban)	51
Sub-health Centre	14378
Total	17689
Source: GoR, 2019	

Table 3.3: Average number of villages covered by SHC, PHC and CHC in Rajasthan

Average Number of Villages covered by	Rajasthan	India	Kerela	Maharashtra	Andhra Pradesh
A SHC	3	4	0	4	2
A PHC	21	25	1	24	15
A CHC	76	114	4	121	88
Source: GOI, 2019					

While these indicate that the state government has paid attention to primary level care in rural areas, potential access of these institutions across districts reverses that claim. This can be expressed through two dimensions of access- availability and acceptability.

- Availability of Public Health Services

More than 3/4th of the population lives in rural areas in 26 out of 33 districts in the state. The average number of health facilities in these districts is approximately half (416) of those present in the remaining

seven districts (804) which contribute to only 26% of the state's rural population. Moreover, the distribution of rural health facilities does not commensurate with the percentage of the rural population across districts.

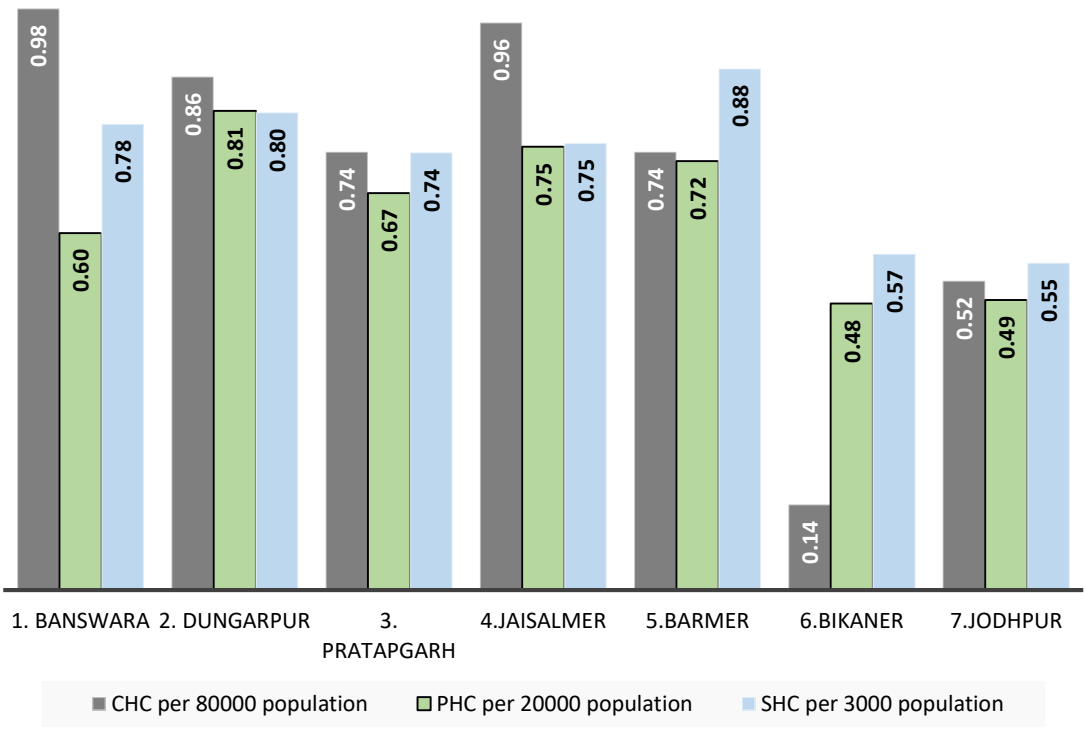
Table 3.4: Distribution of CHC in select districts of Rajasthan

Name of districts	Populations of the district (in lacs)	Number of CHCs
Alwar`	3.67	38
Jodhpur	3.69	24
Banswara	1.80	22
Jalore	1.83	11
Bundi	1.15	14
Dholpur	1.20	7

Community health centres are important for both primary and secondary level care. According to the IPHS norms, these are mostly located at the block headquarters and are expected to serve 1.2 lac people each. According to the Annual Report of the State Health Department, CHCs in Rajasthan meet this criterion serving 1.17 lac populations. 13 districts have 20 or more CHCs while in five districts the number is less than 10. While this is linked to the population of the district, there are some districts with similar population sizes, but the numbers of CHCs are unequal. This can be illustrated with a few examples (Table 3.4).

The average number of health facilities in desert districts and tribal districts is lesser than the prescribed norms[29].

Graph 3.4: Health facilities in desert and tribal districts



Data source: Annual Report (Pragati Prativedan), Department of Health, Government of Rajasthan, 2019

There are also gaps in the availability of human resources in all these facilities. According to the District Level Household and Facility Survey Report (2014), only 52.9% and 10.6% of SHC have female and male health workers respectively. In the PHC, the basic requirement is of a doctor, but a doctor is available in only 81.3% of these institutions; the female doctor is present in less than 10% PHCs.[30] As only 76.5% of the PHC can provide 24 X7 services, the next level of public health facilities

[29] Fully Tribal Districts are Banswara, Dungarpur and Pratapgarh and Desert Districts are Jaisalmer, Barmer, Bikaner and Jodhpur For such districts, the IPHS norms are one CHC per 80000, one PHC per 2000 and one SHC per 3000.

[30] Many of the medical staff at the PHC are contractual, although the numbers are not clearly mentioned in any of the government documents. This can be deciphered from the job vacancies for doctors advertised by the Govt. of Rajasthan on contractual basis, but all government recruitments are stalled. Under this arrangement, continuity of staff cannot be ensured.

that people seek care from is the community health centres. 108 out of 606 CHCs have been upgraded as the First Referral Unit, but only 58.83% are providing all the services mandated, as there is a shortage of specialists in the public sector. Many of these institutions lack basic services like staff residence, electricity, water supply and also sanitation facilities. Only 12% of CHCs have blood storage units, an essential prerequisite for health services provided at that level.

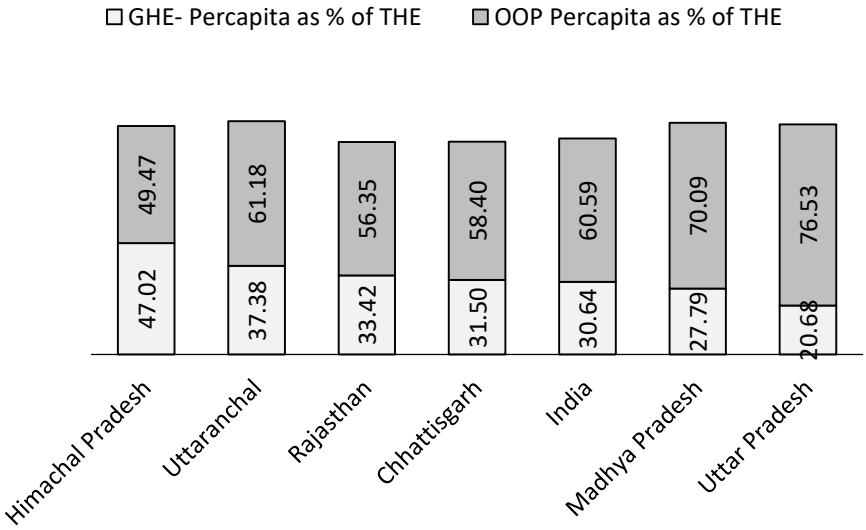
Some small-scale studies have also provided additional insights into the functioning of public health institutions in Rajasthan. There is a high rate of absenteeism among public staff at the primary care level. This meant that service provision at the SHC was infrequent since most of these centres are managed by a single staff (Banerjee, Deaton and Duflo, 2004). Besides, it was difficult to predict when these centres would open. In those cases, where the staff is present the proportion of the population receiving services from these public facilities were those who resided closer to the facility. The distribution is inequitable because poorer families stay farther away from the rural facilities as compared to the richer (Mohan; 2005).

2.1.2 Financing

The pattern of financing of health care is a marker of affordability, which is the third important dimension of access. Both Central and state governments are important sources for financing public health institutions and also for purchasing healthcare from the private sector under different schemes. The other dominant source is out-of-pocket expenditure (OOP). Recognizing the importance of public funds and OOP in access to services it is necessary to review the current scenario vis-à-vis both these sources. This involves two levels of analysis: first is the comparison between public expenditure and OOP and second is the share of central and state budget in total public expenditure.

According to the estimates by National Health Accounts for the financial year 2015-16, the Total Health Expenditure (THE) of Rajasthan is INR 23869 crores, which is 3.5% of Gross State Domestic Product (GSDP). This is lower than the 2010 estimates of 4.76%. The public share of THE, Government Health Expenditure (GHE), in the state is 33.4% while the OOP share is 56.4%. Comparison of Rajasthan with the High Focus States in Northern India, it shows reveals that while it performs better than three other states including Uttar Pradesh which has the same THE (INR 3226) as well other as the national average, but it performs worse when compared to Himachal Pradesh and Uttaranchal, both of which has much higher per capita THE than Rajasthan (Graph 3.5). When the current OOP (INR 3326) is compared to that of 2010 (INR 2700), it shows that accessing health care has become costlier in the last five years in the state, which is a threat for equity.

Graph 3.5:
Comparison of Government Health Expenditure and Out-of Pocket Expenditure



Source of data: NHSRC, 2019

While the state has registered an increase in public health expenditure from 1996-97 till 2013 -14, the share of public expenditure to GSDP has been almost stagnant. Based on the above-mentioned information it can be inferred that people, in the state, have to spend more from their resources to utilize health services. In other words, government expenditure is not able to meet the health care needs of people adequately.

Recognizing the association between high OOP and poor access to health services, the state government has initiated the Bhamasha Yojana, a public insurance scheme funded by government resources. The state had also implemented Rashtriya Swasthya Bima Yojana (RSBY) which was part-funded by the national government. The coverage of these schemes in the rural areas (22.6%) has been lesser than the urban areas (28.6%); even though more (Rural -16.1%; Urban -10.7%) fall in the Below Poverty Line category in rural than urban areas of the state (Chowdhury and Mukherjee, 2019).

Public health expenditure in Rajasthan is financed primarily by the state. Comparing the union government's budget in the GHE shows that there has been a steady increase since 2005 till 2008, from 14% to 31% respectively. The proportion stagnated for the next two years and in 2011 the share decreased to 22% (GoI, 2019).

2.1.3 Stewardship

The third function of the health system is stewardship; which is exclusively the responsibility of the government, but it is not clear which officials in the state are accountable for performing this function. There is no single point of contact for understanding how this function is performed. The principal Health Secretary (PHS) followed by the Mission Director (MD) are the bureaucratic heads. These officials are managing multiple programmes, but do not always understand the technicalities.

Also, these officials often get transferred within a span of three years. From the personal experience of the researcher, it has been observed that between the years 2011-2014, the Mission Director changed five times.

Thus this function is usually performed by technocrats. The Department of Health, Government of Rajasthan has three Directors – Director RCH (earlier the post was called Director Family Welfare), Director Public Health and Project Director. The first two are medical officers of the state health services while the third is a Rajasthan Administrative Service (RAS) officer. They are assisted by a team of Joint Directors and Deputy Directors, who are state government doctors, as well as consultants under the National Health Mission [Interview with a retired director of the health department, Jaipur, August 2019].

> "*Although the head of the department is an IAS, the task of monitoring projects is performed by the directors. All the projects are divided among the three directors. For each project, there is a special officer, who can be a government employee or a consultant. All letters and complaints are marked to these project-specific officers, who then put up the matter before the respective directors*."

The role of the public sector in stewardship, in Rajasthan, is fraught with different problems. First, the state-level officials seldom visit the districts and the relationship with the CM&HOs is not very congenial. Second, consultants did not have any authority to take action. As reported by one of the directors, that they handled small problems while bigger issues that warranted punitive action were taken by bureaucrats at the highest levels. Lack of role clarity and authority of lower-level staff were the key issues in stewardship in Rajasthan [Interview with Project Director, Jaipur, August 2019).

> "*We do not allow the consultants to take any decisions. The power to take decisions related to day-to-day functioning rests with us. but for bigger problems, the matter is put up for the scrutiny of the higher-level officials, who then direct us on how to go about."*

The Health Minister of the state, an elected representative from the ruling party, exercises authority in decisions related to the health sector. The other members of the Legislative Assembly, the opposition party, often raised questions related to health sector schemes. The answers to these schemes were drafted by the respective officials in the department. Based on the number of questions asked in the legislative assembly on health it seems that it was one of the priority sectors (PTI, 2018). However, the nature of the questions asked was largely related to government policies and guidelines or about the inputs factors like deployment of human resources and constructions of infrastructure. It was very rare for questions about the state of implementation to be raised.[31]

As far as the regulation of the private sector is concerned, the Government of Rajasthan is one of the few states that have adopted the Clinical Establishments Act. However, the implementation has been restricted to only tertiary public hospitals. The private sector bodies have suspended its implementation owing to the disagreement about some of the clauses that according to them were violating their interests [Interview with a member, Rajasthan Chapter of Indian Medical Association, Jaipur, September 2019].

> *"We are still in talks with the government about certain clauses in the Act. It is not that we are opposing it without any reason. One of the clauses in the current Act is the involvement of police in the regulation of private facilities. There are some other problems also. We are waiting for the government to address those issues."*

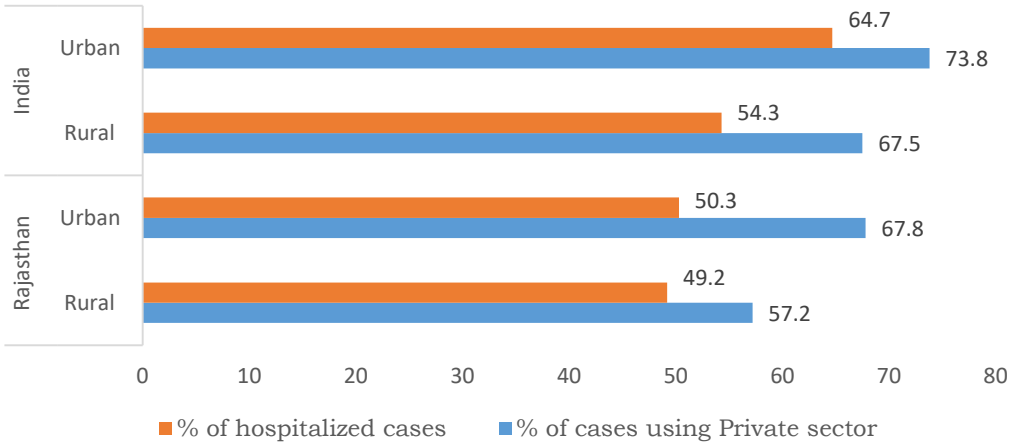
2.2 Private For-Profit sector

In Rajasthan, the private sector is not a dominant provider of healthcare, both in rural and urban areas. This can be inferred by comparing the utilization statistics of private health facilities in Rajasthan

[31] This is the researcher's independent view based on her work experience in the Department of health. A content analysis of the questions is required to give a better picture of the nature of questions as well as the answers is necessary.

with that of India average (Graph 3.6). Another aspect that needs to be considered while interpreting this data is that many of these private providers are informal in nature with no medical degree or training.[32] This indicates that the percentage of the formal private sector is even lesser than what the data shows.

Graph 3.6: Utilization of private health facility - Rajasthan and India



Data source: NSS 75st Round, July 2017- June 2018

One of the factors for the low utilization of private facilities is the high cost of care as compared to the public facility. The OOPE for institutionalized care at a private health facility in rural Rajasthan is almost 3.5 times the public (Private 25,788 INR and public 7332 INR). This shows that the private sector are charging high user fees in the state. However, OOPE in public hospitals is more in Rajasthan than overall in India but higher for private and charitable institutions across rural and

[32] According to a study conducted in rural Rajasthan, 41% of the private providers who called themselves doctors did not have any medical degree, 18% did not have medical training and 17%had completed high school. See Banerjee, Deaton and Duflo, 2004.

urban areas (GoI, 2019). This alludes to poor regulation of this sector by the state government.

Another factor that determines the utilization of private facilities is that, like the rest of the country, most of these facilities are located in urban and peri-urban areas. Although there is no statewide data for this, a mapping exercise of the private sector was conducted under the Rajasthan Health Sector Development Project, in three districts representing four geographical zones of the state – plains, desert, tribal. Although conducted in June –August 2008, the study covers 18 blocks across three districts, each representing three zones. It captured a range of issues related to the private sector in the state. Many parameters were covered in the study; the ones most relevant to inequities are described in detail. These are distribution, ownership and nature of services delivered by the private sector, qualification of the provider and cost of care. Also, the year of establishment of these facilities is relevant to understand the general trend.

- Distribution of private facilities in the district – Against the popular belief that district headquarters are the hub for the private sector, the data shows that blocks, which were nearer to developed districts or where a majority of the people were in the high and middle-income category had more private facilities. To illustrate, the data from Tonk district show that out of the 6 blocks covered, most (80%) of the private sector was in 3 blocks (Deoli, Newai and Malpura). The block Newai is at the border of Jaipur and Tonk and Deoli is closer to Kota. Most residents of Deoli belonged to the Jain community who are relatively better off. When compared to the district headquarter Tonk, it was more backward with a majority of residents belonging to the minority community. This trend was also seen in the other two districts, but the only difference is that in Bikaner and Udaipur

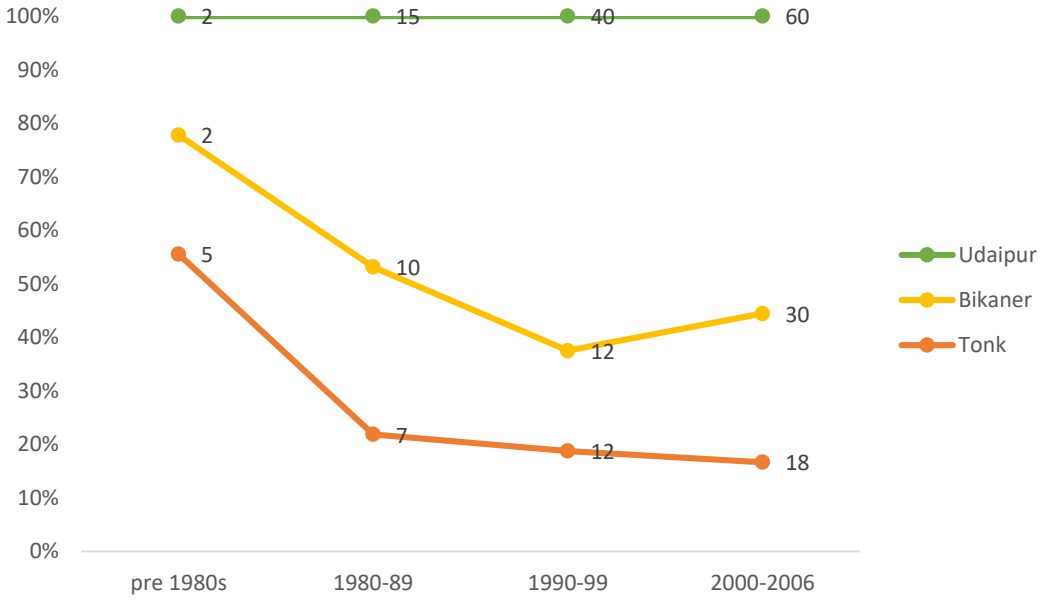
most of the private sector was located in the urban areas of the district.

- Ownership and nature of services delivered by the private sector: Out of all the private providers (317), only 17 were managed by NGOs/ Trusts. The remaining were registered as sole proprietorship institutions or as partnership firms. In two out of the three districts, most of the private providers were running clinics (Tonk -20/44, Bikaner 43/ 26, Udaipur – 438/131). There were private nursing homes in all the districts with Udaipur having the highest followed by Bikaner and Tonk. It is important to note here that Tonk is located between Jaipur and Kota, the two most developed cities of the state in terms of health infrastructure. So, the likelihood of people traveling to these areas for inpatient care was more than Bikaner and Udaipur. The nature of ownership did not overlap with the services provided.
- Availability of trained medical professionals – This was done at two levels. First, to identify the trained medical professional and weed out the informal or less qualified ones and second, to see their availability. In all the districts there were a handful of private providers who were not trained to provide health care. Many of the trained professionals were working on a part-time basis in other private institutions in the district. Some in-service government doctors were associated with services in these private facilities.
- Cost of care- There were three types of charges levied by the private sector. First, prescription charges were the highest in Udaipur between 70 -100 INR, while in the case of Tonk and Bikaner the charges were between 30-50 INR. Those clinics that were providing normal deliveries were charging between 300-1100. But, the cost of C-section services was as high as 8000INR. It was also interesting that the cost varied with the location. For instance, the cost of a C-section in Udaipur city, with a majority of the private facilities, was

around 8500 INR while in Kherwara, which had a single private provider it was 6000 INR. This means that competition did not regulate the price, the ability to pay did.

- Year of their establishment- Most of the private facilities in these three districts were set up after the 1990s. There was an exponential rise in the number of private facilities in these three districts between 1990 and 2000. A graph depicting the number of nursing homes in these three districts, from the period from 1980 to 2006, reveals the phenomenon (Graph 3.7).

Graph 3.7: Year of establishment of private sector



Source: RHSDP Study on Private Sector, n.d.

There were some new trends in the private sector in the state. First, big corporate hospitals were being set up, but most of these were in Jaipur and Kota, and very few in the districts. As reported by an ex-official in charge of the RHSDP project, the private sector was much more interested to start their work in those areas where the public sector was already present. He shared that this was the reason why PPPs could not be initiated in the block towns [Interview with retired official working in the RHSDP project, Jaipur, July 2019].

> *"When we tried to promote the private sector providers to establish their hospitals in the blocks, not many were interested. They wanted to work in and around the district or in those blocks where the public system was already working. We could not promote this, because we knew that this will lead to a weakening of the public sector and our aim was just the opposite."*

It was reported that the genesis of private sector growth was because there was pressure from the political leadership as well as central government to engage the private sector. Each and every bureaucrat wanted to showcase their ability by forging more partnerships. He used the term '*kamau poot'*. While a literal translation is not possible, it meant that all bureaucrats wanted to forge partnerships 'to score brownie points' [Interview with a retired official at the Health Department, Jaipur, August 2019].

> *"There was a lot of pressure from the political leadership on the bureaucrats to identify potential private partners and start a PPP project. They were not interested in the implications of such projects, so the terms were drafted in such a way that more private players would be interested. Everyone wanted to be a kamau poot (sic) of the government, no one was bothered about how this will affect the public sector and the people."*

Speaking about the current trend in the private sector, a respondent from one of the professional associations said that there is a declining trend in solo doctor units as well as private clinics because people want a package of services that these facilities cannot provide. As a result, many of these doctors are working in private sector hospitals in their area. Only those who have an entrepreneurial nature will not join, but they need

some sort of subsidy from the government to be financially viable. One of the ways is to forge PPPs [Interview with the representative of the professional bodies, Jaipur, September 2019].

> "*Many of the doctors who were running clinics have stopped the individual practice. Instead, they are working as resident doctors in corporate hospitals. Only a few of these private doctors have started their nursing homes, but they are not able to generate enough money. These hospitals generally go for PPP projects to get more patients."*

The same respondent had a very interesting spin on the concern for equity. He said that the public sector had to take care of the poor and the most vulnerable. For the private sector, the concern is of quality. To explain this he compared hospitals with hotels, in which the private sector is a three-star and above, while the public sector is two stars and below. When people can afford it they will always like to stay in a better hotel, but those who cannot have to go to the cheaper one. He also mentioned that the private sector should not also cater to all, otherwise its quality will reduce. At best, it can adopt some practices like free camps in slums or vaccination drives to help the deprived [Interview with a representative of a professional body of doctors, Jaipur, September 2019].

> *"Private sector is not responsible for providing services for the poor or deprived sections of the society. At best they can conduct some camps in the slums, but that is a voluntary effort. The main aim of the private sector is to provide good quality of service. I see private facilities as hotels with three stars and above. If patients have the ability to pay they would prefer to visit these facilities."*

2.3 Private Non-Profit

This sector, in common parlance, is known as non-government organizations; also referred to as civil society organizations. In this thesis, these comprise the Private Non-Profit (henceforth PNP) institutions. These organizations have played a significant role in human development as well as in advocating for policy changes in the state as well as nationally (Vyas, 2008)[33]. PNP organizations working in Rajasthan is not a monolith; there is a variation based on their ideologies, approaches, the scale of operation, and the extent of connection with the community (Box 3.1).

Box 3.1: Typology of NGOs in Rajasthan (Arya, 1999)

- Private philanthropy/ charitable trusts deliver relief and welfare services
- Intermediary organizations engaged in research, support and training for grass root organizations
- Grass root development organizations implement development projects directly with communities.
- State sponsored and dependent organizations promoted outside the government for flexibility and reduced government interference.
- Social Action Groups that strive to change the governance process and structure; adopt the method of confrontation and community mobilization.

This diverse range of organizations evolved over some time from the 1960s onwards. Bhargava (2007) provides a historical snapshot of the NGO movement in Rajasthan. Based on that, the evolution of the PNP sector in the state can be categorized into broadly three phases – (i) starting in the late 1960s and 70s, (ii) 1980 and 1990s and (iii) post-2000. These three periods also capture the three generations of PNP organizations in Rajasthan; because there were both quantitative and qualitative changes in the nature of these organizations. It is important to note that this categorization includes the PNP sector as a whole, not limited to those working in health. This is because of two reasons; first,

[33] The Right to Information Act and the National Rural Employment Guarantee Act were based on the initiatives championed by PNP organizations, which were later formalized into a legal framework. See Bhargava (2007)

many of these organizations deal with multiple themes and second some of these organizations that started with a goal to improve education or other social issues, later entered into a partnership to deliver health services.

In the period between the 1960s and 70s, socio-cultural transformation movements like Sarvodaya Movement, the adult education movement followed by the Sampurna Kranti Movement led by Jai Prakash Narayan, laid the foundation for secular voluntary action in the whole of India as well as in Rajasthan. Few organizations were established in this period namely Social Work and Research Centre in Ajmer, Urmul Trust in Bikaner, Gramin Vigyan Vikas Samiti in Jodhpur and Seva Mandir in Udaipur. Their vision was to build democratic consciousness and mobilize the community for realizing their rights, social reform and social justice (Bhargava, 2007). These organizations worked in the spirit of volunteerism.

Besides engaging in development activities that supplement and complement government programmes, most of these organizations also invested resources to develop the capacities of the rural population to address their problems. The pioneers also facilitated the creation of new organizations in other parts of the state. These smaller organizations were supported with initial funding and other managerial support. This was vividly described by a respondent who had worked in an organization named ARAVALI.[34]

> "*The first generation NGOs in Rajasthan not only contributed to developing new approaches to facilitate development, but they also provided technical and financial assistance to establish new organizations in other parts of the state. The leadership of these newly formed organizations was handed over to the local people, most of them were working in the parent organizations. This has resulted in some*

[34] ARAVALI was initiated as a result of the joint effort of the Government of Rajasthan and a few leading voluntary agencies in 1994 to promote innovations in development and act as an interface between the Government and the voluntary organizations. See http://aravali.org.in

> *good organizations in tribal and desert regions."* [Interview with a professional with more than 20 years experience with PNP sector in Rajasthan, Jaipur, August 2019]

While the second generation of PNP organizations started to emerge by the end 1970s, the proliferation was witnessed in the 1980s. There was an influx of international organizations and donors who chose to fund the PNP organizations because they were convinced about the effective and low-cost service delivery models that were demonstrated by the first generation organization; most of this funding was of a long-term nature (Bhargava, 2007). Some officials in state bureaucracy were also interested to learn from the innovative approaches adopted by some of these organizations to increase coverage of the government programmes; along with political will for such efforts.

> "*Based on my experience with NGOs in Rajasthan, I think the positive opinion about these organizations among some of the top echelons in the state bureaucracy, was one of the key reasons for them to flourish. Two names that are worth mentioning in this context are Meetha Lal Mehta, former Chief Secretary and Anil Bordia, Education Secretary. NGO sector in Rajasthan flourished under their leadership. There was support from the then ruling party."* [Interview with professional working in GO-NGO partnership in Rajasthan, Jaipur, August 2019]

This enabling environment for the PNP sector slowly faded after the 2000s. First, the funding modalities of the International Organizations had changed. Those that provided long-term grants for developing models had changed focus to more short-term projects like research and advocacy. Some of them adopted strategies to strengthen the public system directly rather than funding the PNP organizations.

> "*There have been some changes in the role of international donors. Earlier the international organizations provided long-term support for 10 years or so, recognizing that the process of development needs time. However, currently, these organizations are offering only short-term grants to NGOs and that too mostly for research and advocacy or to organize training for public functionaries. The current approach is to fund the government."* [Interview with professional, working with an International Organization in Rajasthan, Jaipur, September 2019]

Following this, the state government's response towards such an organization was significantly altered. It refused to recognize the crucial role of PNP organizations in creating new models. They were only keen to support those organizations, which agreed to be an extended arm of the government. Thus the majority of the PNP organizations in the state succumbed to such norms and joined hands with the government (Bhargava, 2007).

The PNP organizations in Rajasthan, driven by the mandate of first the international donors and later by that of the government, faced the challenge of increasing professionalization as well as bureaucratization of their structure and functioning which created a new relation for serving the purpose of NGO self-preservation (Gupta, 2014). Moreover, the process of professionalization altered NGO-client interactions (O'Reilly, 2015). Based on an ethnographic study of a PNP organization working in Rajasthan, O'Reilly argues that this can be attributed to deskilling and degrading the work of an NGO field worker. Consequently, there was a rapid turnover of senior staff and employment of low-paid, low-caste fieldworkers. This resulted in tensions about the status of the NGO's work as providing a social service.

By the end of the third phase, the PNP sector in the state had been fragmented. On one hand, there were organizations, which showed their allegiance towards their donors, rather than the community. They propagated the idea of achieving social justice through empowerment of marginalized sections; rather than questioning the structural factors for inequity. This was the approach not only of the recent organizations but also some of the pioneering ones. On the other hand, some institutions took a confrontationist stance against government programmes, but they did not have adequate resources and were hardly successful in garnering mass support (Bhargava, 2007). As a result, they were not very successful

in altering the status quo. In the context of PNP organizations of Rajasthan, Bhargava states

"The civil society efforts to build democratic consciousness, where there is freedom from discrimination, freedom from fear and injustice and a more equal and just society, remains on the margins or there is big and frightening silence on their part." (Bhargava, 2007; pg 280).

Having deliberated on the evolution of the PNP sector in Rajasthan, the current profile of these organizations is of greater relevance. Das and Kumar (2016) used the information available from the Census of Non-Profit Sector by the National Accounts Division of Central Statistics Office, Government of India to understand the attributes of PNP organizations working in the health sector. In their study, they presented a state-level picture as well.

The first level of classification was based on the actual existence of the PNP organization.[35] In Rajasthan, out of the 100272 registered organizations, 20.28% (20336) could be traced as compared to the national average of 22%. This shows that many organizations exist only on paper and hence are not engaged in any sort of developmental activities. There is also heterogeneity among these organizations (Table 3.5). This point was also articulated by one of the respondents.

> "*Although there is a common perception that there are many NGOs in Rajasthan, there are districts where there are no organizations. In terms of capacities also there are huge disparities within those who are currently working*." [Interview with professional with more than 20 years experience in the PNP sector in Rajasthan, Jaipur, August 2019]

[35] The CSO- NAD had collected data in two phases. In the first phase they had collected information about the number of organizations registered and in the second phase they had traced these organizations using the available information to ascertain their functionality. See Das and Kumar, 2016

Table 3.5: Profile of PNP sector in Rajasthan and India

Characteristics	Rajasthan (In %)	India (In %)
Employment status and size of an organization		
Micro – run by volunteer	31	55
Small – employment size below 20	63.3	34
Medium – employment size ranges between 20 and 100	5.3	10.6
Large – more than 100 employees	0.3	0.2
Legal Status		
Societies Act	99.4	89.6
Trusts Act	0.2	2.3
Both the Acts	0.4	8.1
Operational Area		
Health	10.2	3
Social Service	22.6	36.5
Education and Research	54	24.1
All other	13.3	36.4

Source of data: Das and Kumar (2016)

Analyzing the data for health-specific PNP organizations presented in Das and Kumar's report reveals that Rajasthan is one of the top four states with respect to the PNP sector in health (2071) in the country and 10.2 % of those in the state. This includes 7.4% and 2.6% primary and subsidiary health organizations respectively. A majority of these organizations across both categories provide outreach services and a few also conduct medical research. [36] The top three outreach health activities performed by PNP organization in Rajasthan are health awareness (65.6%), blood donation (30.6%) and immunization programme (24.1%). The funding for these activities is through grants (84.3%) and some from donations (10.4%); very few reported generating resources through user fees (1.9%). Currently, the biggest provider of grants is corporate (47.8%) followed by the government (26.7%). The contribution of foreign funding is less than 2% (Das and Kumar, 2016)

[36] This were subdivided into six categories – health awareness, surgical camp, diagnostic camp, immunization programme, blood donation camp and Maternal care services.

Das and Kumar (2016) also collected primary data on the expenditure pattern of the PNP sector. They estimated the current health expenditure of this sector. Rajasthan contributes to 3.1% of it despite having a significant number of organizations working on health because most of the organizations are in the small or micro category (see Table 3.5). Almost 75% of the expenditure incurred by PNP organizations working in health is towards preventive care followed by 21.6% in ancillary services; only 2.3% of expenditure is on curative care.

Besides, these PNP organizations described above, there are two important actors engaged in welfare in Rajasthan, which merits mention. First, is the business class comprising mostly the Marwari and Jain followed by the Christian Missionaries. The former has a more prominent role in the state; however, their role has been limited to a few districts. They have set up educational institutions and built *Dharamshala* (public rest houses); a few of them have also invested to set up hospitals. These institutions, by their very nature, are based on the principle of charity and provide services to a limited geographical area. According to one of the respondents

> *"Many of the top industrialists in India hail from the Shekhawati region of Rajasthan like Bajaj, Birla, Goenka, Modi. They have limited reach in terms of geographies and also their motivation is to do charity rather than welfare and development."* [Interview with professional with more than 20 years experience in the PNP sector in Rajasthan, Jaipur, August 2019]

Rajasthan also has some health institutions that are being managed by Christian Missionary organizations. There are 11 secondary and tertiary health facilities with a bed strength of 77 that are providing services to the poor and vulnerable population residing in the hard-to-reach areas. These organizations are largely funded through international donations. Regulations related to foreign funding have posed difficulties in their services (Cherian et al, 2014).

Section 3: PPPs in Health Sector in Rajasthan

The history of PPP in Rajasthan is very old. The merchant communities have engaged in philanthropic activities to support the public sector during droughts. While these were mostly sporadic and dependent on the values of the philanthropists, almost every department of the Government of Rajasthan has designed policies and programmes that promote partnership with private sector organizations in different social sectors. Arya (1999) categorized the government and PNP sector partnership in Rajasthan based on their motivations –

(i) Facilitate generation and replication of innovation and alternative approaches to development – These are instances where the state government has relied on the PNP sector to provide newer approaches to resolve development problems.

(ii) Deliver development programmes and services to rural communities efficiently

(iii) Induce systems/ institutional reforms such as reorienting departments towards bottom-up planning and implementation

(iv) Improve people's ability to place demands on public systems

One of the earliest programmes in Rajasthan was the Women Development Programme (WDP), launched in 1984. In this, the government partnered with NGOs to form women's collectives under the leadership of a village-level worker known as the *Sathin*. Another important and pioneering endeavour was the Shiksha Karmi Project. The review of these programmes is outside the ambit of this thesis, but it is worth mentioning a few characteristics of these so-called models. First, all these projects were conceived by the higher-order bureaucrats. For instance, Mr. Anil Bordia was the Secretary of Education when *Lok Jumbish* was conceived. Second, despite that support, the field-level government cadres were not very supportive. Third, although these programmes have triggered some

changes in the model of delivering social sector services, most of those faded over time (Sawhny, 1995; Ramachandran, 2003).

3.1 Types of PPPs in health

The government of Rajasthan's experience of partnership with the private sector for the delivery of health services can be classified into two types – institutional and techno-managerial. The institutional partnerships are those in which the government encouraged private players to set up institutions like medical colleges and hospitals mostly catering to tertiary care, while the techno-managerial partnerships were of different kinds across the three levels of care. The fundamental difference between these two partnerships was that in the former part of the financing and complete service delivery was to be done by the private sector with some support from the state government; while in the latter the state government was the main financier and service delivery was done by the private sector organizations. So in the case of institutional partnership projects, the eligible private partners were mostly corporate PFP organizations and in the techno-managerial ones, there was an engagement of both the PFP and PNP.

The techno-managerial category can be further subdivided into two groups (i) those that were designed and implemented by the state and (ii) those that were implemented in the state, as a part of the national health programme designed by the government of India. The process in Rajasthan started with the national programmes and contracting in the private sector to manage non-clinical services but later the state drafted its PPP policy and recently PHCs have also been outsourced to the private sector. In this section the evolution of PPPs in Rajasthan will be traced, focusing on the techno-managerial partnerships.

The beginning of PPP in service delivery can be traced back to the 1980s when a PHC in a remote tribal block was handed over to a PNP organization, named Prayas because there was a shortage of staff in such

areas. As the founder of the organization was himself a medical doctor it served the purpose well.

> "*We were given the role because government doctors did not want to go to remote locations. We were already working in those villages and since I was a medical doctor it suited their purpose."* [Interview with head of PRAYAS, Chittorgarh, July 2019]

The next phase of PPP was in the 1990s. Most of the projects in this time were in the tertiary care institutions for non-clinical services like diet, sanitation, security and laundry. The first drug store was also established in the PPP model at the Sawai Man Singh Hospital. The private sector, in this case, was an individual who had the required degree and also experience in running a drug store. The hospital authority purchased the required drugs; the private partner was responsible to sell them instead of a fixed salary and one percent commission on the sale (Venkat Raman and Bjorkman 2009).

During the same period, PNP organizations were engaged in the delivery of Information Education Communication campaigns of the government, as the government did not have adequate staff to conduct those. According to a retired official responsible for the IEC in the health department,

> *"In many IEC campaigns, the health department involved NGOs working in rural areas. The human resources for these activities belonged to the NGOs; the government just incurred the cost of the activity.*" [Interview with ex-government official, in charge of the IEC department, Jaipur, July 2019]

The first PPP policy for the health sector in Rajasthan was drafted in 1996, for allotting land to hospitals and also provided fiscal incentives that include exemption from payment of taxes on medical equipment, plant and machinery. Private partners were also eligible for credit provided by Rajasthan Finance Corporation and Rajasthan Industrial Development and Investment Corporation. In exchange, the private sector hospitals were expected to provide services, free outpatient care one hour every day and also 10% of beds for in-patient care, to economically weaker sections

(Raman and Bjorkman, 2006). Some PFP hospitals were established under this scheme for providing tertiary care, but mostly in Jaipur and some big cities. This scheme did not have much impact on the backward regions.

> "*All the private sectors who applied were corporate hospitals. They were interested to set up institutions in cities closer to Delhi as it was more lucrative. Only a few institutions could be established because of the scarcity of land in the bigger cities."* [Interview with an ex-government official in charge of the project, Jaipur, August 2019]

During the decade from 1990- 2000, implementation of PPPs under the national health programmes, like Revised National Tuberculosis Programme (RNTCP), the National Aids Control Programme and the Reproductive Child Health Programme (RCH), National Blindness Control Programme (NBC)) commenced. In NACP and RCH, the role of the PNP sector was more prominent while the PFP sector engaged in cataract operations and family planning services. The majority of the private providers involved in RNTCP were untrained but had a strong community presence especially in the rural areas as well as in urban slums. In some parts of the state Christian missionary organizations were also entrusted as DOTS providers, but these were very few. PFP sectors were also not too keen to participate in the programme. After the Supreme Court order of involvement of the private sector in disease surveillance activities, they were also compelled to participate in surveillance of communicable diseases, especially tuberculosis.

> "*In villages, people mostly go to private providers, who do not have any formal training but they provide health services at the doorsteps. That is why we chose to work with them in RNTCP. The private doctors in the district did not want to join the scheme as they felt recordkeeping was too much* while *the remuneration under the scheme was too little*." [Interview with an official in charge of RNTCP, Jaipur, August 2019]

Many PPP organizations working in these national programmes received funding from international organizations; the most prominent in

the health sector were United Nations Children's Fund (UNICEF) and the United Nations Population Fund (UNFPA). The donor organizations supported the government to pilot innovations in which they mandated the involvement of PNP organizations. One such large-scale project was the Integrated Population and Development (IPD) Project which had two phases. In both these phases, the focus was to improve access to reproductive health-related services and information. A two-pronged approach was adopted – (i) strengthen the service delivery mechanism of the government and (ii) generate community demand. CHARCA Project was another UNFPA initiative for HIV/AIDS [Dwivedi and Jacob, 2007].

Similarly, the Border District Cluster Strategy (BDCS) of UNICEF, launched in 1995, aimed to strengthen the maternal and child health interventions through the participation of the PNP organization [Kumar, 2007]. While these projects do not qualify strictly as PPP, because there was no formal relationship among the public and private organizations, but they fostered a working relationship between these two sectors. This association was capitalized by the PNP sector to partner with the government.

> "*Our projects aimed to ensure better access to maternal and child health service. For that, we worked both with the government for the supply-side factors and also with NGOs for the demand generation. This provided an opportunity for NGOs to work in government programmes*." [Interview with a representative of UNICEF-Rajasthan, Jaipur, July 2019]

The major push towards private sector engagement was after the launch of the World Bank-funded Rajasthan Health Sector Development Project (RHSDP) in 2004. The Project Implementation Plan of RHSDP recommended the state government to position itself as a facilitator to build an environment of trust with the voluntary and private sectors for a range of activities (Box 3.2). INR 126.3 million was allocated for these (GoR, 2003).

Box3.2: PPPs proposed under RHSDP (GoR, 2003)

- Management of ambulance services
- Management of diagnostic centres in secondary level public hospitals
- Information Education and Communication
- Management of Primary Health Centres in the tribal areas.
- Operating mobile health clinics in remote and hard to reach areas
- Management of pharmacies in secondary hospitals
- Contracting-in of specialists and technical staff in health facilities

The idea to contract out the diagnostic services was implemented in 2004 when the state government initiated a partnership to install, operate and maintain MRI and CT scan machines in the SMS hospital. In this arrangement, the private provider had to invest their own resources for the purchase of the machine as per the specification of the government. The private provider could charge the users, according to the rates pre-decided by the government, in lieu of the services provided, but was obligated to provide free services to 20% of BPL families. The selection of a private partner was a time taking process due to political interference (Venkat Raman and Bjorkman, 2009).

Notwithstanding the advantages of this arrangement, for the government, the private partners as well as the patients, there were some difficulties. There were no institutional mechanisms by the SMS hospital authority to address the problems faced by the private provider. The staff employed by the private provider was less while the workload was very high. The patients also complained about the quality of service provided by the private partner (*Ibid*). As concluded by the Raman and Bjorkman (2006), in their study of PPPs in Rajasthan,

> *"In such arrangements, the public agency officially gets more benefitted, while the private sector also gains experience and popularity. There is very little scope of the private sector to make a profit, which triggers undesirable practices; resulting in problems for patients, especially the poorer sections."* [Venkat Raman and Bjorkman, 2009, pp.212]

With the launch of the National Rural Health Mission in 2005, PPPs became more prominent. As one of the high focus states in the Mission, the state started implementing other PPPs like operationalizing Mobile Medical Health Services and Emergency Referral Services for remote areas along with RCH clinics in the urban area. The PPPs under the national health programmes also continued. All these arrangements were based on the guidelines of the central government.

The emergency referral was one of the new services launched under NRHM in 2008 known by the name 108. By February 2009, there was a fleet of 100 ambulances across 58 towns of Rajasthan. The Government of Rajasthan provided the capital cost for purchasing and equipping these ambulances as well as 95% of the operational cost. Besides, it also provided the space for the Call Centre. Operationalizing and management of these ambulances and backend support from the Call Centre was the responsibility of the private player. There are no user charges for these services, even the phone number to call for emergency service is also free.

The second PPP policy, drafted during this time, was more holistic compared to the previous policy. The foremost stated objectives of PPPs, as per the policy, were to improve equity and access to essential quality and cost-effective healthcare services i.e. increase penetration to remote areas and provide services to economically and socially vulnerable sections free or at subsidized rates. It also aimed to improve the quality of healthcare services and efficiency in the allocation of resources in the healthcare sector, enhance community ownership in healthcare programmes and strengthen existing healthcare delivery systems in that state (GoR, 2008).

According to the document, the private sector, divided into for-profit and not-for-profit, had certain inherent strengths namely presence at all levels of the community, viable business model and market presence with

existing client base, good management system, efficient and flexible style functioning. The public sector, on the other hand, was characterized by a large-scale presence, a lot of technical and professional expertise, available in rural and inaccessible areas and more equitable functioning. The term partnership was also clearly defined in the policy (Box3.3*)*.

Box 3.3: Partnership Definition (GoR, 2008)

A collaborative effort and reciprocal relationship between two or more parties with clear terms and conditions to achieve mutually understood and agreed upon objectives, following certain mechanisms, formed with the intent to utilize the relative strengths of the public health system and private sector.

The framework for implementation of the policy mandated a district-specific model of PPP to ensure that PPPs are customized to the needs of the districts as well as based on the capacities of the private and public sectors in the district. For successful transactions between the two sectors, it proposed to: (i) enhance the skill of public sector officials (ii) constitute a *Committee of Standards*, at the state level to lay down the performance indicators for a range of services and also issue guidelines to facilitate accreditation of the private sector by the district level officials, (iii) seek stakeholder participation to develop standards for the primary health services and (iv) design a financial and accounting system, for verification and settlement of claims by the private partner, which is efficient as well as responsive.

This document alluded to three partnerships for health service delivery; two of these were techno-managerial while one had both techno-managerial and institutional components. Of the first two, the first partnership was for the operation and maintenance of the Primary Health Centre (PHC) or Community Health Centre (CHC). The second consisted of specific healthcare services, both outpatient and inpatient, related to maternal health, child health and family planning along with ancillary services viz. pharmacy, diagnostics, emergency transport. It

also included preventive services like school health programmes and the adoption of block and districts by private medical colleges.[37] The third model was setting up new medical or other educational institutions associated with existing hospitals.

According to the policy, the authority with regards to PPP transactions was delegated to the District Medical Relief Society, which included identification of potential partners and monitoring, while the selection of partners was to be done by the State Medical Planning and Resource Committee. This body was supposed to function under the chairmanship of the Principal Secretary, Medical, Health and Family Welfare Department. Out of 12 members, 11 were from the government department, and one was a private member associated with the medical profession but nominated by the government. Besides, for regular monitoring of the PPP activities, a special cell was to be formed at the state level and also at the district level.

To select the private sector for these partnerships, the government proposed to follow either of the two approaches –

(i) private sector identified by the district level officials followed by open bidding
(ii) private sector approaching the government followed by a scrutiny of the proposal.

In either case, the private partner had to meet some essential eligibility criteria, both technical and financial. For a PNP, there was registration under proper Acts, followed by a minimum three-year experience, annual turnover (specified on a case by case basis), but for the PFP the registration of the medical doctor was the only requirement. For

[37] In 2006, the state had also formulated a policy to promote private sector medical colleges in the state. That policy was under the Department of Medical Education, hence outside the purview of this thesis.

the PNP organizations, another criterion was that it should not be a defaulter in any other government projects.

In the duration of RHSDP (2004-12), the state government was unable to foster partnerships with the private sector to manage CHCs in remote areas. As reported by a retired government official who was working in RHSDP, the private sector organizations showed very little interest in adopting the CHCs in remote areas. The private sector was likely to show interest in those CHC that were well functional. These providers were largely situated in the vicinity of these public facilities.

> *"We attempted to encourage private healthcare providers to adopt Community Health Centres, especially those in the remote blocks, but there was not much response. Most of them wanted to adopt those institutions which were already well functioning, while the department wanted the private sector to provide services in the remote blocks."* [Interview with ex-government official leading the RHSDP, Jaipur, August 2019]

3.2 PPP for primary level care

The state had adopted the PPP strategy for primary level care under the national health programmes, which will be discussed in greater detail in the following two chapters. However, it is also important to mention the recent developments in state-promoted PPP for PHCs. The process started with a rapid assessment conducted in 2014, to examine the scope for private sector participation in managing public health facilities. This study was funded by a corporate foundation that had approached the state government for adopting PHCs. The study revealed that while there is adequate potential for a successful PPP, there are many bottlenecks within the public system that inhibit its realization.

According to a senior official of the health department, a cell was constituted with health department officials at the state level under the leadership of the Additional Mission Director (NHM) to formulate the PPP. For technical support to this cell, a group of external experts was also identified which included academics known for their work in PPPs,

ACCESS Health International, Max Institute of Healthcare Management and Wadhwani Initiative for Sustainable Health (WISH). It is of relevance here that WISH was the organization that had proposed to adopt 30 PHCs before the launch of this scheme.

For the execution of the new scheme, the government adopted an open tender approach. First, a Request for Proposal (RFP) was advertised on July 23, 2015, for 300 PHCs. The RFP mentioned certain minimum eligibility criteria like the prior experience of managing any government hospital or any 10-bed hospital and an annual turnover of more than INR 10 million for the last three years. The government had estimated an amount of INR 3 million per PHC annually that will be payable to the private partner, but the selection was based on the lowest bidder. The private partner who entered into the partnership with the government was expected to pay INR 0.5 million per PHC at security deposit, employing an 11-member team led by an allopathic doctor at the PHC. Besides, one Auxiliary Nurse Midwife had to be positioned in all SHC in the PHC catchment area by the private partners [Gupta and Pachauli, 2015].

This decision of the government triggered antagonism. A protest was launched by the Association of Nurses in Rajasthan in June 2015 [TOI, 2015]. Initially, they demanded to roll back this decision as it would affect the people; although later it was evident that they intended to secure the government jobs of the nursing staff. According to one of the members of the core committee, the decision to withdraw the protest was taken when the officials of the department had assured that the currently sanctioned positions of the nursing cadres will not be affected by this decision.

> "*We were assured by the higher officials of the government that the sanctioned posts of nurses, across grades, will not be reduced. So we did not have any further grounds for protest."* [Interview with a representative of Rajasthan Nurses Association, Jaipur, August 2015]

This process was completed by September 2015, with only 90 of 300 PHCs allocated to private sector organizations. 12 PHCs were handed over to private medical colleges that used these as their training sites for their doctors. Similarly, 10 PHCs were private hospitals. Out of the remaining majority, 17 were allotted to the WISH Foundation. Around 25 were given to the PNP sector but most of them did not have the required experience of managing any health facility. Currently, only 74 PHCs are being run in the PPP mode [Annexure 2].

While the state has been implementing PPPs in the health sector, very few studies have been conducted to evaluate the effect of these partnerships on service delivery. For that, it is important to review these studies and complement that with insight from important and relevant stakeholders who have been either associated with the project or have contested it.

3.3 Experience of PPP in the state

The focus of this chapter is on the health sector. From the above-mentioned description, it is explicit that the history of PPPs, in Rajasthan, the social sector in general and the health sector in particular, is since the 1990s. The interest to form a partnership was expressed by the PNP organization and the international donor agencies, but not by the PFP sector. The first PPP with Prayas (PNP), in Chittorgarh, was discontinued despite the support of the state government officials. The key respondent from the organization reported that they faced resistance from the district-level officials, which eventually resulted in discontinuing the scheme within a year.

As mentioned in the interview, there was an incident in which the government officials in the district had misleadingly reported about the organization's work in the community. As a result, the contract was terminated after one year.

> *"We decided to improve the immunization coverage in the area, so began administering all the vaccines under the programme. As is the case with*

> *DPT vaccines the patient ought to develop a fever if it is administered properly. As the immunization coverage improved with concerted efforts from our end, many children had a fever. Although we counselled the family about the side effects and also provided medicine for that, the district administration spread a rumour that the vaccines were of inferior quality as result there was fever. This left a bitter taste and we decided to quit the partnership."* [Interview with a representative of Prayas, Chittorgarh, July 2019]

The incident is an indication that even when the government initiated the process of partnership, the level of acceptance between the different tiers of the public sector was not similar. Thus, even if the state government officials promote PPPs, the disapproving attitude of the district level officials towards the PNP organization may be a deterrent for the sustainability of the partnership.

Some concerns have been raised by different respondents about the current PPP for PHC. First, the process of selection was conducted at the state level, with hardly any participation of the district officials. While the justification given for this was lack of capacity at the district level, the same problem was found at the state level also. According to the officer in charge of the PPP cell, the cell at the state level lacked the adequate capacity to manage PPPs.

> *"In the PPP cell, I am the only person. As I am a medical doctor I do not have the required skills to prepare and manage a contract. Moreover, I do not have any support to monitor these private providers."* [Interview with one state-level official responsible for PHC-PPP, Jaipur, August 2019]

The second issue was that the private sector engaged in the partnership varied in their capacity as well as in motivation While some of them were interested in promoting their technology, others saw this as an opportunity to get more patients to their institutions.

> *"I have serious doubts about the selection process of the private organization under the scheme. There are NGOs in the list whose performance in the Urban RCH project was not up to the mark."* [Interview with an ex-government official of the department, Jaipur, August 2019]

> *"The biggest challenge of giving PHCs to private hospitals is that they would eventually benefit the provider more than the people as patients will be referred from the PHC to these private hospitals."* [Interview with a representative of PNP organization, Chittorgarh, August 2019]

The third problem is linked to the second one. According to the MOU, the PHC, managed by the private sector would otherwise function like any of the government facilities, but they can also charge the users for some additional services. These services were not included in Indian Public Health Standards. This clause of the contract could be misused by the private sector by introducing high-cost services which will help them recover the cost of running a PHC and may also be for profit-making (Gupta and Pachauli, 2015).

There are other anecdotes shared by different respondents which reflected that district officials often supported those organizations which were willing to bribe. The culture of corruption is inimical to the effective implementation of the project and the monitoring of the partners.

> "*There is rampant corruption at the district levels in the release of payments. The district officials tend to trouble those organizations which are not willing to give them any extra money (upri kamayee), while they turn a blind eye to the functioning of those who do. There is a difference in the way they monitored these two types of organizations. The state government officials do not intervene in these matters much."* [Interview with a representative of a leading PNP organization, September 2019]

Section 4: Discussion

Rural and urban differences in health status in Rajasthan can be partly attributed to the characteristics of health services that are available in the hinterland. The distribution of public health services in the state does not address the needs of the rural population. The reasons are many shortcomings in the service delivery mechanism, financing and regulation. There is a shortage of human resources as well as gaps in the infrastructure in those areas. The budgetary allocation for health has also stagnated between 2014-15 and 2018-19 (CBGA, 2019). The regulatory mechanism in the state is also not adequate. Having said that, it is important to acknowledge that the state government has introduced schemes for free drugs and diagnostics at public facilities.

The PFP sector in the state has also added to the plight. These services are mostly centered in the urban and more developed areas in the districts. This makes it difficult for the rural population to access those. The cost of care in these facilities is relatively higher than in the public sector but without any guarantee for quality. The PFP sector is also less visible in the tribal regions. As far as the PNP sector is as concerned, the focus is mostly for demand creation rather than service delivery. There has also been a change in the structure of these organizations which has distanced them from the population that they served.

Despite these lacunae in the private sector organizations, the government of Rajasthan adopted different approaches to engaging them. While the process started in the tertiary level care, in 2015 there was a decision to hand over some PHC to private entities. Drawing from experiences of the PPPs in the past as well as those that are currently operational it is evident that the strategy has not addressed the problem of inequity in access, although it was one of the justifications for forging partnerships with the private sector. The issue of unsatisfactory

functioning of the PPP for PHC was brought to the notice of the Rajasthan High Court, which then ordered the state to discontinue this arrangement with immediate effect (Iqbal, 2020).

All these facts indicate the problems with the PPP models of service delivery in the context of Rajasthan. However, there is not much empirical evidence, except journalistic reports on this matter. The latter two chapters, therefore, are dedicated to two such programmes where the private sector has been engaged.

Chapter IV: Public-Private Partnerships for Reproductive Health Services in Rajasthan

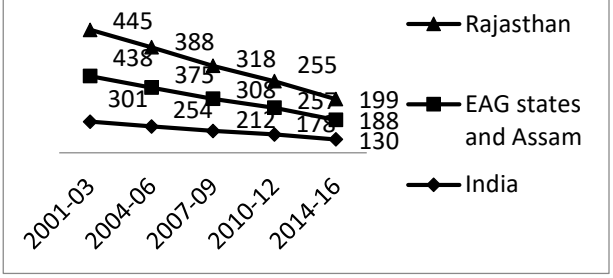
The public sector is the most preferred service provider for reproductive health services. The private sector delivers services to only urban and upper-class people. Then, why do we need a PPP model for these services in rural areas? [Interview with the retired director, State Health Department]

Reducing the Maternal Mortality Ratio (MMR) was one of the Millennium Development Goals (Goal -5) and continues to be a priority under the Sustainable Development Goals (Goal 3.1). Although India's MMR has reduced since independence, it is one of the countries which registered very slow progress in achieving the target of MDG and the rate of decline in MMR has been decelerating in recent times (Joe et al, 2015). There are also differences in MMR across states. Rajasthan is one of the states whose MMR is more than the national average (India -130, Rajasthan -199). It has the third-highest MMR after Assam (237) and Uttar Pradesh (210) (SRS, 2020). However, there has been a steep decline in the MMR figures in Rajasthan, as compared to the EAG States and Assam (Graph 1).

There is evidence that clinical interventions along with primary level care and referral childbirth services can reduce MMR. Although providing these services is the responsibility of the government, but the issue of inequitable access to these services has not been addressed adequately in the different phases of reproductive health programmes launched in India (Joe et al. 2015). As a result, the rural areas in the poorer states have

higher MMR and IMR as compared to their urban counterparts in the richer states (Montgomery et al., 2014).

Graph 4.1
Decline in MMR:
India, EAG states and Rajasthan



Data Source: Joe et al., 2015 (2001-03 to 2010-12); SRS, 2018 (2014-16)

Broadly three criticisms can be leveled against those programmes. First, reproductive healthcare has focused more on family planning services. This, in turn, has reduced the investments for other primary-level health services. Second, there is not much attention to improving the status of women in general and their health in particular. Third, the programme so far has been driven by the central government with very little state and local government engagement (Qadeer, 2011; Sen Gupta, 1998).

There has been an engagement of private sector organizations since the launch of the Family Planning Programme(FPP) in 1952. Presently, the programme has been subsumed under the National Health Mission, but there is a scope to involve the private sector in delivering sterilization and institutional childbirth services. However, the public sector continues to be the primary provider of both these services, in India as well as in Rajasthan (Table 4.1a and 1b). The role of the private sector is much less in rural Rajasthan compared to the national average.

Table 4.1a: Utilization of Female and Male Sterilization Services (in %)

Type of Provider	Location	Female Sterilization		Male Sterilization	
		India	Rajasthan	India	Rajasthan
Public Sector	Urban	71.8	87.7	82.1	-
	Rural	86.8	94.1	94.1	-
	Total	81.8	92.8	90.4	-
Private Sector	Urban	27.2	12	16.4	-
	Rural	12.7	5.7	4.9	-
	Total	17.5	7	8.2	-

(*Data Source: IIPS, 2017*)

Table 4.1b: Utilization of Healthcare Services for Childbirth (in %)

Type of Provider	Location	India	Rajasthan
Public Sector	Urban	46.2	57.6
	Rural	54.4	65.1
	Total	52.1	63.5
Private Sector	Urban	42.5	32.7
	Rural	20.7	17.2
	Total	26.8	20.5

(*Data Source: IIPS, 2017*)

Under the current programmatic framework, there are two modes of engaging the private sector to deliver sterilization and childbirth services. First is cost reimbursement, in which the accredited private facilities that meet certain criteria are contracted by the government to provide free services. Second, a specialist from the private sector is contracted to provide services in public institutions. The first mode is adopted for both institutional childbirth and sterilization services. This is akin to strategic purchasing that was proposed by the Planning Commission's High-Level Expert Group (HLEG) on Universal Health Coverage (UHC) as well as in the National Health Policy, 2017. According to the policy, adopting this approach would enable the government to play the stewardship role in directing private investment towards those areas and those services for

which there are no providers or few providers (PHRN, 2018). Thus, the purpose of promoting PPP for reproductive health services is to increase the pool of service providers so that the coverage increases.

This chapter attempts to understand the experience of the PPP in addressing the barriers to access to sterilization and childbirth services in rural areas. The chapter is divided into five sections. The first section traces the evolution of PPP approaches that have been adopted for family planning and childbirth services in India as well as in Rajasthan. The second section is a review of the literature of different PPP experiences in sterilization and institutional childbirth in India. The distribution of PPP in Rajasthan is presented in the third section. The fourth section presents a granular description of selected PPPs, currently functional, in Udaipur and Sirohi, the two study districts of Rajasthan. The final section discussed the findings of the empirical study in light of the existing evidence related to the PPP in reproductive health services in India.

Section 1: Historical overview of Reproductive Health Services in India and Rajasthan

In the Indian context, the history of reproductive health services can be divided into two phases– (i) from 1952 till the 1980s and (ii) From 1990 till date.

1.1: From 1952 till the 1980s

The genesis of reproductive healthcare can be traced back to the Family Planning Programme launched in 1952 to address the problem of population growth. Initially, the programme was envisaged as part of the general health services, but it was given priority over other services. A very high proportion of the funds and resources were deployed for this programme (Qadeer, 2011). An extensive network of birth control strategies along with a variety of approaches for mass communication, training and research was adopted. One such strategy was to encourage

the non-government organizations (NGOs) who were already active in the birth control movement to spread awareness about small family norms and avail of family planning services offered through the government facilities. Till the mid-1960s, these NGOs were engaged to educate and motivate local communities about contraception through community groups as well through service units, but especially in the densely populated urban areas (VHAI 1992).

Following the recommendation of the first United Nations Mission to review the FPP in 1965-66, the Post-Partum Programme was launched in 1969-70. The objective of the programme was to provide advice and services on contraception primarily to obstetric and abortion patients in the hospital (VHAI 1992). Owing to the shortage of trained staff, private maternity homes and practitioners were also included under the ambit of this programme, especially for sterilization and insertion of Intra-Uterine Device (IUD) (Ledbetter, 1984). Special efforts were also made to encourage members of the Indian Medical Association and other professional bodies to participate and contribute to the programme in their clinics or any clinic run by the government (Banerji 1985).

In addition to demand generation and institutionalized family planning services, the government also engaged the private sector in the Contraceptive Social Marketing (CSM) programme in 1968. The primary objectives of the programme were – (i) to ensure availability of quality and affordable condoms to the low-income groups closer to where they live through the distribution channel of companies in the category of Fast Moving Consumer Goods (FMCG) and (ii) leverage the sales strengths of the private sector in the FPP. Initially, the programme for the distribution of condoms, Oral Contraceptive Pills (OCP) was also introduced in 1987. These Social Marketing Organizations (SMOs) were also permitted to launch their special brands. By the early 1990s, the NGOs were the

dominant SMOs as the leading FMCG companies withdrew from the programme (UNFPA 2015).

The roles of the private partners engaged in family planning during this period can be classified into three categories– NGOs engaged in generation of demand for family planning services; private hospitals and practitioners delivered sterilization services; and the FMCG companies, as well as NGOs involved in social marketing of contraceptives. While these partners were working in tandem with the goal of the country's goal to contain population growth, the funding for their services was, primarily, from international donor agencies promoting the agenda for population control. Thus, the NGOs who were engaged in these programmes did not have much choice in setting the priorities (Ramachandran 1998). Besides, the involvement of the private sector in the distribution of contraceptive measures also indicated a trend towards private investment and user fees for services that were earlier free (Ledbetter, 1984).

1.2: From 1990 till date

By the 1980s, it was understood that the non-attainment of the targets in the Family Welfare Programme[38] was due to the failure of the public system in addressing people's health needs. The review of the Seventh Five Year Plan (1985-90) suggested that to achieve the targets of FPP significant improvement in maternal and child health service was essential (Connelly, 2006). Subsequently, in 1990 the International Conference on Population and Development in Cairo ushered a paradigm shift in family planning towards the reproductive and child health (RCH) approach.

The period after ICPD coincides with the health-sector reforms era in which there was a shift from public provisioning of health services to

[38] The name of the Family Planning Programme was changed to Family Welfare during 1978-79. This change was to emphasise the decision to implement the welfare component and steer clear of coercion, force and disincentives (VHAI 1992, p 202).

private provision with public financing/ purchasing. Following the health sector reforms agenda, engagement of the private sector was promoted. According to the World Bank's report titled 'India's Family Welfare Programme: Moving to a Reproductive and Child Health Approach' the private sector was necessary to increase coverage but there was a need to monitor the engagement of the private sector to ensure its applicability in different locations.

> "Private sector offers a substantial potential for increasing the coverage of some reproductive health services. In some instances, for example, contracting private doctors, the financing may come from the public sector, while the services can be efficiently provided by the private sector. This will result in providing clients with a wider choice and will enhance service quality." (World Bank, 1996; pg 6)

The advent of the RCH approach in population control ideas globally led to the launch of the Reproductive and Child Health (RCH) programme, in India, in 1997. Launched during the health sector reforms era, the programme embarked on initiatives to increase the involvement of private medical practitioners in providing family welfare services to the poorer sections, especially in the under-served areas. These health care providers were given orientation training and it was ensured they had ready access to contraceptives, drugs and vaccines free of cost (Bhat, Maheshwari and Saha 2007).

The Mother NGO (MNGO) scheme, also launched under the RCH programme was one of the largest initiatives to involve NGOs to deliver RCH services in under-served and unserved areas where NGOs were involved in multiple levels starting from the village to the state (*ibid*). Two types of NGOs were involved in this scheme- the Mother NGO (MNGO) and the Field NGO (FNGO). The MNGO selected at the central level in consultation with the state government was responsible for the capacity

building of FNGOs who are working in remote areas. The role of the FNGOs included both awareness generation as well as the provision of some non-clinical RCH services. However, it was found that states with high fertility and mortality rates still have a large number of districts without any NGO presence (*ibid*). Later in 2003, the Service NGO was introduced in this scheme. Those NGOs "with an established institutional base and delivery infrastructure are encouraged to complement the public health system in achieving the goals of the RCH programme" (GOI 2003).

In 2005, the RCH programme was subsumed under the National Rural Health Mission (NRHM). Janani Suraksha Yojana (JSY), one of the important schemes under this mission, was aimed to promote institutional delivery. To increase the pool of providers in the scheme, two modes of engaging the private sector were recommended under the scheme. One of them was to accredit and empanel private facilities with certain criteria to provide institutional childbirth services free of charge. According to the national guidelines for the scheme, there is no provision for reimbursing the private sector but the woman who avails services from those institutions would be entitled to the cash incentive mentioned under the scheme (GOI, 2015). Gujarat was one of the first states to engage private facilities for childbirth under the Chiranjeevi scheme in December 2005. Since then other states have contracted private hospitals in the delivery of services; some also contracted private gynaecologists into the public facility.

The revised compensation scheme and national family planning insurance scheme, under NRHM, were also launched to promote PPP in family planning. NGO/ Private Clinics were accredited for these schemes to increase the provider base for family planning services, especially sterilization (GOI 2007). To further buttress the involvement of the private sector in high populous states, the National Population Stabilization Cell (NPSC) also launched the 'Santushti' scheme in June 2012. According to

this Scheme, an accredited private Nursing Home/ Hospital (Quality assurance manual for Sterilization services), working under Mission can sign a Memorandum of Understanding (MOU) with NPSC. Upon signing the MOU, private hospitals/nursing homes shall be entitled to get an incentive, whenever it conducts 10 or more Tubectomy/Vasectomy cases in a month (GOI 2018).

Recognizing the poor health status of the urban poor, the Urban RCH scheme was launched under the NRHM. This was implemented in partnership with NGOs. Once selected the NGOs were given the contract to establish and operationalize the urban PHCs in the selected locations. The performance indicators for the programmes included uptake of maternal (ANC, PNC, institutional childbirth), child (immunization), reproductive (contraception and RTI/ STI treatment) and family planning. However, the scheme was discontinued after the National Urban Health Mission was introduced.

In 2016, the Pradhan Mantri Surakshit Matritwa Abhiyan (PMSMA) was launched to improve the quality and coverage of Antenatal Care (ANC) including diagnostic and counseling services for all pregnant women in the second and third trimester. In this programme, private doctors like obstetricians and gynaecologist, radiologists and physicians are encouraged to provide voluntary services at public health facilities once a month (PIB, 2018). According to the PMSMA website (pmsma.nhp.gov.in), 6200 private doctors have volunteered for the programme across India. Yet another mission, the Mission Parivar Vikas was launched in 2016, to substantially increasing access to contraceptive and family planning services in 146 high fertility districts across seven states (GoI, 2016). Among the different approaches adopted in the mission, the High Focus District Compensation scheme encourages accredited private/ NGO facilities to participate. While similar provisions have been there earlier, the amount payable to the private sector was increased slightly (*ibid.*)

1.3: PPPs for reproductive health in Rajasthan

Although 'Health' is a state subject, the history of engagement of private actors in family planning in Rajasthan has been as per the national guidelines. Since the inception of the programme, the private non-profit (PNP) organizations were engaged in demand generation for family planning services as well as the distribution of condoms and oral pills. Most of these efforts were funded by international donors and some organizations also received financial support from the government to promote family planning services. Condoms and oral contraceptives to these organizations were supplied by the government.

The process of partnering with the private for-profit (PFP) sector gained momentum in the 1980s with the Post-Partum Programme under which such hospitals were empanelled to conduct static sterilization camps under this programme. The state government was given a target by the centre, for which it required the help of private partners who were already providing obstetric and gynaecological services (Box 4.1; Quote 1).

Another reason for the involvement of the private sector in Rajasthan was the presence of PNP sector organizations like Marie Stopes International which were already delivering family planning and abortion services since the 1980s. In the initial stages, these centres were functioning independently with the financial assistance of international donors and through nominal user fees. In the 1990s, they started taking part in government programmes for delivering sterilization services (Sohoni, 1994).

The MNGO scheme was also implemented in Rajasthan for a brief period. With the launch of NRHM, the MNGO and the FNGOs were engaged in an innovative project to ensure access to JSY services through a telephonic helpline. The project started in November 2006 across 28 districts of Rajasthan in partnership with NGOs. Despite the good performance of this project, it was terminated in an ad-hoc manner within

six months of its implementation by an order of the then Principal Secretary Health of Rajasthan. The head of the organization responsible for this project suspected that this decision was taken because the staff in the public facilities did not want to be monitored by the NGO functionaries (Box 4.1; Quote2).

Under NRHM, the Urban RCH programme was also implemented for about three years between 2008- 2011 in eight cities of the states. The implementation of this programme, in Rajasthan, was through the private sector institutions, mostly NGOs. While the state government officials were responsible for the drafting of the contracts as well as the selection of the private partners, the task of monitoring them was with the District Health Societies. The programme was discontinued, in the state, after 2012 for two main reasons. First was the non-availability of private partners who could deliver RCH services and second was laxity on part of the district officials in monitoring those private organizations selected under the programme (Box 4.1; Quote3).

Currently, PPPs are operational in family planning services for sterilization and IUD insertion as well as for social marketing of contraceptives. The contract for the latter is managed by Govt. of India with no operational link with the state department. For the former, private sector facilities are accredited. A similar strategy is followed for engaging the private sector under the JSY scheme. While the history of PPP in sterilization was seamlessly integrated, the state government functionaries were reluctant to engage with private sector facilities under JSY.

In 2012, after the Supreme Court judgment, the central government mandated the state governments to ensure that institutional childbirth facilities were available to all. Hence, the state government started the process of empanelling private providers for JSY (Box 4.1; Quote 4). Besides, Rajasthan is the first EAG state to successfully engage almost 800 private practitioners in the PMSMA. The state government's effort

under this campaign has also been appreciated by the central government (PIB, 2018). However, an evaluation of this campaign conducted by GoR revealed that the participation of private doctors in the scheme is very less because there is no provision of cash incentives under this campaign (GoR,2020).

Box 4.1: Responses on history of PPP in Reproductive Health Services in Rajasthan

1. "To attain the high targets set for sterilization it was necessary to increase the number of institutions who could provide sterilization, so the private sector organizations were included in the Post-Partum Programme launched in early 1980s. This was the first time when for-profit sector was engaged in delivery of any government programmes in the state." (Interview with Ex Official, Family Welfare, Govt. of Rajasthan, Jaipur, August 2015)

2. "The government staffs were not comfortable with the help line, they felt that there work was being monitored, so they abruptly discontinued the programme". (Interview with NGO staff engaged in JSY helpline, Jaipur, August 2015)

"Urban RCH Programme was not successful as it was difficult to get good NGOs. Most of the NGOs did not employee adequate staff and adopted corrupt practices. There were gaps in the monitoring by the district officials in the backward districts" (Interview with Officer in charge of Urban RCH programme, DMHS, Govt. of Rajasthan, Jaipur, September 2015)

3. "Though the Government of India repeatedly asked us to engage private sector for providing institutional delivery, the higher officials in the state did not think it was necessary. This decision was taken after the central government mandated all states to empanel accredited private health facilities." (Interview with Ex Official, DMHS, Govt. of Rajasthan, Jaipur, August 2015)

Section 2: Experience of PPP in reproductive healthcare

There have been different types of PPPs in reproductive health services in Rajasthan, namely social marketing of contraceptive and contracting- in of gynaecologists in public health facilities. In this study, only those PPP models are included in which private facilities are being accredited and empanelled for delivering services under any public health programmes and schemes[39]. These two services are for sterilization and

[39]These two form of PPP were not included for two reasons. First, objective of this study was to capture the plurality of partnership which required an in-depth analysis of the different types of partners. By concentrating the study to one model of partnership offered the scope to delve deeper into the structure and function of different types of private/ NGO partners involved and their relationship with the government. Second, it was also possible to gather information about the other models of partnerships through these existing partners, who were engaged with those models in the past or currently.

institutional childbirth. This section presents a review of literature, from India and other countries, for these two services.

2.1: For sterilization

Among the various national health programmes in India, PPPs have been most common for family planning. There has been the involvement of both private for-profit (PFP) and private non-profit (PNP) sectors. The role of PFP facilities was more in the delivery of sterilization services because most of the specialized doctors were employed in those facilities while the involvement of the PNP organizations was mostly for demand creation for family planning services and social marketing. Few PNP organizations were also delivering sterilization services in the social franchising model in some states (Ravindran,2011; Baru and Nundy, 2009).

In the Indian context, research on the PPP models in family planning in general, and sterilization, in particular, is limited. Studies about the role of PNP organizations suggest good practices, but these models have not been successfully scaled up (Baru and Nundy, 2009). The PFP sector's role, albeit small, has been more on promoting emergency contraceptive pills, spacing methods and social marketing of contraceptives (Pachauri 2014). Moreover, the PFP sectors were mostly interested to take part in the provision of abortion services (Muttreja and Singh, 2018).

Some international agencies have initiated programmes for engaging the private sector in family planning. United States AID (USAID) promoted the Sambhav Scheme in six cities of Uttar Pradesh. In this scheme, the PPP approach was adopted to improve access to reproductive healthcare, including family planning. The evaluation of this scheme buttresses the claim that the voucher model was successful in reducing the inequities in access to family planning services (Rajani et al, 2010). Based on the

indicators of the study[40], it can be argued that the scheme was designed to encourage and extend commercialization in public sector health care in India. This service delivery model is also gender insensitive as it focuses only on the women who required service without challenging the gender differentials associated with seeking reproductive health care (Gideon, Hunter and Murray, 2017).

The two examples of the Social Franchising model of PPP are Janani Clinic in Bihar and Jharkhand, and Merrygold Network in Uttar Pradesh. The Janani Clinics was designed to provide a range of maternal health services at the village level with a referral system. After the launch of JSY, they focused their services on oral contraceptives, condoms, injectable contraceptives, Copper T, emergency contraceptive pills, sterilization as well as abortion, both medical and surgical. There is evidence that some users preferred to seek sterilization services in these clinics even though they did not get the cash incentives payable to beneficiaries at public health facilities. However, there is no study on the functioning of these clinics (Ravindran, 2011).

The Merrygold Network was a four-tier system. The first tier was at the village level comprising Registered Medical Practitioners, ASHA, practitioners of ISM, and chemists who provided counseling for family planning services and also undertook social marketing of various products. Quantitative data on clients indicated that the franchise catered predominantly to better-off sections of the population. According to the manager of one of the franchised clinics, the poor could simply not afford their service (*Ibid*). Studies have also shown that most of the private institutions recruited into a franchise are those who are already in business, are located in areas with sufficient population and are well

[40]One of the three evaluations of the Sambhav Scheme reported that it had little prospect of financial sustainability after the donor funding was withdrawn. Despite this, the report recommended that the state government explore the option of PPP for strengthening the health service system. (see, Gideon, Hunter and Murray, 2017)

connected with transport (Gideon, Hunter and Murray, 2017). As a result of these characteristics, the franchise does not serve the under-served regions.

The experience of private sector engagement in the delivery of family planning products and services in other countries also provides valuable insight. In this context, a study commissioned by USAID in 11 countries of Eastern Europe and the Eurasia region highlights three key findings. First, the private sector is more interested to deliver those services for population control that have high-profit margins. Second, they prefer to operate in urban areas with a higher concentration of people, especially where the majority of the population is willing to pay for family planning services. Third, the private sector also enters the market where there is demonstrable demand for FP services thereby reducing the cost for marketing and awareness generation (Francoise et al., 2007). A similar trend was also seen in Rwanda, where the PPPs for family planning services were mostly located in the urban areas and were serving a small section of the population. While strongly recommending social franchising and voucher schemes for family planning services, the study acknowledges that a strong government leadership manifested through technical support to providers as well as monitoring is crucial for the quality and equity of reproductive healthcare (Rajani et al., 2010).

The above studies not only pose questions about the veracity of the claims regarding the positive effects of engaging the private sector for sterilizations it also refutes that this model of service delivery is promoting equitable access. Despite that, the strategy of PPP continues to be adopted for providing these services.

2.2. For institutional childbirth

JSY is currently operating nationwide schemes that adopt PPP for institutional childbirth, hence most of the studies are on this scheme. A

review of these schemes becomes imperative to capture the experience of PPP in India for institutional childbirth. Comparison of the institutional childbirth data between 2004 and 2014 showed that the bulk of the increase was in the public sector (23% in 2004 to 53% in 2014), with a modest increase in the use of private sector services (22% in 2004 to 30% in 2014). Decomposition analysis of the data indicated that 51% of the reduction in socioeconomic inequalities was associated with pro-poor distribution in the public sector (Joe et al., 2018).

A concurrent assessment of JSY, conducted by UNFPA, in five EAG states (Bihar, Madhya Pradesh, Odisha, Uttar Pradesh and Rajasthan) revealed that PPP was not an effective approach for increasing access to institutional childbirth services. One of the indicators in the study was awareness about accredited hospitals in the scheme. Across all study states, only 36.6 percent of women were aware of the private facilities. U.P (66%) ranked the highest in this indicator, and the lowest was M.P (5.6%) followed by Odisha (7.1%) and Rajasthan (11.1%). The other relevant indicator was the place of delivery. In this category, it was reported that only 1.4 percent of childbirths were in accredited hospitals. The figure across states ranged between 0.2 percent in M.P and 2.4 in U.P. Regarding accreditation of private facilities under JSY, the study showed that states did not actively pursue this agenda due to issues of malpractices in private facilities, lack of appropriate facilities and also a dearth of facilities in backward and rural regions (UNFPA, 2009). The problem of low participation was found to be more in the high focus states, where the need was more. This was because private sectors in these states were not very developed, especially in rural regions and sub-district levels.

For childbirth, the Chiranjeevi Scheme of Gujarat had drawn traction in the policy cycles. Initial research claimed that the scheme was able to target 94% of below poverty line (BPL) households (Mavalankar et al 2009). Contrasting evidence indicates that the strategy of engaging the

private sector in this scheme did not increase access to private institutions by the vulnerable beneficiaries (De Costa et al 2014, Ravindran 2011, Acharya and McNamee, 2009). Studies have repeatedly found that although the scheme leads to an increase in institutional childbirth mostly in public institutions, it could not improve the access to private deliveries among women from BPL families residing in rural and tribal areas. These facilities seldom attended to complications. The engagement of private providers was also found to decrease over time.

The performance of PPP schemes for institutional childbirth in UP had several problems; most of these private players were based in the urban centres, only a few of them were accredited under the scheme and the complete package of services was not being delivered (Intrahealth 2013, Ravindran 2011). The factors affecting include lack of guidelines and incentives for beneficiaries and community health workers as well as no private sector involvement in policymaking. The other challenges included lack of will of government officials stemming from the absence of managerial capacity to handle contracts, inadequate publicity and a poorly functioning payment system. Lack of mechanisms to ensure monitoring, quality assurance, reporting and grievance redressal was also one of the factors.

Rapid assessment of six private hospitals working under JSY in Ahmednagar district of Maharashtra concluded that the PPP model for institutional childbirth services is an interim measure for reducing the barriers to access emergency obstetric care (EmOC) services but without much effect on the out-of-pocket (OOP) expenditure. It identified that the key factor affecting the performance of the private provider in the scheme was rooted in the government's capacity for managing the partnership. This includes poor role clarity, lack of trust and cooperation between both parties and inappropriate payment modalities (Chaturvedi and Randive, 2011).

Evaluation of the Mamta Friendly Hospital initiative in Delhi showed that most of the private hospitals that were registered wanted to quit the partnership because according to them the remuneration was lower than the prevailing market prices and in the case of C-section the amount was lower than the actual cost being incurred. Besides, there was a cumbersome reimbursement process and too much paperwork involved. From the beneficiaries' point of view, they were bearing OOP, complicated cases were being referred and post-natal care was not provided. Some beneficiaries could not access the scheme because they did not have proof of their BPL status or residence in Delhi followed by distance from the clinic and also lack of awareness about the services (Ravindran 2011). Similar problems were reiterated in the evaluation of Janani Sahyogi Yojana of the MP government (*Ibid*).

Yet another study was conducted by Jhipiego, an international non-profit health organization affiliated with Johns Hopkins University, under their project to improve the quality of maternal health services in private health facilities of tier-II cities in UP and Jharkhand. This qualitative research highlighted that both the public and private sectors agreed about the merit and need for PPP. The private sector organizations expressed interest to partake in the scheme because it would increase their clientele, help them earn more revenue and also enhance their legitimacy (Yadav et al., 2017).

One of the objectives of the study was to understand the barriers that discouraged the process of forging and sustaining PPPs for institutional childbirth. The first set of challenges was regarding the public sector's attitude towards the private sector. Most private sector participants in the study mentioned that cost restriction was imposed under the schemes and there was delayed reimbursement of costs. Excessive documentation, strict adherence to guidelines by government officials and trust deficit between the two sectors were also mentioned as

impediments. The second category of the barriers was related to poor public health services during pregnancy. As a result, many women who came to institutions for childbirth were in the high-risk category; hence required blood transfusion facilities, which were not available in many private facilities. Third, was the substandard quality of services provided in some private facilities, which made it difficult for the public sector to choose the right partners (*Ibid*).

Studies conducted in other countries like Brazil and Nicaragua have shown that interventions for promoting childbirth at private facilities to reduce maternal mortality have overriding biomedical consideration and hardly any scope to address the underlying socio-economic factors that cause exclusion of certain sections of the population. Studies from Latin America have shown that women are more likely to be adversely affected by the marketization of health services than men (Gideon, Hunter and Murray, 2017).

While it is evident from the above review of literature that there were various lacunae in the PPP model to deliver both sterilization and institutional childbirth services, in these studies there are very little analysis of the nature of private sectors and the approaches they follow in the delivery of services. This study focuses on those issues, as they are critical for addressing the factors associated with access. Also, as the study is conducted in rural areas of two tribal districts in Rajasthan, it captures the nuances in remote areas, which is a reason for inequitable access.

Section 3: Design and distribution of PPP in reproductive healthcare in Rajasthan

This section attempts to give an overview of the PPPs in two reproductive health services – sterilization and institutional childbirth that is currently functional in Rajasthan. For this section, the data was collected from both annual reports of the Medical and Health department

of the Government of Rajasthan as well as through key informant interviews with respective state-level officials for sterilization and institutional childbirth.

3.1: For sterilization

The scheme was declared in 2007 for the entire state of Rajasthan as per the Government of India guidelines. As per the guidelines, the government contracted private facilities for providing sterilization services. The government would reimburse a fixed amount to the private providers per case basis. This amount was fixed by the central government. According to the state government officials, the PPP model was not very effective in improving the coverage of sterilization services in Rajasthan, barring the efforts of a few NGOs. They did not agree that engaging the private sector was, in any way, able to fill the gaps in public health facilities in that district (Box 4.2, Quote 1). On the contrary, they noted that the number of empanelled private facilities was more in those districts which already had better functioning public health systems[41].

According to the state government official, the number of empanelled private facilities under the scheme is based on the number of private facilities present in the district and the inclination of the district level officials towards encouraging those private doctors to take part in the scheme (Box 4.2; Quote1). They also expressed that mere numbers of private partners do not always result in contributions in achieving family planning as many of the private institutions did not conduct even a single case of sterilization since their empanelment (Box 4.2; Quote 2).

[41]To substantiate their point they compared Jaipur and Kota cities with Pratapgarh and Barmer. While the public sector facilities were relatively well-functioning in the first two in comparison to the latter two, yet more private partners were empanelled in the first two.

Box 4.2: Responses of state government officials on PPP for sterilization

1. *"Number of private institutions empanelled in any district is not related to the condition of the public sector in that district. Districts like Jaipur and Kota have a well functional public health system, yet they have more empanelled private facilities. This is just the opposite for Baran and Pratapgarh. What affects the empanelment of private partners is the number of private health institutions in any district as well as the activeness of the district level officials to engage with private institutions."*. [Interview with a state-level official Health Department, Government of Rajasthan, September, 2015]
2. *In my experience, many empanelled private facilities have not conducted a single sterilization case so far. For this, the role of Addl CMHO, Family Planning, is very crucial."* [Interview with state-level official, Medical and Health Department, Government of Rajasthan, September 2015)

Currently, there are 320 private providers across 30 out of 33 districts in the state. The data shows that although the average number of empanelled institutions for family planning services in a district is 11, in most districts (56.67%[42])the number of private institutions empanelled is less than the state average, and almost 40% of private institutions are in only 4 districts of the state (Table 4.2). The top three districts based on the number of private facilities empanelled were Jaipur (52%), Kota (33.6%) and Sri Ganganagar (24.8%). In the first two districts, a significant proportion of the population was in urban and peri-urban areas while in the third district the economic conditions of the people, in general, were better.

[42]Although Rajasthan has districts of 33, the calculation is based on 30 as three districts do not have any private institutions empaneled under the scheme..

Table 4.2: Distribution of NGOs/ Private allopathic Clinics Registered under the Family Welfare Programme (as of July 2017)

No. of Institutions	No. of Districts	% of total empanelled
1-5	11	36.67
6-10	6	20
11-15	8	26.67
16-20	2	6.67
20-25	1	3.33
25-30	0	
30-35	1	3.33
35-40	0	
Above 40	1	3.33

Source: Dept. of Medical, Health and Family Welfare, Rajasthan

3.2: For Institutional Childbirth

Like sterilization, for institutional childbirth services also, the state government largely adhered to the JSY guidelines. The central government directed that private hospitals should be accredited in at least two blocks per district. Following this, the officials in the state government ordered the district officials to identify any potential partners at the block level. They also discouraged the accreditation of private facilities at the district headquarter town/ city. Second, according to the national guidelines, the state decided that there will be no reimbursement of the private sector facilities using public funds. The state government also imposed a cap on the user fees of Rs 500 that the accreditated private facilities could charge the users. Based on the accreditation process and consent of the partners, a contract was signed between the Block Chief Medical Officer (BCMO) and the private partner. The beneficiary who decided to seek the services in the accredited facilities were also eligible for the cash incentive payable to all JSY beneficiaries, but the ASHAs were not given their incentive if they accompanied women to private facilities (Box 4.3; Quote 1).

According to the official, this was not a PPP model in the true sense. The scheme was designed, in such a manner, to discourage those private nursing homes to join. The scheme also discouraged the pregnant woman to seek services from private facilities and the ASHAs to promote childbirth in private institutions. He explained that the reason for not adopting the cost reimbursement mode, like some states, was that if the government had to reimburse the cost of services on behalf of the patients it would increase the budget manifold and would also put additional burden on the district health authorities to manage the finances) (Box 4.3, Quote 2).

Currently, there are 216 private institutions, including NGOs accredited under the scheme. Almost 60% of the total accredited private hospitals and NGOs were located in 11 districts. Of the remaining 40%, 17.18% and 16.51% were located in five and ten districts respectively. Only 16 are in the eight backward districts of the state (Table 4.3).

Table 4.3: Distribution of NGOs/ Private allopathic Clinics Registered under the Janani Suraksha Yojana Programme (as of July 2017)

No. of Institutions	No. of Districts	Percentage of total empanelled
1-10	8	7.38
11-20	10	16.51
21-30	5	17.18
31-40	7	31.81
Above 40	4	27.11

Source: Dept. of Medical, Health and Family Welfare, Rajasthan

The data on the number of accredited private facilities was not updated and the state officials thought that it was the responsibility of the district and the block level health officials' responsibility to do so (Box 4.3; Quote3).

Box 4.3: Responses of state government officials on PPP for institutional childbirth

1. *In Rajasthan, the government is just responsible for the accreditation of private hospitals for institutional delivery but the cost of care is borne by the user. I do not think it can be considered a PPP in the actual sense of the term.* (Interview with a state-level official Health Department, Government of Rajasthan, Jaipur, September 2015)
2. *This model only limits the cost spent on the scheme by the government but also reduces the burden on the district health team from the additional task of managing the finances.* (Interview with state-level official, Medical and Health Department, Jaipur, August, 2015)
3. *We do not have any updated information because there is no audit requirement. Also, the main responsibility in this scheme is with the block and district level health officials. We are here to support them in case they have any problems.* (Interview with state-level official, Medical and Health Department, Jaipur, October, 2015)

Section 4: Implementation of PPP in reproductive healthcare

The above description provides an overview of the design and distribution of the PPP models adopted, for sterilization and institutional childbirth, in Rajasthan. Besides, it also reveals that the role of the state-level officials in these models is limited to issuing orders as per the central government guidelines. The responsibility of execution depends on the health officials at the districts. Hence it is important to understand the status of implementation at the district level. This section is based on interviews with 20 government officials at the state, district and block level and 15 staff members across four types of private facilities in the two districts.

The section is divided into two subsections– (i) architecture of partnership and (ii) perception about inequities in access and the benefits of PPP in achieving it. For the architecture of partnership, the role of the

private sector and public sector were examined with respect to their capacity to perform their respective functions and their motivation to join the partnership. Subsequently, perception about inequity was captured through their views about factors affecting the utilization of their services.

4.1: Architecture of PPP in reproductive health services

4.1.1 Role of Private Sector

The guidelines for both these schemes mention that both NGO and Private allopathic clinics can be empanelled. The profile of these private partners varied according to their capacity to deliver services. In Rajasthan, four different types of partners were found – state-level non-government organization (henceforth SNGO), national non-government organization (henceforth NNGO), small private hospital/ nursing homes led by one to three regular doctors (henceforth NH) and multi-specialty hospital (MH).

- Capacity to perform the expected role

For sterilization three categories of institutions were identified – NNGO in Udaipur, NH in both Udaipur and Sirohi and multispecialty hospital (MH) in Udaipur. Private providers, for institutional childbirth services, belong to two categories – SNGO in Udaipur and NH in Sirohi.

1. General Profile

The NNGO, registered under Societies Registration Act 1860, is affiliated with a global organization providing contraception and safe abortion services across 37. In India, the organization has been working in three states. In Rajasthan, the project started in 2009 with a static clinic in Udaipur city. It was a six-bed facility with two operation theatres; managed by a team of 20 comprising surgeons, gynaecologists, nurses, paramedics and administrative staff. It also employed field workers for community outreach.

The MH had been working for 17 years in the Udaipur district. It also had an ISO 9001 certification. The managing director of the hospital was an office-bearer of the Indian Medical Association, Udaipur. This hospital was established by a highly successful doctor in Udaipur City. It was a 100 bedded hospital with economic wards, deluxe and AC rooms. The staff strength was 200 including 30 full-time doctors, around 100 well-trained nurses and paramedics and other support staff. In addition to the in-house specialists, some senior doctors from the Rabindranath Tagore Medical College and District Hospital (tertiary public health facility in the district), also provided on-call services to this hospital. The hospital had nine departments, four operation theatres, an in-house pharmacy and laboratory services. It did not have a blood bank. The hospital also runs a nursing college and diagnostic centres in Udaipur and seven other cities of Rajasthan.

The NH in Udaipur, under the sterilization scheme, was owned and managed by a single male doctor. He was a gynaecologist with more than 15 years' experience in the government of Rajasthan. He has worked in different positions in the Primary Health Centre (PHC)and the Community Health Centres (CHC). Some on-call doctors are also associated with the hospital. There was a team of ten regular staff including five ANMs, two GNMs and the remaining male and female sanitation workers. The hospital was built in 2009, but it became functional only in 2012 after the owner left his government job. The hospital was not registered, but it is enlisted with the Municipal Corporation of Udaipur. The nursing home was a three-story building; the top floor is also the residence of the owner, which ensured round-the-clock availability of the doctor. It also had 20beds, one operation theatre and one labour room and a huge waiting area for OPD patients. There was no laboratory facility in the institutions, but the owner had a tie-up with diagnostic centres nearby the hospital.

The NH at Sirohi for sterilization was managed by two doctors –a male gynaecologist and a female ayurvedic doctor. Before joining this nursing home, the male specialist was working at the district hospital in Sirohi. Initially, this nursing home was providing only outpatient services; it started offering IPD services in 2013 after the gynaecologist joined. The hospital had three rooms, of which one is for OPD service, one room had three beds and the third was a labour room. The owner of the nursing home owned a medicine shop in the same building. There was six regular staff; mainly ANMs and one sweeper but no nurse.

The SNGO at Udaipur, providing institutional childbirth services, was registered in 2012. The founder member of the organization was a paediatrician and a reputed public health professional who had worked with an international organization for more than a decade at the national and the state level. Currently, the NGO runs three clinics. The community donated the buildings for these. All the clinics had one labour room and another room with three beds. Besides providing delivery services, the clinic also offered a package of antenatal, postnatal and childcare services. It also treated patients suffering from tuberculosis and other communicable diseases. The management of these clinics is done by the NGO's office at the block level.

Each of the clinics was managed by three female GNMs, who resided in the same building as the clinic. Thus, the round-the-clock availability of trained medical professionals was ensured. A doctor visited these clinics twice a week for OPD services. There was also a male community outreach worker, for each clinic, who covered five to six adjoining villages. The organization had also created a cadre of village-level female volunteers.

The NH accredited for institutional childbirth in the Sirohi district was managed by three doctors belonging to the same family. Among them, one was a gynaecologist, one paediatrician and one MBBS doctor. The gynaecologist is a lady doctor. They also sought the services of doctors

working with the public sector in the area. There were four nurses and ten ANMs. It was a 20 bedded institution that was extendable up to 30 in times of need. There are both general wards as well as a few deluxe rooms. There was also an operation theatre, but no regular Anaesthetist. There was neither laboratory nor a kitchen in the hospital. For the laboratory, they had a tie-up with the diagnostic and pathology laboratories in the block.

It was observed that many of the empanelled and accredited private facilities did not meet the basic requirements mentioned in the guidelines of the schemes for sterilization and institutional childbirth. According to the guidelines, all private organizations should be registered, but only the NNGO and SNGO delivering sterilization and institutional childbirth respectively were registered. The district officials said that because the Clinical Establishment Act was not implemented in the state there was neither a need nor scope for registration of private nursing homes and hospitals (Box 4.4; Quote1).

The other gap was that the human resources, as well as the infrastructure available with some of the private partners, was insufficient yet they were accredited. While most of the district officials were aware, but they stated that they had selected the best among those private players who had applied for empanelment under the scheme. They were also compelled to empanel private providers to comply with the orders from the state officials, even when they were not entirely convinced about their eligibility (Box 4.4; Quote2).

Box 4.4: Response of district officials about the profile of the private partners

1. *There is no provision for registration of private hospital because the Clinical Establishment Act is not implemented in the state. We only check the registration of the doctor who owns the facility.* [Interview with district official, Sirohi, August 2015]
2. "*Unfortunately only those private providers with limited resources want to join the scheme. There is also a lot of pressure from the state to engage private sector. So we select the most eligible among those who have applied.* [Interview with district official, Udaipur, November 2015]

2. The vision of the private partners

Most of the private partners, engaged in the delivery of reproductive health services, stated that their primary objective was to ensure that good quality healthcare is accessible to all sections of people in these areas. According to them, the public sector facilities in these regions were inadequate, both in number as well as in quality. Poor people had to travel to other districts and bigger cities to access health services, which was both expensive and time-consuming. They believed that because of their facilities these people were getting services closer to their house and at a reasonable rate.

On further probing, all these organizations shared other goals as well. Some respondents from NH category institutions shared that their institutions were business ventures. One of them explained it in terms of the demand and supply rule in economics. He said that due to the lack of public sector health facilities, there was a demand for services that their organization was supplying (Box 4.5.1; Quote 1). The head of the MH added that their goal was also creating the human resources required for healthcare and providing employment opportunities to them. In this context, he mentioned that the hospital had also started a nursing college (Box 4.5.1; Quote 2). According to the manager of the NNGO, introducing new forms of contraceptives like injectables and advocating for policy changes were also goals of their organization (Box 4.5.1; Quote 3). The founder of the SNGO shared that through their work at the community level they were developing a model to deliver comprehensive primary healthcare as envisaged in the Alma Ata Declaration; which the public sector can emulate (Box 4.5.1; Quote 4).

Box 4.5.1: Responses of private sector representative about their vision

1. *"See, there is a demand for health services in this district but the government alone is unable to meet the demand. I am here to do business. My goal is to supply health services to those in need for it."* [Interview with the owner of the NH, Udaipur, November 2015]

2. *"When I opened the hospital my father had said that even if do not earn enough from the hospital, the name of the family should not be compromised. We honour that value. Our services are of good quality and affordable healthcare to all, especially those in the middle and lower-middle class. We also want to contribute in generating human resource for health services. So we started the first nursing college in Udaipur.* [Interview with the Managing Director of the MH, Udaipur, November 2015]

3. *Our primary goal is to support the government in meeting the unmet needs for reproductive health services. We also introduce new forms of contraceptives and approaches to fulfil that goal. Our organization also advocates policy changes for improving the basket of choice for contraceptives."* [Interview with Manager of the NNGO, Udaipur, November 2015]

4. "*I am firm believer of the Comprehensive Primary Healthcare model. Through our clinics we aim to promote that. If successful, the government can also decide to adopt the same to improve the delivery of healthcare at the community level."* [Interview with the founder of the SNGO, Udaipur, November 2015]

When a similar question was asked to the public sector officials in the district, their opinions were mostly similar for most private partners. According to them the goal of NH and MH categories of institutions was to generate profit (Box 4.5.2; Quote 1). For the NNGO and SNGO, they agreed that the pecuniary incentive was not the most important reason instead they felt that these organizations were leveraging funds from the different national and international organizations for promoting alternative health service delivery mechanisms (Box 4.5.2; Quote 2).

Box 4.5.2: Responses of district health officials about the vision of private sector partners

1. "*Almost all the private partners engaged in the schemes are profit-making organization. Their main goal is to expand their business.*" [Interview with the district official, Sirohi, August 2015]
2. "*The NGOs engaged in the schemes are interested to promote their own agenda, be it in the form of products or service. They pursue the agenda of their national and international donors.*" [Interview with the district official, Udaipur, July 2015]

3. Location and coverage

Among the private partners empanelled for delivery of sterilization services, the NH and MH in Udaipur were located in the district headquarters while the NH of Sirohi was working in the Pindwara block of the district. The NNGO, in this scheme, was managing a static clinic in Udaipur city, but it also conducted camps at the community health centres (CHC) and sometimes at the Primary Health Centres (PHCs) in remote areas. The SNGO under JSY operated from remote villages of the Salumbar block of Udaipur, while the NH in this category was located in Abu Road, a block in Sirohi.

The MH in Udaipur and the two NH in Sirohi reported getting patients from all over the district and also from the adjoining districts as well as from Gujarat. The coverage area of the NH in Udaipur is mostly the adjoining block of Jhadol as it is located closer to that block and also because the doctor had earlier worked as the MOIC of the CHC in that block. The SNGO was only catering to the nearby villages of the clinic while the NNGO could cover both the rural areas and some urban populations.

There was a huge variation in the patient-load of these four institutions. For the two NHs providing sterilization services the patient load per day was between five and ten, while the multispecialty hospital received about 70-100 patients per day on an average. Patient load differed because the

MH has been delivering healthcare for the past 17 years (Box 4.6; Quote 1). The NH in both Udaipur and Sirohi was relatively new but the patient load varied according to their location. While NH in Abu Road reported that they get approximately ten to twenty per day, in Pindwara the footfall was 5 cases in an average day (Box 4.6; Quote 3). It is important to note that all the private partners were providing a range of services and the patient- load reported was a cumulative figure. When asked about the footfall especially for the services under the scheme, the numbers were much less.

The manager of the NNGO reported that in each camp the number of patients ranged between five and ten cases, while the number of people coming to state clinics ranged between 12 and 15 on an average (Box 4.6; Quote 4). According to the SNGO staff, the footfall in the clinic was six to seven patients on average. The number of patients increased on those two days of the week when a doctor visited these clinics. Besides, during home visits, the staff also reached 10 patients per day (Box 4.6; Quote 3). The district officials seemed to be unaware of the caseloads of these private facilities.

Box 4.6: Responses about location and coverage

1. *"As we are located in the district headquarters and considering our long history we get patients from all blocks of Udaipur, as well as from adjoining districts. We have also treated patients from Gujarat. The patient load for sterilization services is only two per cent."* [Interview with the Managing Director of the MH, Udaipur, November 2015]
2. "*My hospital is only three years old. This is the main reason for a low case load."* [Interview with the owner of NH, Udaipur, November 2015]
3. "*There are two reasons for low footfall. First, this hospital is located in a remote block and also the transport facility from the villages to the town are not very regular."* [Interview with NH, Pindwara, Sirohi, September 2015].
4. *"We provide all kinds of reproductive health services in the static clinics so the patient load is higher than the fixed day camps where only two kinds of services are provided."* [Interview with the manager of NNGO, Udaipur, November 2015]
5. *"The clinic delivers different types of health services and child birth is only one of those. The number of deliveries conducted in a month is only five to six."* [Interview with a nurse in the SNGO clinic, Udaipur, October 2015]

4. Approach to deliver reproductive health services

The focus in this section is on reproductive health services under the PPP model only. The following aspects concerning the approaches to deliver those were captured in the interview.

i. Generating awareness about services
ii. Customize services according to patient's needs
iii. Cost of providing the service
iv. Building rapport with the users
v. Release of incentives to the beneficiaries

The NNGO had a multipronged approach to generating awareness about the services. It employed female outreach workers who visited adjoining villages of the CHC to inform the people about the upcoming family planning services. There was also a special focus on male involvement in family planning; for that, the 'Buddy Scheme' was launched. After

identification of the possible clients, the counselors in the organization discussed with him/her about the package of services. They never began the discussion with sterilization as it generally intimidated the users. In case the patient chose sterilization then he/ she was asked to attend the camp on the fixed date and time. Services like sterilization and IUD insertion were not charged, however for other services the charges were nominal so that the patient could easily pay for them. After the procedure the staff also makes follow-up visits to detect complications and also inform the client about the necessary precautions. This step was considered to be important because it built trust between the client and the organization. The manager reported that neither the government staff nor any other private partner empanelled in the schemes did this step (Box 4.7.1; Quote 1).

The respondent from the multispecialty hospital reported that when the hospital was smaller in size they conducted regular camps in the adjoining villages to generate awareness about different services including family planning. This practice was discontinued as the caseload in the hospital had significantly increased. Currently, the nursing staffs in the labour rooms were responsible to inform the patients about adopting contraceptives. They were specially trained and instructed to counsel women and their family members to adopt any of these measures immediately after childbirth or abortion. Sterilization was suggested only as an option for those who have more than three children. If the patient and her family member gave their consent, the desired procedure was adopted with no additional cost. During discharge, the patient and family were asked to come for follow-up check-ups, but they seldom did (Box 4.7.1; Quote 2).

Box 4.7.1: Responses on approaches for sterilization adopted by private partners

1. "*Once the potential cases are identified, our field team counsels them about the different contraceptive measures. We do not force any measure, but if the woman wants to go for sterilization, we inform her about the date and place of the camp. After the procedure our staffs make follow-up visits to ensure that there are no post-operative complications. This step is important, but no other partner does it. There are no charges for sterilization and IUCD insertion.*"[Interview with Manager, NNGO, Udaipur, November 2015]
2. "We have trained nurses in the labor rooms to counsel woman for adopting contraceptives. S*terilization is only recommended if the woman has more than three children besides the newborn, for the rest we promote PPIUCD. If the client agrees, we conduct the procedure immediately without any additional cost. Follow-up instructions are given during discharge, but very few abide by those."* [Interview with the Managing Director ofMH, Udaipur, November 2015]

The gynaecologist in the NH, in Udaipur and Sirohi, mentioned that they did not conduct any special awareness generation activities but they incentivized the frontline public functionaries for referring cases to their nursing homes. This amount was usually more than the incentive paid to these workers by the government. These doctors also counseled the mothers and their families who come to their institutions for delivery and also sometimes for any other gynaecological problem. Direct counseling by the doctors gave an impetus for the uptake of sterilization services. When the patients agreed, the process of sterilization was undertaken with no additional cost. The gynaecologist in the NH of Udaipur also reimbursed the travel cost of the patient. He also mentioned that he spoke to the patients on the telephone if they did not return for follow-up (Box 4.7.1; Quote 3).

Box 4.7.1: Responses on approaches for sterilization adopted by private partners

3. "*I give incentives to ASHA and AWW to send cases to my hospital which is more than what they are entitled to get from the government. I also pay travel cost to the families who seek sterilization services at my facility. Besides, I personally counsel the man/ woman because I feel that when doctors say, the families respond better. I also request then to come back for follow-up check-ups. If they don't then I call them and ask. I do this because I feel it is my responsibility to take care of those who trusted me. Though I have a limited staff, I make sure that the necessary documentation is done correctly and on-time, so that the patient's receive their incentives."* [Interview with the owner, NH, Udaipur, November 2015]

4. "*It has come to our notice that some private partners were paying additional money to ANMs and ASHAs for referring cases to their facility, but we cannot take any action because these doctors are paying from their pockets*." [Interview with district official, Sirohi, September 2015]

5. *"This practice of private hospitals giving additional incentives to our ANMs and ASHAs promotes corruption. But we cannot take action as there is no proof."* [Interview with district officials, Udaipur, December 2015]

When the public officials responsible for this scheme in the district were asked about the strategies adopted by the private partners to implement this scheme, there was a mixed response. While all of them were aware of the practice of private hospitals paying incentives to frontline health workers employed in the government to refer patients, some did not consider it wrong because the amount was paid by the doctors from personal resources; while others considered this as a corrupt practice but could not take any action because there is a dearth of evidence (Box 4.7.1; Quotes 4 and 5). On the same issue, all the respondents agreed that the private sectors do not undertake activities to generate awareness about the scheme.

The SNGO adopted different approaches to generate awareness about institutional childbirth from an early stage of pregnancy. The staff in the clinic conducted regular visits in the adjoining villages to identify pregnant women. According to them, women in that area seldom stepped

out of their villages mainly because of their busy schedules managing household chores and agriculture. These village-level interactions helped in reaching basic services to these women as well as building trust between the clinic staff, pregnant women and their families.

To facilitate early identification, the SNGO staff had identified as well as trained female volunteers from each hamlet in the village. Once identified, it was ensured that every pregnant woman received at least four ante-natal checkups. If they observed any danger sign in course of the pregnancy period, they prepared the family to take the women to the block CHC at Salumbar for childbirth. In the case of normal delivery, the staff in the clinic ensured that the mother stayed in the institution for 48 hours. The staff also ensured postnatal care of the mother during the village visits (Box 4.7.2; Quote 1).

According to the respondent from NH in this case, they did not conduct any awareness generation activities about the JSY scheme as it was not mandated in the MOU. The information is generally spread through the word of mouth. The gynaecologist also mentioned that they did not have any role in providing antenatal and postnatal care in rural areas. The facility provided these services mostly to the urban population (Box 4.7.2; Quote 2).

While both the respondents stated that they only charged 500 rupees from the family as per the MOU between SNGO and the Government, it was difficult to verify this information. They also mentioned that the hospital staff completed all the documentation work on behalf of the patient and submitted it to the designated block office for the release of JSY incentives to the patients. While the SNGO staff met the block officials regularly to expedite the release of incentive payable to the beneficiaries, but those in NH did not take any responsibility for that. Instead of that, they asked the patient's family to do the follow-up for

release of the amount. Both these private facilities only admitted a pregnant woman who was likely to have a normal delivery. As reported, this was because they did not have the resources to conduct a Cesarean Section. When they suspected complications in childbirth they referred the patient to the CHC at the block headquarters or to the district hospital.

The response of the district officials concerning the approach to service delivery adopted by the private partners varied across the two districts. However, there was not much difference in the ways they addressed those concerns.

On one hand, the district official in Sirohi expressed his displeasure about the fact that the NHs in the district were not publicizing their empanelment in the JSY scheme. They also alleged that some of them may be charging additional amounts from those who came for childbirth to their facility (Box 4.7.2; Quote3). On the other hand, the officials in Udaipur were happy that the SNGO was providing institutional childbirth facilities at the village level, but they did not appreciate their role in providing ANC and PNC services. According to them, this was the role of the ANM. They were of the view that the SNGO staff should support the ANM to reach all pregnant women (Box 4.7.2; Quote 3). Despite these complaints, all the government officials expressed reluctance to take any corrective actions apprehending that if they were strict about these issues the private players might withdraw from the scheme (Box 4.7.2; Quote4).

Box 4.7.2: Responses on approaches for institutional childbirth adopted by private partners

1. *"We conduct home-visits especially for those women who are unable to come to our clinic for ANC and PNC. This also helps in building a close bond with the women and their families. For generating awareness about maternal healthcare, local women have been trained to counsel pregnant women and also detect danger signs. We also help the family to prepare for childbirth, especially if the women were in the high risk category. Both ANC and PNC are free of cost, but we charge Rs.500 for normal delivery as per norms. After the delivery we submit all the necessary documents to the block level officers. Our team in Salumbar meets the government officials at least three times in a week so that the amount is released as soon as possible."* [Interview with a nurse in the SNGO clinic, Uaipur, November 2015]
2. *Under the MOU we are mandated to provide only childbirth facilities, so we do not do any awareness generation activities. Although the facility delivers ANC and PNC services, but it mostly caters to the residents in and around the Abu Road town. Majority of the rural pregnant women come for childbirth only. Our role ends once we have complete the necessary paper works and submitted those at the block office. The family of pregnant woman is asked to do the follow-up for their JSY incentives."* [Interview with the owner of NH, Sirohi, August 2015)
3. *"I know that the NGO clinic is doing good work by conducting normal deliveries at the village but they duplicate the work of the ANMs. This creates a rift between the clinic's staff and the ANM of that area. Their role should be supporting the activities of the frontline workers. This will help the government in reaching more beneficiaries."* [Interview with district officials, Udaipur, December 2015]
4. *"The private partners in the district do not want people to know that they are empanelled under JSY because then they cannot charge their usual fees for childbirth related procedures. It has come to my notice that some private hospital owners charge more than 500 rupees, but I do not have any proof. Also if we confront them they might opt out of the scheme."* [Interview with district officials, Sirohi, September 2015]

5. Source of Capital

Three among the four categories of the private sector empanelled, under sterilization and institutional childbirth schemes reported that their primary source of funding was user fees. All of them mentioned that they invested their own money to set up the facility and also took bank loans as per requirement. The Managing Director of the MH added that they also generated revenue from the public insurance schemes like Rashtriya Swasthay Bima Yojana and Bhamasha Yojana of the state government as well as from private insurance (Box 4.8.1; Quote 1). The SNGO generated resources from different international and national funding agencies as well as from individual donors. They also charged five rupees for outpatient services. There were additional charges for medicines and diagnostic kits, but those were priced as per actuals. This was the same for NNGO which received most of the funding from their parent institution, yet levied user fees for abortion services and contraceptives which were not under the government schemes (Box 4.8.1; Quote 2). Respondents from both these categories mentioned that amount collected from the users was very little and did not contribute in any way to the organization's expenses. None of the agencies identified the government scheme as a source of income for their institution.

Box 4.8.1: Responses about source of funds for the private sector

1. *"Our main source of income is fees collected directly from the clients. If users have cashless insurance we get the money from the insurance companies or the government as we are empanelled under the Bhamasha Yojana. For major expenditure we also take loans from the private banks."* [Interview with Managing Director, MH, Udaipur, November 2015].
2. "*This organization is a part of an international organization. Most of our funds come from there. Our head office in India also raises funds from national agencies. At the district level, we do not have any resource generation activities. While we charge a nominal amount for some services which are not a part of the government schemes that does not contribute to the total budget that we spend."* [Interview with NNGO Managing Director, MH, Udaipur, November 2015].

On further probing, all the respondents from the private sector agreed that they had gained financially from their engagement in those schemes. According to the respondents in the NH category, their involvement in the government schemes had increased the footfall in their facilities which indirectly raised their income (Box. 4.8.2; Quote1). The NGO representatives mentioned that due to their association with the government they have been able to leverage more funds from other donors (Box. 4.8.2; Quote2). To illustrate this the founder of SNGO shared that recently an international organization that had partnered with the Government of Rajasthan to manage Primary Health Centres had contacted them. The Managing Director of the MH expressed that the facility was empanelled under the publicly-funded insurance scheme of the state government and also got permission for conducting medical termination of pregnancy after they had demonstrated their suitability in the delivery of sterilization services. Both of these had contributed immensely to increase their income source and bankability status (Box. 4.8.2; Quote 3).

Box. 4.8.2: Responses about reproductive health services under the schemes as a source of funds for the private sector

1. "*After joining the scheme, the footfall in my hospital has increased to some extent. This has contributed to the revenue that I earn per month."* [Interview with the owner, NH, Udaipur, November 2015]
2. "*As an NGO, we are dependent on external funding for our day to day activities as well as for new innovative projects. Generating funds is a long process but it becomes faster and easier, when we started working with the government. There were some funding organizations and individual who approached us, which was not the case earlier. That way I feel that that we have also gained financially from this scheme. It might not have contributed much to the regular budget, but it has certainly expanded the source of funding.*" [Interview with the founder, SNGO, Udaipur, December 2015]
3. "*Although the hospital doesnot earn any money by conducting sterilization under the scheme, it definitely easied the process of getting permission for doing MTP. It also helped in being emapneeled under the Bhamasha YojanaBoth these helped in increasing the hospital's income and also enabled us to leverage bank loans."* [Interview with the Managing Director, MH, Udaipur, November 2015]

- Motivation to join the partnership

All private partners, irrespective of their capacities, claimed that they joined the partnership because they wanted to help the government to achieve the national health goals and for the benefit of their clients. However, some nuances revealed after probing reflected the underlying motivations of these private institutions in joining the partnerships.

According to the NNGO respondent, besides complementing the public health system's measures to deliver family planning services, the partnership arrangement facilitated the organization in achieving its mandate of improving access to family planning services in Rajasthan. He expressed that this partnership had enabled the organization to expand its services to remote areas with a nominal additional budget. To illustrate the point further he shared the experience of Kotra, a very remote block in the Udaipur district. The public health system in that block was under-resourced leading to a high unmet need for family planning services. The NNGO had tried to provide family planning services in that block but realized that their efforts were not yielding any results. Later, when they started working with the public health system under the scheme, they got encouraging responses from the community on the uptake of family planning measures promoted by the organizations. For this, he gave the credit to the awareness generated by frontline health workers working in the public health system. He also mentioned that due to their close relationship with the government, they could advocate for including injectable contraceptives into the government programme (Box 4.9.1; Quote 1).

The head of the MH shared that their hospital had been offering sterilization and PP-IUCD services to middle and upper-middle-class households. By joining this partnership, the hospital could transfer the financial incentives for the beneficiaries under the scheme to those people.

This was cited as one of the reasons for joining the scheme. On further probing, he also revealed that the partnership was to honour the request of the district officials. The decision to join the scheme was, therefore, taken to maintain their 'good' relationship with the government (Box 4.9.1; Quote 2). Almost all respondents from the NH category agreed that after empanelment under these schemes the footfall in their facilities had increased. One of the NH respondents shared her motivation in detail. She was working as a consultant gynaecologist in the CHC Abu Road, where she had gained popularity among the beneficiaries as the only lady doctor. When she decided to quit and start her nursing home, her colleagues in the CHC had suggested that she should empanel her hospital under the scheme because by doing that the patients who utilized the services of her institutions would be entitled to the JSY incentives. This, in turn, would encourage people to avail private facilities (Box 4.9.1; Quote 3). All the respondents from the public health system also expressed similar views on the issue of the private sector's motivation (Box 4.9.1; Quote, 4). The only exception was the SNGO in Udaipur. The head of the organization, as well as its staff, were of the opinion that this partnership was helped in ensuring that the women in their catchment areas could receive the benefits of the JSY scheme, even when they delivered at their facility, was the only motivation for joining the partnership (Box 4.9.1; Quote, 5).

Box: 4.9.1: Responses on motivation of private sector

1. "*It is the goal of our organization to provide access to family planning services. This partnership helped in that as well as provided the scope to advocate for policy changes in the family planning products. "* [Interview with the NNGO representative, Udaipur, November 2015]
2. "*We agreed to join the partnership when the CM&HO had approached me directly. Had we not joined the scheme, we would have antagonised the government officials who are also our colleagues and we need to maintain a good relation with them."* [Interview with the Managing Director of the multispeciality hospital, Udaipur, November 2015]
3. *"I took the decision to empanel for the scheme because my ex-colleagues had suggested that it will help in attracting more users to my new nursing home."* [Interview with the Gynaecologist and owner of NH, Sirohi, October 2015]
4. *Most of the private hospitals enrol in the scheme when they are not very well established. Because of these schemes they get cases for sterilization. These cases not only give them some revenue they also advertise for the hospitals*." [Interview with district health official, Udaipur, December 2015]
5. *"Most women in the catchment area of our clinic are from tribal community who hardly have any access to skilled human resources and to facilities for childbirth. Our decision to join the scheme was driven solely by our commitment to ensure that tribal women in the areas, can deliver safely closer to their homes and also receive the incentives of government schemes."* [Interview with founder of the SNGO, Udaipur, November 2015]

4.1.2 Role of Public Sector

A plurality of public officials was found to be involved in managing the PPPs in the state of Rajasthan. Broadly these actors can be divided into three categories based on their primary roles – designing, selection, financing and monitoring. Although the expected roles were laid out in the guidelines of the scheme, the way it is executed hinges on the capacity and motivation of the public staff in delivering public services in partnership mode. This section describes both these aspects of their role.

- Capacity to perform the expected role

1. Designing the scheme

As health is a state subject, the function of designing PPP schemes related to sterilization and institutional childbirth should also be the

responsibility of the state officials. As the budget for both these schemes comes from the central government, the state abides by the centre's guidelines in both these cases. According to the state as well as district-level respondents, the decision to implement the central government's guidelines for PPP was because there was not much scope for incorporating state-specific modifications. However, in the case of the latter, the states were free to design their schemes, yet the state decided to adhere to the guidelines.

The other important aspect that was highlighted by particularly the district-level officials was that they were seldom consulted while drafting the design of either of the schemes. According to them, many of the problems that emerged in course of the execution had emanated from the design flaws, which could have been addressed in the design itself to yield better results (Box 4.10; Quote 1). The two key issues about the design were about the selection of suitable private partners and the payment modalities (Box 4.10; Quote 2). These same concerns were raised by the public sector at the block level as well as the private providers.

Box 4.10: Responses regarding the designing of the scheme

1. *"We were never consulted in designing the schemes. When we shared our problems about the design of schemes, they were also brushed aside. We had no choice but to implement the schemes, along with all its flaws. The result is that the schemes have not contributed much in the coverage of these services."* [Interview with a district official, Sirohi, September 2015]
2. *"The two common problems we face while executing the schemes are in selection of suitable private providers and in payment of the empanelled providers."* [Interview with a district official, Udaipur, December 2015]

2. Selection of PPP schemes

The first and foremost task in the execution of the PPP schemes for both types of maternal health services was the selection of private players. According to the guideline issued by the state department, this is the responsibility of the district-level health officials in case of sterilization services, while for institutional childbirth the task is delegated to the block

level officials. To capture the capacity of the public sector cadres in this role the process needs to be reviewed.

Step 1: Identification of NGO/ Private Clinics for the scheme:

As per the guidelines for sterilization services, the Addl/Dy CM&HO, FW, designated official at the district for all family planning services, has to organize a workshop or a meeting with the private hospitals and NGOs in the district to generate awareness about the scheme. This workshop is generally conducted once a year. After that, the NGO or the private allopathic clinic interested to partake in the scheme then submits an application to the Addl/ Deputy CM&HO, FW for registering in the scheme.

In practice, the identification of potential partners is not possible in this process as very few turn up for these meetings. Most of those who attended these meetings were new hospitals. Under such circumstances, the district officials approached the well-established private hospitals/ nursing homes directly and motivated them to participate in the scheme (Box 4.11.1; Quote 1). Although this process was time-consuming, it was also a more effective way to identify the eligible private partner. Rarely the information of the scheme was also advertised in the local media because many 'fake' NGOs applied. Besides, it required an additional budget (Box 4.11.1; Quote 2). Respondents from the private partners stated the same process of identification. Some also reported that they were aware of these schemes because they were working in the public sector (Box 4.11.1; Quote 3).

Box 4.11.1 Responses regarding identification of private partner for sterilization services

1. *"We approach the well-established private facility at our level and convince them to be a part of the scheme."* [Interview with district official, Sirohi]
2. *"Putting advertisement in the local newspaper(s) requires additional budget so we do not prefer that approach to select private partners. "* [Interview with district official, Udaipur, November 2015].
3. *I came to know about this scheme when I was working as PMO in District hospital. When I joined this clinic, I told the owner to apply for empanelment under this scheme."* [Interview with the doctor in small nursing home, Sirohi, September 2015]

For accreditation of the private players under the JSY scheme, the state government health officials had issued orders to district officials to identify two private health institutions per block. The state official in charge of the scheme mentioned that although initially, the plan was to authorize the block level officials to identify suitable private partners, finally it was decided to give the responsibility to the head of the district health department, the Chief Medical and Health Officer (CM&HO). When probed about the reason for this decision, he alluded to two issues – lack of capacity and corruption (Box 4.11.2; Quote 1).

There was a minor, yet important difference in the identification process followed across the study districts. In Udaipur, the CM&HO led the process from the district level, while in Sirohi, the task was delegated to the BCMO. In some of the blocks of Sirohi, where that post was vacant, the task was given to the Medical Officer in charge (MOIC) of the Community Health Centre (CHC). According to the district officials in Udaipur, as there were no private facilities, at the block level, that could be engaged under the scheme, the CM&HO had set up a team at the district level to identify potential partners. In this team, he had invited some of the reputed organizations and public health experts working in the district to those meetings. Among them, two of the organizations agreed to take part in the scheme (Box 4.11.2; Quote 2). The district official

in Sirohi expressed that as the monitoring of the scheme was to be done at the block level, the CM&HO had decided to give the power to the BCMO to identify the private partners. He justified this decision with the fact that the number of private hospitals that joined the scheme, in Sirohi was more than its neighbouring districts (Box 4.11.2; Quote 3).

Box 4.11.2: Responses regarding identification of private partner for institutional childbirth services

1. *"All block level officials do not have the capacity to identify suitable private providers. Sometimes corruption is also there. So we decided that it would be best to give the responsibility to the CM&HOs. They can always engage the BCMOs if they felt the need to."* [Interview with the state level official in charge of JSY, Jaipur, February, 2016].
2. "*We formed a committee of government officials and also some reputed public health experts in the district to help us in selecting suitable private partners."* [Interview with the district level official, Udaipur, November 2015].
3. *"In Sirohi, the task of identifying the private facility under this scheme was given to BCMO because they were responsible for monitoring these institutions later. This helped in identifying more private facilities as compared to other adjoin districts."* [Interview with the district level official, Sirohi, September 2015]

Step 2: Accreditation of the private partners

The next step in the selection process of private partners for sterilization services, as per the guidelines, was an inspection of the facilities by a technical committee comprising Additional/ Deputy CM&HO, Family Welfare, an experienced gynaecologist and one surgeon. The committee members were expected to physically verify the infrastructure and human resources capacity of the identified institutions to deliver the required services based on the criteria prescribed in the guidelines of the Government of India. After the inspection was completed, the committee submitted a formal recommendation to the government health officials at the district for empanelling the private facility.

In both the study districts, such a committee existed and the members of the committee were aware of their roles mentioned above. The

members reported that during the inspection they assessed the competency of the private institution based on the checklist provided by the district officials. They also checked the patient registers of these organizations. Some of them added that they informed the private clinics about the shortcomings so that they make the necessary modifications and reapply (Box 4.12.1; Quote 1). None of them reported that they were either lured or compelled to recommend particular institutions. However, one of the committee members in Udaipur shared that there was a tendency to assess the new nursing homes more strictly than the well-established hospitals. According to her, the accreditation was also an important step for weeding out fake or spurious private facilities as they can harm the health of the users as well as deceive the government (Box 4.12.1; Quote 2).

Another expert shared that although the process of accreditation is a very important step in the selection of suitable private sector it is not given adequate attention. In his tenure, he had seen that even those private facilities, which he had rejected, later got empanelled under the scheme (Box 4.12.1; Quote 3). While he did not want to explicitly state the reasons for the same, he hinted that district officials were compelled, by the state-level officials to empanel private players. Few members of the inspection committee also reported that the assessment checklist did not include aspects that should be mandated for the delivery of sterilization services (Box 4.12.1; Quote 4).

Box 4.12.1: Responses regarding accreditation of private partner for sterilization services

1. *"We do the inspection according to the checklist provided by the government. Based on our observations, we recommend whether the private facility is suitable for providing sterilization services. Sometimes we also inform the private hospital owners of the shortcoming so that they can modify and reapply."* [Interview with a member of the Inspection Committee, Sirohi, September 2015]
2. *"While inspecting the nursing homes we are generally a bit stricter than when we assess the big hospitals. This is because some of the new nursing homes do not meet the required criteria yet they apply for these schemes."* [Interview with a member of inspection committee, Udaipur, December 2015].
3. *"The process of inspection is merely a formality. I know that private sector facility are empanelled under the scheme even after they have been rejected."* [Interview with a member of inspection committee, Sirohi, October 2015].
4. "*In my opinion, the questions in the evaluation checklist does not cover all the requirements for delivering sterilization services."* [Interview with a member of the Inspection Committee, Udaipur, December 2015]

The accreditation process for private facilities under JSY was much simpler. Once identified and if the head of these private facilities agreed, they had to fill a Self-Evaluation Checklist and submit it along with an application letter. This was followed by a physical verification process which was conducted by the BCMO's office in Udaipur while in Srohi it was delegated to the MOIC of the CHC of the block. In Udaipur, district-level officials also accompanied the block team during the process (Box4.12.2; Quote 1). According to the officials involved, the process of accreditation was relaxed because public finances were not involved. The only concern was that the private facility had the basic infrastructure and essential human resources to conduct safe deliveries (Box 4.12.2; Quote 2).

Box 4.12.2: Responses regarding accreditation of private partner for institutional childbirth services

1. *"Once the private sector submits the completed self-evaluation checklist, a physical verification process is done by the block officials. Sometimes we also accompany them during the process."* [Interview with district level official, Udaipur, December 2015]
2. *"During the visit, we just check whether or not the basic requirements are met. We cannot be too strict; otherwise no private facility would like to join the scheme."* [Interview with block level official, Sirohi, October 2015].

During the interviews with the officials at the block level, it was observed that they were hesitant to answer the questions about inspection. Although none of them explicitly mentioned, it appeared that they were either not an active participant or did not endorse the selection process that was adopted.

Step 3: Empanelment of the private provider

The selection process of private players culminated with the awarding of the contract to the empanelled private providers. This process was similar for both sterilization and institutional childbirth services. A three-member committee, chaired by the District Collector, was formed at the district level. The other two members were the Addl/ Deputy CM&HO and the CM&HO. Before finalizing the private partner, the committee reviewed the recommendations of the experts.

As per guidelines, the process of registration of the hospital should be over within one month of submission of the report by the technical committee. But, this condition was not always met. Most of the respondents from the private hospitals said completing the registration process under the scheme requires more than one month to a year. According to the owner of one NH providing sterilization services, it generally took longer for the new facilities (Box. 4.13; Quote1). While the district officials agreed to the views of the private providers, according to them it was either due to incomplete documentation by the private provider or due to delay in conducting the meeting with the district collector (Box 4.13; Quote 2).

The guidelines also suggested that the private providers engaged in the scheme should be reassessed every two years. According to one district official, this step was necessary to discontinue the non-performing providers. He also accepted that due to workload this step was skipped. It was also mentioned that the assessment did not take into account the

number of users under the scheme as well as their experience with the private sector (Box 4.13; Quote 3).

Box 4.13: Responses regarding the empanelment process of private providers under the scheme.

1. "*The process of empanelment often takes a very long time. In my case, it took almost six months. The process is much faster for the well-established private providers because they already have a huge client base*." [Interview with the owner of NH, Udaipur, November 2015]
2. "There are two reasons for the delay in completing the empanelment process. First, the private providers do not fill the forms correctly and second, the meeting with the district collector takes time. There are rarely delays from our end." [Interview with district official, Sirohi, October 2015]
3. "*We conduct a rapid assessment of the private providers after two years. The points in the assessment are the same as during the inception. There is no mention of the number of cases sterilized and also no scope for including the experience of the users. So, we end up empanelling the same provider every two years*." [Interview with the district official, Udaipur, December 2015]

3. Financing

Under the scheme, NGOs/ Private allopathic clinics were reimbursed if they provided any of the types of sterilization services – tubectomy, post-partum sterilization and vasectomy. Initially, the sum was Rs.3000 for all kinds of services, which included Rs1000 as wage compensation to the beneficiary. They also received Rs1100 and Rs1600 for female and male sterilization respectively from Govt. of India under the Santusthi Scheme of JSK. Out of this amount Rs500 was for the motivator. In total the private institution earns Rs2600- Rs3100 per case. Besides the government also provides insurance to indemnify the NGO/ Pvt Clinic's expenditure incurred to fight litigations related to sterilization. After the launch of Mission Parivar Vikas, the amount has been increased for both the public and private sector facilities (Table 4.4).

Table 4.4: Revised financial package (in INR) under Mission Parivar Vikas (GoI, 2016)

Payable to	Tubectomy		Post-Partum Sterilisation		Vasectomy	
	Public	Private	Public	Private	Public	Private
Facility	500	2500	600	3000	600	2500
Client/ Acceptor	2000	1000	3000	1000	3000	1000
Motivator	300	---	400	---	400	---
Total	**2800**	**3500**	**4000**	**4000**	**4000**	**3500**

This central government scheme was for only 145 high focus districts with a Total Fertility Rate (TFR) more than or equal to 3. Although 10 districts of Rajasthan were on the list, the state government decided to universalize the scheme across the state. According to the state-level official, this was done to promote sterilization in those districts with lower than TFR 3, but still on the borderline. As almost all districts were in that category, it was logical to apply the scheme for the entire state (Box 4.13.1; Quote 1).

As per the guidelines, the payment for sterilization to the Private Clinic/ NGO should be done every month by the DyCM&HO/Addl CM&HO, FW of the district. To ensure the release of payment, a list of documents had to be submitted by the private partners. All the above forms were provided to the private institutions by the Addl/ Deputy CM&HO FW. The NGO/ Private clinic submitted the completed forms by the 10th of every month. The process of verification should be done by the 25th of each month and the payment was released by the 30th.

Owing to the busy schedule of the district official, the block officials are engaged in the verification process. They, in turn, gathered the confirmation from the field workers like ASHA, Anganwadi Worker, Jan

Mangal Couple and ANMs. In some cases, the MOIC of the nearest PHC spoke to the case telephonically. It was reported that the Addl/ Dy CM&HO, FW also himself/herself checked at least 10% of the cases. Besides, the staff in their office also checked if the documents submitted by the NGO/ Private Clinic regarding the sterilization cases were complete and correct (Box 4.13.1; Quote 2).

The district officials reported the delay in payment was due to the incomplete paperwork submitted by the private institutions. The state officials were also considered to be partly responsible because of two reasons – (i) for designing such a complicated procedure for claim settlement which was also very time-consuming and (ii) for not releasing the funds regularly. The state department also had a role in processing the payment for the Santushthi Scheme of the Population Stabilisation Cell, which was also irregular (Box. 4.13.1; Quote 3).

Box 4.13.1: Response regarding the financing of sterilization scheme

1. *"The state government decided to universalize Mission Parivar Vikas because there are many districts in the state which are slightly less than TFR 3. It is important to promote sterilization in those districts as well. When the idea was shared by the central government officials, they approved it because there aren't any cost implications."* [Interview with a state-level official in charge of Mission Parivar Vikas, Jaipur, March 2019]
2. *"The process of claim settlement starts with verification of cases reported by the private sector. It is difficult to complete the process at the time mentioned in the agreement document because there is a shortage of staff at the district level. So, we engage the block and PHC level staff as well as the ASHAs. Besides, my staff also checks all the forms submitted by the private provider. When time permits I too speak to some of the beneficiaries."* [Interview with a district-level official, Udaipur, April 2016]
3. *"Most of the delay in payment is because of two reasons. First, the private providers do not submit the claims in the correct order. Second, the fund from the state is not released timely. Also, the process of verification mentioned in the state guidelines is very elaborate for which there is not enough staff at the district or the block."* [Interview with a district-level official, Sirohi, March 2016].

The government did not have any role in financing the private providers delivering institutional childbirth services as it was borne by the users. However, under the scheme, the government was supposed to pay the same JSY incentive to the users of private facilities as they did for those who used the public health facilities. According to the contract document the payment would get released within a fortnight after the necessary paperwork was submitted to the health department office at the block. The private providers engaged in the scheme complained that this was never followed. It was reported that the staff of the private facilities had to pay repeated visits to expedite the payment (Box. 4.13.2; Quote 1). At first, the public sector officials denied the allegation. However, on further probing, they divulged the problem of fund shortage at the block level. They also stressed the fact that the delay in payment of JSY beneficiaries of the private facility was more than those of public facilities because the latter was allowed to pay the client from the funds available with them (Box. 4.13.2; Quote 2). Some public officials also attributed the problem to untimely and incomplete documentation by the private providers (Box. 4.13.2; Quote 3).

Box 4.13.2: Response regarding the financing of institutional childbirth scheme

1. *"Government does not release the incentive to JSY beneficiaries who deliver in our facility. It sometimes takes more than 3 months. Our block-level staff regularly visits the block health office to expedite the payment."* [Interview with NGO staff, Udaipur, November 2015]

2. "*The delay in payment happens when there is a shortage of funds with us. This problem arises mostly when the patient delivers at private facilities. In the case of public facilities, the respective facilities have untied funds which are used to pay the beneficiaries."* [Interview with Block Medical Officer, Udaipur, January 2016]

3. "*The delay is caused when the private provider under the scheme either does not submit on time or they do not fill the forms correctly. In that case, we send the forms back to the provider and ask them to fill it again."* [Interview with Block Official, Sirohi, February 2016]

In addition to the problems in financing attributed to the public sector, the government officials also highlighted that there was a tendency of the private partners to over-charge the patients. This was more obvious in the case of institutional childbirth services where the self-financing model was adopted. This point is described in greater detail in the next section because it is related to the monitoring function of the public sector.

4. Monitoring and supervision

The guideline for sterilization services mentions that all private partners should be physically inspected every three months by a technical committee, But, most of the district officials reported that this was not possible as the technical team comprised of independent experts who were busy and since they were not paid anything they did not want to devote time for this visits. Some of them mentioned that whenever they had time they go for visits to the small nursing homes to check if they were maintaining quality standards (Box 4.14.1; Quote 1). However, from the manner they responded to the question of regularity of this visit, it was evident that it was rare. All the private sector respondents vindicated this view. According to the district officials, these visits were conducted after giving prior intimation to the private facilities. One of the district officials explained that if they did not inform it could be construed as an affront by the private providers, which was not intended in a partnership (Box 4.14.1; Quote 2). The NH in both the districts shared that they were not informed before their visit, but that was not the case with the MH.

The other monitoring function of the health officers of the district was related to financing. They are expected to verify the users of the scheme who sought services from the private sector. They also asked about the fees that the user paid for the service and the amount of incentive received. Based on the verification, the payment is released. This process has been discussed in the above section.

In the case of the services provided by the NNGO, the district officials mentioned that they had delegated monitoring to the MoIC of the Community Health Centre (CHC) and the Primary Health Centre (PHC) where the camp was held. According to the two Medical Officer in charge (MoIC) interviewed, they were not aware of this task; instead, they were instructed to facilitate the work of the NNGO. Both the MOICs stated that on the day of the camp they were busy with organizing and coordinating with the frontline health workers who were bringing cases for sterilization. They also mentioned that it is difficult for them to monitor the SNGO doctors because all of them were very senior. One of the MOICs also mentioned that one of the doctors working with the NNGO used to be his teacher in medical college (Box 4.14.1; Quote 3). There was no role of the state officials in monitoring the camps, both in the guidelines as well as in practice.

One key weakness of the guideline and the MOU was that there was no mention of any grievance redressal mechanism. The district officials specified that in the case of sterilization there can be only one kind of grievance which is the failure of the sterilization operation. Though such cases are reported they cannot be held against the private partner as negligence as there could be other medical reasons. When probed about overcharging for the services, the official considered it impossible because when the cases are motivated to undergo sterilization they are already aware of their entitlements. Moreover, they felt that no one will get themselves sterilized by paying from their pockets. Similarly, for the question of paying the incentive, they stated that the people were well informed about it (Box.4.14.1; Quote 4).

Box 4.14.1: Responses regarding monitoring private providers under sterilization scheme

1. *It is not possible to conduct a physical inspection by the experts as mentioned in the guidelines as the experts have a very busy schedule. Sometimes we pay a visit to the private facilities to see how the facility is functioning.* [Interview with district official, Sirohi, February 2016]
2. *"I generally prefer to inform them before I go to the private facility. They might feel insulted if I reach without prior information."* [Interview with district official, Udaipur, January 2016]
3. *"On the camp days, I am busy coordinating with the ANM and ASHA. It is also difficult because one of them happens to be my teacher when I was studying in the medical college."*[Interview with MOIC, CHC, Udaipur, January 2016]
4. *"The issue of overcharging does not arise as people who seek these services are already aware that the services are free otherwise they will never go for sterilizations."* [Interview with district officials, Udaipur, November 2015]

The responsibility of monitoring is more crucial in the case of institutional childbirth services because of two reasons. First, as per the provisions of the scheme in Rajasthan, the payment has to be made directly by the user. Second, the amount laid down in the scheme is much less than what private providers usually charged for providing the service. Dovetailing these two conditions there is a tendency of the private sector to overcharge the user unless properly monitored. However, it was found that there is no monitoring of the scheme in any form. The public officials at the state and district voiced different opinions about it.

First, those in the state felt that as there are no financial implications for the government, so there is no scope for monitoring (Box 4.14.2; Quote1). Second, some district-level officials indicated that users go for private facilities despite knowing that they will have to incur expenditure, much more than public facilities where the services were almost free. According to them, it was the patient's choice so they did not want to intervene. Moreover, as it was not mentioned in the scheme guideline documents, they did not consider it important (Box4.14.2; Quote2). When probed about people's discontent with the private sector's services, one of the district officials responded that they had not received any such written

complaint so far (Box 4.14.2; Quote 3). Third, a block-level stated that he avoided monitoring the facility because the owner of the private hospital had strong political connections (Box 4.14.2; Quote 4). Moonlighting by many of the district and block level doctors was cited as yet another reason for the public officials not strictly monitoring the private sector. This was disclosed by a retired state-level official but not by any other respondents (Box 4.14.2; Quote 5).

Box 4.14.2: Responses regarding monitoring private providers under JSY

1. *" As the government is not paying the private sector any money, we do monitor them."* [Interview with a state-level official in charge of JSY, April 2019]
2. "*When people choose to deliver in the private sector even though the services are almost free in the charges in the public facilities, it means that they are willing to pay. Then why should we intervene? Also, there are no such directions from the state department or in scheme guidelines. "*[Interview with a district official, Sirohi, February 2016]
3. "So far we have not received any written complaint on the issue of overcharging by any user. When we get one, we will certainly take corrective actions." [Interview with district officials, Udaipur, January 2016]
4. "I do not know if I should share this, but the private hospital is owned by a gentleman who is a very close friend of the local MLA. So I do not interfere in the work of the facility." [Interview with block-official, Udaipur, March 2016]
5. "Most of the government doctors in the block as well as some in the district practice in these private facilities. How can they monitor their employer?" [Interview with retired director, Health department, Jaipur, April 2019]

- Motivation to form a partnership

There were multiple opinions of the respondents about the need for partnership in the delivery of healthcare related to sterilization and institutional childbirth. The responses can be clubbed into three broad categories. The first, and the most common response of the district level officials, as well as some junior officials at the state, was a compulsion to follow the state and the national government orders. They reported that they did not have any authority to question the decisions of the state

officials (Box. 4.15.1; Quote 1). Although it was not explicitly mentioned, it was evident from their tone that there was very little motivation to form partnerships.

The second point of view was about increasing the coverage. A few district officials and the senior doctors associated with the process of selection replied that although it is the state's responsibility to deliver health services to attain the national health goals in their present form, the public health facilities in the blocks were unable to provide health services to achieve those goals. Therefore the state had chosen to buy the service from the private sector (Box. 4.15.1; Quote 2). This was mostly said in the context of sterilization services. The third category of respondents believed that through PPP, the government will be able to regulate the private sector, albeit to some extent (Box 4.15.1; Quote 3).

Box. 4.15.1: Responses of public sector officials to execute PPP in maternal health services

1. "*We are following the direction of the state government regarding forming PPP. That is a part of our job and we do not have a choice in this matter*." [Interview with a district-level official, Sirohi, February 2016]
2. "*The public facilities in this block particularly are in a very pitiable state. Hence to achieve the national health goals, it is important to engage the private sector providers*." [Interview with a block-level official, Udaipur, March 2016]
3. "*Through PPP, the government can control the quality of services delivered by the private sector healthcare providers, but only to a small extent.*"[Interview with a member of the expert committee engaged in the accreditation of private facilities, Udaipur, January 2016]

According to some of the private partners, the government officials at the district and block level lacked the motivation to promote and nurture partnerships. Some of them also added that although the senior government officials at the state level were keen on forming such partnerships, they did not see the same urge in their district counterparts (Box 4.15.2; Quote 1). A few of them also thought that PPP for delivery of maternal health services was being promoted by the government to make

good quality health services available to those sections who would not be able to access it because of the cost (Box 4.15.2; Quote 2).

Box 4.15.2: Responses of the private sector about the government's motivation to form a partnership.

1. *"I have interacted with various national, state and district level officials. When I speak to those at the top level, there is a keenness to work with the private sector that is much less in those at the districts and almost missing at the block level."*[Interview with the managing director, MH, Udaipur, November 2015]
2. *"The government is promoting the PPP model to deliver reproductive health services so that the good quality healthcare delivered at the private facilities is accessible to all sections at a subsidized rate.*" [Interview with a doctor of NH, Sirohi, October 2015]

4.2 Perception about inequity in access and the possible role of the partners in the Reproductive Health Services

This section captures varied opinions of public sector officials and private providers across levels, regarding; factors causing inequities in access and the possible role of private partners in addressing them under the schemes related to sterilization and institutional childbirth. The responses are presented according to the category of partners.

4.2.1 Private Sector

The majority of the respondents in this category opined that people in rural areas had very little awareness about the importance of preventive health services, especially those related to reproductive health. This was cited as the major reason for poor utilization. The practices of home deliveries were also mentioned by some public officials at the district and block. There was a myth regarding sterilization among men that inhibited uptake of vasectomy. As far as tubectomy was concerned, the poor status of women and their limited autonomy to make decisions related to family planning were the most common barriers to accessing health services. In

short, the private providers attributed the inequity to population-level characteristics.

When probed about the supply-side factors, there was a consensus across the different types of private providers that the state of the public health system in the rural areas was to some extent responsible for the inequities in access. Besides inadequate human resources to manage the rural public health facilities, lack of proper infrastructure and poor management of the existing resources as reasons for poor service delivery. Some of them also shared the problem of the dominance of local untrained healthcare providers. While these traditional birth attendants were easily available, they did not have the required knowledge to deal with obstructed labour. Many times this was the cause of maternal mortality. In the case of family planning, the private providers shared that local faith healers prescribed emergency contraceptives, indiscriminately, and also conducted medical termination of pregnancy. Both these practices led to severe morbidity and also mortality among rural women (Box 4.16; Quote 1).

On the issue of the potential of PPPs in bridging the barriers in accessing health services to reduce inequities in access, while most of the respondents said that they were doing their part, they also solicited better cooperation from the public sector cadres. Based on their experience, the SNGO and NNGO representatives shared that cooperation between the frontline functionaries of the public sector and the private partners is necessary for the success of PPPs in addressing the barriers to access (Box 4.16; Quote 2). The MH and the NH, delivering sterilization services also mentioned they can perform as per the scheme only if the public sector referred patients to their facilities (Box 4.16; Quote 3).

Box 4.16: Response of the private sector about factors affecting inequities in access and on the potential of PPP in addressing inequities in access

1. *"Harmful practices adopted by the local untrained healers were very common in rural areas. These include deliveries conducted by unskilled birth attendants who did not have any knowledge about how to tackle the most common cause of maternal mortality like obstructed labour and post-partum haemorrhage. They were also promoting emergency contraceptives indiscriminately without telling the ill-effects of the drug."* [Interview with SNGO representative, Udaipur, November 2015]
2. *"We are doing our bit to ensure that all sections of the community have access to safe childbirth services, but the frontline health workers should also cooperate with our staff. Till this happens, adopting the PPP model will not lead to any significant improvement in the inequities in access."* [Interview with the district manager of NNGO, Udaipur, November 2015]
3. *"Although we are keen to conduct more sterilizations we do not get many cases because we are not in direct contact with the community. For that, the frontline health workers of the public system have to send us cases."* [Interview with the managing director of MH, Udaipur, November 2015]
4. *"In a PPP there are two parties. For us to provide services as per the scheme guidelines we need the public sector officials should ensure these steps. First, the ANMs should do the complete ANC checkups and also maintain the records well. Second, the block and district officials should ensure that the beneficiaries who delivered in any private facility receive the incentives on time. The district officials should also allow emergency transport vehicles to bring patients to their facilities as well if the patient's family was willing to come."* [Interview with the owner of NH, Sirohi, October 2015]

The representatives of NH delivering institutional childbirth services delineated two types of actions. On one hand, the ANMs should ensure proper ANC process is followed and the results are documented well. This can help the doctors to see the pregnant woman's medical history when they the private facility. On the other hand, the block level officials should release the incentives of the JSY beneficiaries, who gave birth at the private hospitals, on time. They also suggested that district-level officials should permit emergency transport vehicles to bring patients to private hospitals depending on the patient's choice. According to them, these measures will motivate them to seek services of the private facilities (Box 4.16; Quote 4).

4.2.2 Public Sector

The point of view of the public sector officials about determinants of inequities in access did not vary much from that of the private sector respondents. Most of them cited lack of awareness and poor educational level among the rural families as the leading cause for poor access to maternal health services. A few of them also alluded to poverty and the low status of women in rural society. Besides these demand-side determinants, another most common factor was the lack of transport facility in these areas, especially at night.

In delineating the supply-side factors, the officials at the district and block said that they had adequate frontline health workers with at least one ANM in each sub centre (SC) and for bigger catchment areas there were two ANMs. However, they agreed that because the ANMs were overburdened with documentation work and activities related to other diseases their role in maternal health services suffered. While few alluded that most ANMs also did not reside in the SCs because the infrastructure was in an inhabitable condition, most of them use this justification for PHCs (Box 4.17; Quote 1). This made it impossible to provide regular maternal health services in these facilities. As confessed by a block official, none of the PHC in that block was functioning round the clock. All these factors made it difficult to deliver these services in rural areas. When probed about the role of private sector facilities in addressing equity the public sector officials unequivocally refused that those facilities had any significant role vis a vis maternal health services in the state (Box 4.17; Quote 2)

Responding to the next question, the majority of the public sector respondents, across all three levels – state, district and block, were reluctant to accept that the PPP model could play any role in bridging the barriers to access, especially those concerning rural areas. Besides the

issues of availability only in urban areas, the public sector officials were doubtful that the private sector providers could overcome their urge to earn profits (Box 4.17; Quote 3). Some of the district and block officials expressed that the PPP model had some benefits but only for those beneficiaries who want to seek maternal health services from the private facility and yet get the benefits of public schemes (Box 4.17; Quote 4). The response was interesting because it in a way hinted at the middle-class population living in the urban and peri-urban areas.

Box 4.17: Responses of public sector officials regarding inequities in access and the potential role of PPP in addressing it

1. *"To make maternal health services available to rural women ANMs have been posted in all SCs, but they are kept busy with numerous reports and also other diseases. They are just able to provide ANC services. The PHCs were also unable to provide round-the-clock service because there were no doctors and poor infrastructure."* [Interview with a district official, Sirohi, October 2015]
2. *" If you look at the NFHS data you will understand that the private sector has a negligible role in delivering the maternal health services in Rajasthan."* [Interview with a state-level official, health department, Jaipur, February 2016]
3. *"I do not have many hopes on the PPP model in meeting the national goals related to maternal health. First of all, they are located in urban areas and second, they will never stop making profits from the patients. So, I don't see how they can address factors affecting inequities in rural areas."* [Interview with a district official, Udaipur, November 2015]
4. *"Such [PPP] arrangements will only benefit those patients who would anyway go to private hospitals for their delivery, but because of the scheme they are now entitled to the incentive."* [Interview with a block official, Sirohi, October 2015]

Section 5: Discussion

At the onset, the reasons for focusing on these two services, institutional childbirth and sterilization, were twofold. First, PPP models have been adopted in both these services since their inception and continue to do so. Second, there is a plurality in the types of private sector engaged in these services. This discussion predominantly aims to analyze the outcomes of the PPP model adopted to deliver these two services. To do so, it is important to revisit the factors, especially those related to the supply-side, that affect their uptake. While there are many micro studies from across India on the utilization of institutional and childbirth services, for the analysis, studies that have used national-level quantitative data to ascertain the factors are only included.

A comparative study of NFHS 3 (2005-06), UNICEF Coverage Evaluation Survey (2009) and Assessment of JSY by National Health System Resource Cente (2011) reveals that the most common reasons for not delivering at institutions are primarily– (i) patients did not consider to be necessary, (ii) family did not allow. (iii) too expensive, (iv) too far/ no transport and (v) poor quality of service/ received better care at home (Satia, Mishra, Arora and Neogi, 2014). While the first two are related to the demand –side, the last three are directly related to the service delivery aspects.

From the data presented above sections, it is clear that the PPP model adopted in Rajasthan did not alter the third and fourth factors in any significant manner. Except for the NGO in Udaipur, which adopted a low-cost model and was located in the village, all other private facilities were in the block headquarters. The Government of Rajasthan's decision to empanel only those private facilities in the block level for JSY must be appreciated in this context. However, as mentioned in the interviews, the number of private facilities empanelled was more in those blocks where the public health facilities were better. Moreover, in blocks that had a

dysfunctional public health system, there were at the most only two private facilities. In most cases, these did not have the required resources to deliver round-the-clock services.

The expenditure incurred was completely neglected in the PPP model, because the government did not share the OOP expenditure incurred. There was also hardly any institutional mechanism to check the user charges levied by private facilities to provide institutional childbirth services. Although most of the private sector respondents stated that they were charging beneficiaries as per the scheme guidelines, there was a high possibility that these did not include the medicine charges. The scheme also did not cover the travel cost. Under such circumstances, only those beneficiaries who could afford to incur these costs were the only ones giving birth in these facilities.

The third aspect was the quality of services. Although the study did not examine quality in technical terms but based on the nature of human resources and infrastructure available in these empanelled private facilities it can be inferred that the quality was not uniform. Apart from being managed by a medical doctor, the other staff members in these facilities were often ANMs. In the case of the NGO, there was no doctor available in the facility; services were provided by GNMs. The infrastructure in most of these facilities was also inadequate. Most of them had limited bed strength and none of them had arrangements to tackle obstructed labour and other emergencies that emerged during childbirth.

The finding of a descriptive analysis of the Round 3 of District Level Household Survey by Kumar and Dansereau (2014), reveals that availability of labour rooms, opening hours of the facility, and adequacy of general medical equipment and infrastructure are the primary facility-level drivers of institutional delivery. Except for the availability of labour room, the private sector facilities empanelled under the scheme lacked all other attributes. This implies that the PPP model to deliver institutional

childbirth service, in this case, was not a very effective model to address the inequities in access because it does not bridge the gaps in supply-side determinants.

According to a study on factors affecting the choice of institutions for family planning services in India by Nair, Feeney, Mishra and Retherford (1999) using the NFHS 2 data the private providers were mostly consulted for temporary methods of contraceptives like pills (68%) while only 6% for sterilization. Moreover, the correlation between the TFR and the percentage of users relying on the private sector source was only -0.11. Thus engaging the private sector in the delivery of any family planning services, including sterilization is less likely to reduce the TFR, which was the aim of the scheme. This was found to be especially true for rural areas.

This study reveals that private providers did not have much role in enhancing access to sterilization services. First, as most of the private facilities were in the urban and peri-urban areas, it is less likely that people from rural areas will travel to district headquarters to avail the service. Second, most of the private providers did not have any direct connection with the community, except the NNGO. The private sector also did not pay much attention to post-operative care. Moreover, the private sector organization that showed interest in participating in the scheme were those that were just being established. The bigger private sector, like the MH, was mostly a dormant partner.

Thus for both these services, engaging the private sector organizations does not seem to improve the inequities in access, especially in rural areas. Instead, it adds a burden on the existing district and block-level public sector officials to manage them.

Chapter V: Public-Private Partnerships for Mobile Medical Services in Rajasthan

"In a PPP model, the public sector is happy that they do not have to manage the services and the private sector is earning profit. None of them is concerned about the health needs of the people in the underserved areas. There is no question of achieving equity." [Interview with a senior official in charge of MMS, Health Department]

In a vast country like India, there are pockets, both in urban and rural areas, which are medically underserved. As the term suggests, people in these areas have very little or no access to formal healthcare facilities provided by the public sector. The formal private sector in these areas is absent in these areas. Moreover, inhabitants of these areas mostly belong to lower socioeconomic status as well as have poorer educational levels. The situation is worse in rural areas with a significant tribal population. All these factors, combined, exacerbates the inequities in access to health care due to logistic and financial barriers experienced by the clients. Social factors like poor client-provider communication and lower client trust also render these populations under-served (Hills et al, 2012).

Recognizing these challenges, the Government of India introduced the Mobile Medical Service scheme, under the aegis of the National Rural Health Mission launched in 2005. Many states decided to adopt this approach to deliver health services to under-served areas. Like most states, Rajasthan also adopted the strategy of Public-Private Partnership (PPP) for executing the MMS. Provision of primary level care comprising preventive, curative and diagnostic services, was the objective of the scheme. Besides, availability, the scheme also aimed to address concerns of affordability and approachability. Hence, it was imperative to include this scheme in this study.

The chapter is divided into five sections. The first section presents a historical overview of mobile medical services in India and Rajasthan. The second section is a review of existing studies on mobile medical services from other states of India, to identify the broad domain concerning their functioning. The third section describes the design and distribution of mobile medical services in Rajasthan. The fourth section is based on primary data gathered from three districts which have predominantly tribal population – Udaipur, Sirohi and Dungarpur. In each of these districts, three types of providers are delivering services. The last section discusses the findings of MMUs operating in Rajasthan in light of the experience from other states.

Section 1: Historical Overview of mobile medical services in India and Rajasthan

Addressing the health needs of people living in medically under-served areas has been a consistent concern for the public health system since its inception. The Bhore Committee recognized that there will be such areas that may not get covered by the primary health centres and sub-centres. For such areas, the Committee suggested 'traveling dispensaries' that will supplement the health services rendered by the primary health centres (GoI, 1946, pp. 37).

> *"In the more sparsely populated parts of individual provinces, it may be found advantageous to provide traveling dispensaries in order to supplement the health services that will be made available to the people the primary health units. The areas in which these traveling dispensaries should be provided and the extent of such provision are matters which can be settled only in the light of local knowledge and we must, therefore, leave it to provincial governments to work out the details."*

Following this, the first five-year plan proposed the concept of mobile dispensaries. These dispensaries, associated with the rural health centres, provided medical care to the population and also carried specialist services to the rural population. The first Mobile Health Units were introduced in 1951, in tribal areas, to provide health services to the 'underserved and inaccessible' areas (Dash et al, 2008). Later, in 1962, the Mudaliar Committee also proposed the same model instead of setting up new PHCs (Qadeer, 2011).

The next milestone in the history of mobile medical services was the Reorienting Medical Education (RoME) Scheme launched in the late 1970s. The scheme was conceptualized by the then Union Health Minister, Raj Narain after his visit from the United Kingdom where he saw the multipurpose ambulances which were like mobile hospitals. Such ambulances were purchased for India with a loan from the World Bank. Despite being technologically ahead of time, these ambulances were used only for a few months (Sircar, 2002).

Another model of mobile medical services, executed under the first phase of the Reproductive and Child Health (RCH) programme were the RCH camps. The scheme, launched in 2001, aimed to increase access to quality RCH services in remote and under-reported areas. They provided services for Antenatal care, referral, counseling for safe deliveries, postnatal care, identification and management of childhood illness as well as family planning services. For this model, a team of government staff, including specialists, medical officers, nurses, laboratory technicians, and also assistants, were selected from the different Community Health Centres and District Hospitals. As per the guidelines, one camp was to be organized every two months for 5 days at the selected primary health centres (PHC). The total annual budget allocated to each district for six camps per PHC in 20 PHCs was 1.2 million INR (SIHFW, 2008). This

amounts to 10000 INR per camp, for all related expenditures including the medicine cost.

An evaluation of RCH camps was conducted in 14 districts of Rajasthan, classified into high and low coverage districts based on the number of camps organized (SIHFW, 2008). Some of the key findings from the evaluation revealed serious gaps in service delivery which are as follows:

1. Planning: The camps were mostly planned at the district level, with hardly any inputs from the medical officers at the block and PHC. The budget for camps was also managed by the district-level officials.
2. Frequency and duration: Camps were organized in an ad-hoc manner, as per the convenience of the district level and block level officers. The majority of the camps were organized for one day. Also, there was very little knowledge about the frequency and duration of these camps among the officers responsible for organizing them.
3. Nature of the healthcare delivered: Although these were supposed to be for providing RCH services, most of the patients reported that they went to the camp for seeking health services for pain or fever; only 10% of the patients used RCH-related services in the camp.
4. Providers: In the majority of the camps (64.6%) services were provided by Ayurvedic or homeopathic doctors. In four out of 14 districts these camps were organized bi-monthly, as per the norms. In these districts, 59%of medical officers participated in the camps, while only 22.4%of officers in the remaining 10 districts did so.

This shows that the barriers to access healthcare services in medically underserved areas could not be effectively addressed through these camps. However, the camps were able to facilitate the outreach of some services to those who were socially backward.

In 2009, the Mobile Medical Service (MMS) scheme was launched by the government of India. Partnership with the non-government organization was cited as one of the models in the operational guidelines for this scheme. According to the Operational Guidelines of the scheme, designed by Govt. of India, two types of vehicles would be used. One would carry medical and paramedical staff while the other would be equipped with necessary diagnostic facilities. Both these together will be considered a unit. Initially, one Mobile Medical Unit was sanctioned for each district, but there was scope for more than one unit based on the number of underserved areas in a district. These units would/shall provide preventive, promotive, and outpatient curative care for common diseases, including communicable and non-communicable diseases, RCH services, with referral linkage to the appropriate higher faculties (GoI, 2015). It will also provide diagnostic services, collect sputum, and generate awareness on a range of health topics.

This scheme has been implemented in many states of India, with some modifications according to their specific need. One of the successful models is the boat clinics being run by an NGO in the riverine islands of Assam, where 10% of the population of Assam resides (Arora, 2014). These clinics started as a social enterprise with the World Bank grant and UNICEF support; which was later approved in the NRHM Project Implementation Plan. Another similar NGO initiative was found in Sunderbans, West Bengal; this area is also one of the underserved areas in the state (Neogi, 2014).

In Rajasthan, the scheme, launched in 2010, has two models – one is MMU as per the national guidelines; the other is Mobile Medical Van (MMV). Currently, 58 MMUs and 150 MMVs are functional across all districts of the state (GoR, 2020). Also, there are Mobile Surgical Units in Rajasthan, functional since the 1980s under the aegis of the Department

of Medical Education. These units, entirely funded through the state budget, are currently operational in only 3 districts. The camps are organized for a specific time each year with human resources deployed from the Medical College hospital (GoR, 2019).

Section 2: Experience of PPP in Mobile Medical Services in other states

Although there has not been any national-level evaluation of the MMS, there are assessments of the scheme from different states like Jharkhand, Uttarakhand, Chhattisgarh. Along with these studies, the findings of the Common Review Mission conducted annually by the Ministry of Health, Govt. of India provide insights about the performance of the scheme as well as the problems associated with it.

A study of MMU across 3 districts of Jharkhand, assessed the performance of the MMS scheme launched under NRHM (Kumar et al., 2009). The study had four objectives:

1. To assess the infrastructure, human resources, type of services, and frequency of visit
2. To assess whether the staff has been trained
3. To assess the availability of medicines and equipment
4. To assess client satisfaction

In all three districts, the private partner was a single non-profit organization. The findings show some positive aspects, such as; MMUs were delivering services for 22 days in a month, the camps were according to/as per the route plan prepared by the district level officials and medicines were mostly available as per the guidelines. There were some gaps as well. These include a lack of gynecologists in one of the districts and radiographers in all three districts, no separate arrangements for female patients, an average waiting time was more than one hour, and no system for the referral sides. Also, there were limited resources and only a few counselors for behaviour change communication in these units. The

majority of the providers complained regarding the shortage and irregularity of funds. While patients using the services reported that they were satisfied with the providers' behaviour, they revealed that there was no prior information about the camps in the area. This was a cause of concern as without proper information many potential users could not seek healthcare. The majority of the user in all districts (100% in Ranchi to 88% in East Singhbhum) resided very close (less than 1km) to the campsite. The camps were also mostly providing general outpatient healthcare, with very few laboratory and diagnostic tests.

A detailed evaluation of 17 MMUs, managed by a private partner across 13 districts of Uttarakhand was conducted with similar objectives (NIHFW, 2013). The study revealed that although the camps were being organized regularly catering to the minimum number of patients in each camp, yet the outreach to poorer sections was inadequate.

The authors classified the factors affecting utilization into two categories: (i) design-related and (ii) implementation-related. The first design-related factor was the selection of the lowest bidder as the private partner. As a result, the salaries of the staff were much lower than the market rate which in turn led to a high turnover of staff, especially doctors. Also, there was difficulty in getting experienced nursing and paramedical staff at the districts. Second, the duration of these contracts was only one year which indicates that there was a discontinuity in service delivery between the expiry of contracts and re-tendering. Third, these camps were monitored only based on the total number of patients who sought service and not for their specific conditions as per the national health programme priorities like; antenatal care, immunization, and identification of patients suffering from Tuberculosis. The implementation-related challenges were; interference of local leaders for selection of a site for the camps, inadequate

information dissemination about the services in the communities, and that insufficient drugs.

Another study of MMUs conducted in two districts of Chhattisgarh showed that MMU was operational in the state before NRHM (Nandi et al., 2017). These MMUs were mostly financed through the state budget. Although NRHM opened the opportunity for availing funds for these units, the state was not able to operationalize new MMUs until six years due to procurement-related problems. Later, the private partner selected for operationalizing MMUs was involved in a scam in two other states. Besides, the study revealed problems related to the availability of doctors and required equipment and reagents for the laboratory tests. The data also revealed that the cost of financing the MMU by the private sector was six times more than the cost incurred by the government when it was run directly by the state; however, this cost did not include the cost of any human resources. Notwithstanding these lacunae, the study concluded that the MMUs were able to provide services to those areas where earlier no service existed.

Based on the reports of the multiple rounds of Common Review Missions (CRM), conducted under the NHM since 2007, the trend to operationalize Mobile Medical Units through NGOs was found in most of the high focus states through PNP or PFP organization. In most of the places it was found to be functional but there were some common problems.

1. In most states, the units did not have female doctors or any specialists. They also lacked the X-ray technician or radiographer, as a result, the X-ray machine and the ultrasonography machine were under-utilized (GoI, 2009; GoI, 2013).
2. There was no standardized basis for the categorization of villages into difficult and underserved areas across states. In some cases,

MMU was providing services where public health services already existed (GoI, 2009; GoI, 2013).

3. There is also variation in the types of services provided in the MMS scheme across states; hence the experiences related to improving health outcomes were inconclusive (GoI, 2011). There was evidence from Andhra Pradesh, that MMUs operated by the corporate group made the primary health centres and sub-centres in tribal areas dysfunctional (GoI, 2009). Some states reported positive performance of MMU, but the community's response did not commensurate with the claims made by the state (GoI, 2013).
4. The coverage area of MMU and the services delivered were limited. The problem with regular follow-up was reported in most states. In some states stock out of drugs was, hence drugs are dispensed by MMUs are for few days (GoI, 2012; GoI, 2013). Over time there has been an improvement in the delivery of services by MMUs with respect to the type of services namely, some trips per month and footfall. Some states have also adopted technology-based mechanisms, like GPS tracking, to monitor the functioning of the MMUs. Increased involvement of ASHAs in MMU services resulted in better utilization (GoI, 2017).
5. The services provided in the MMUs were mostly for common out-patient care like; cold, fever, body ache, and some units also provided ANC services. However hardly any of them provided any care specific to national health programmes, nor did they invest time in preventive services and counseling (GoI, 2010; GoI, 2011).
6. Despite these problems, a similar model has been adopted in the National Urban Health Mission and Rashtriya Bal Swasthya Karykarm in different parts of the country (GoI, 2016).

The GoI has acknowledged the following operational and contextual inadequacies which affected the outcome of the services provided through MMUs (GoI, 2015):

1. The coverage and outcomes did not commensurate with the investment in most states
2. Planning of MMUs did not follow the principles of inaccessibility
3. The range of services was not such that it addressed the needs of the population living in remote areas
4. Providing effective X-ray services through MMU was not feasible
5. Comprehensive planning and monitoring were a challenge.

Besides these state-specific studies, as well as the findings of the CRMs and the Government of India guidelines related to PPP arrangement, it is also important to deliberate on the merit and demerits of a camp approach to deliver health services. Health camp is a debatable mode of service delivery. On one hand, the health camp supporters believe in the principle of *'something is better than nothing*. On the other hand, those arguing against it highlight the problems regarding continuity of healthcare and trust between the providers (Citrin, 2010). The importance of community participation is unequivocally accepted as one of the most important factors for the success of a camp approach. However, this was barely demonstrated in many of the programmes that promoted this approach (Jamir, Nongkynrih, and Gupta, 2012). This study attempts to capture the implication of operationalizing MMU through PPP mode, on all the above-mentioned factors.

Section 3: Design and distribution of mobile medical services in Rajasthan.

The section attempts to give an overview of the PPP model adopted in Mobile Medical Services in Rajasthan. This includes the type of vehicles used in the MMS scheme, the distribution of these vehicles, and the

different types of private sector engaged under the scheme. The data presented in this section is based on analysis of Operational Guidelines, Memorandum of Understandings (MOUs), and government reports, as well as a review of programme data.

3.1 Types of mobile medical services in Rajasthan.

There are two types of units for mobile medical services in Rajasthan – Mobile Medical Van and Mobile Medical Unit. The Mobile Medical Unit (MMU) comprises of two types of vehicles; one vehicle for movement of health staff and the second vehicle was equipped with diagnostic facilities like; X-Ray, ECG, Film auto Processor, Semi-Auto Analyser, etc. The Mobile Medical Van (MMV) has a single vehicle that carried staff and equipment with basic diagnostic facilities like; glucometer, haemoglobin meters, and sphygmomanometer. In these PPPs, the capital cost which included the purchase of vehicles, equipment, the cost of drugs and supplies was borne directly by the public sector. On the other hand, operating the MMU/MMV was the responsibility of the private partner on reimbursement of the operating cost.

3.2 Coverage

Under NRHM, the scheme was launched in Rajasthan in 2010, to reach the populations in remote and inaccessible rural areas where the regular fixed services are not available. No MMU/MMVs are operational in urban areas. Currently, there are 58 MMUs functioning in 31 districts and 150 MMVs operational across all 34 districts.

As per the GoI guidelines, the norm for the deployment of MMUs is as follows:

a. One MMU for the district with a population of 10 lakhs
b. Two MMUs for the district with a population between 10 lakhs and 20 lakhs

c. Three MMUs for the district with a population between 20 lakhs and 30 lakhs
d. Four MMUs for the district with a population between 30 lakhs and 40 lakhs
e. Five MMUs for the district with a population of above 40 lakhs

The distribution of MMU/ MMVs in Rajasthan does not follow the above-mentioned criteria. In every district, the number of existing MMU/MMV is much more than the national guidelines (Table 1). The number of MMU/MMVs also varies across districts with similar populations. For instance, Jaisalmer and Pratapgarh both had similar populations, but the number of MMU/MMVs was different.

Table 5.1: Population wise number of MMU: expected and actual

Population Category	Population wise number of districts	No. of MMU per district as per GoI Guidelines	No. of MMU in each District
Less than 10 lakhs	2	1	3 (Jaisalmer) and 5 (Pratapgarh)
10 lakhs to 20 Lakhs	17	2	3 (in 4 districts), 4 (in 5 districts), 5 (in 4 districts), 6 (in 1 district), 7 (in 1 district), 8 (in 2 districts)
20 lakhs to 30 Lakhs	9	3	5 (in 1 district), 6 (in 1 district), 7 (in 2 districts), 8 (in 3 districts), 9 (in 1 district), 10 (in 1 district)
30 lakhs to 40 Lakhs	4	4	9 (in 1 district), 12 (in 3 district)
More than 40 lakhs	1	5	6 (in 1 district)

(Data source: www.nrhmrjasthan.nic.in)

As reported by the officer-in-charge of MMS at the state levels, the final deployment was as per the decision of the health minister. The suggestions of the state-level officers, as well as the district, were not heeded (Box 5.1; Quote 1). This point was raised by the district-level officials during their interview as well. It was further clarified by the district level officials in the study districts, that mapping of the medically under-

served area was often not considered while the deployment of MMU/MMVs. (Box 5.1; Quote 2).

Box 5.1: Responses of government officials about the deployment of MMU/MMV

1. *I remember during the initiation of the scheme I had prepared a list of districts and the blocks where there was need for MMU and MMVs. The list was revised based on the comments of the Health Minister.* [Interview with ex-consultant in-charge for MMS at state-level, Department of Health, Jaipur, May 2019]
2. "*We do not have any say in decisions regarding the number of MMU/MMV that is allotted for our district as well as in the deployment to the blocks. While some blocks have more than 50 underserved villages we can reach services to only 30. We have more than what we require"* [Interview with district official, Udaipur, August 2016]

3.3 Nature of private providers

As per the GOI guidelines, the preferred private provider was a private non-profit (PNP) organization; but there is no mention of private hospitals to bid for a partnership.

> "States can also explore the option of outsourcing the vehicle through a public-private partnership with credible NGOs, which would follow the same norms, and be accountable for a similar set of services and outcomes." (GOI, 2014 Para 7.1, pg. 4)

Since the first Expression of Interest (EOI) in 2007, Rajasthan has included Private Hospitals as one of the categories eligible to bid. This decision was taken after a draft Memorandum of Understanding was prepared under the Rajasthan Health Sector Development Project (RHSDP). At that time, it was decided that the private partners shall be selected from the district itself. As many districts did not have any competent PNP organization for the task, it was agreed that private hospitals that are willing to partner and meet the required technical and financial criteria shall be allowed to bid. The officer opined that while

making that decision they were mindful of the possibility that the private hospitals could leverage patients for their respective facility, yet the lack of choice compelled them to make such a decision (Box 5.2; Quote 1).

Presently, there were no private partners under this scheme in five districts. In these districts, MMUs/MMVs are being operated by the Rajasthan Medicare Relief Society, under the leadership of the Chief Medical and Health Officer of the district. Out of the remaining 29 districts, in four districts private hospitals are in charge of the scheme, while in the rest 25 districts MMUs/MMVs are managed by the PNP organization. These can be classified into the following categories – CSR foundation (1) Trust (8), Registered Society (10), and Private Ltd Companies (6). According to state-level officials in charge of the scheme, there was no difference in the performance of different types of partners. However, they mentioned that in some instances it was found that the hospitals were delivering better services; they attributed this to the experience in providing healthcare which some of the PNP organizations did not have (Box 5.2; Quote 2).

Box 5.2: Responses of government officials about the nature of private partners

1. "*Such NGOs who had experience in the delivery of health services was present in only a few districts. In the remaining districts, the only option of private was nursing homes and hospitals."* [Interview with a retired government official, in-charge of RHSDP, Jaipur, July 2019)]
2. "*The hospitals have more staff; including doctors hence they can deliver services more efficiently. The NGOs, especially the new ones, on the other hand sometimes face the problem of human resources."* [Interview with the state-level officer, in-charge of MMS, July 2019]

Section 4: Implementation of PPP in Mobile Medical Services

This section describes three cases of MMUs operational in three study districts. It is divided into two sub-sections– (i) architecture of partnership and (ii) perception about inequities in access and the benefits

of PPP in achieving it. For the section describing the architecture of partnership, the role of the private sector and public sector were examined concerning their capacity to perform their respective functions, and their motivation to join the partnership. Subsequently, the perception of inequity reflected across both providers was explored.

The data in this section is based on in-depth interviews with 29 respondents from the state, district, block officials as well as three private partners and their respective field teams. In the course of data collection, the contract period of the private providers ended and one of the private providers did not renew the contract. This provided a natural experiment situation to explore the reasons for discontinuing the partnership by the provider.

4.1 Architecture of Public-Private Partnership in MMS

4.1.1 Role of Private Sector

There were three types of service providers in the private sector not for profit organization included in the study– (i) a corporate foundation (henceforth Foundation), (ii) a family-run philanthropic trust (henceforth The Trust), and (iii) a not for profit organization registered under the Societies Registration Act (henceforth NGO). This section will capture the details of both the above-mentioned components for each of the providers.

- Capacity to perform the expected role

1. General profile

As per the RFP, the private partner should be registered under any of the Acts namely, Societies Registration Act, Indian Religious, Charitable Act, Indian Trust Act or Companies Act or their state counterparts for more than three years at the time of submission of the proposal. The other

requirements are that they should have a minimum of three years of experience in the operationalization of MMUs or MMVs and have a minimum annual turnover of Rs. 20.00 lacs in the last three financial years. While all the study organization complied with these criteria, their profile, nature of the ownership, and technical capacity were different.

The details of the organization are as follows:

- CSR Foundation

The organization was registered as a Trust in 2007, by a leading Information Technology (IT) Company in India, as its Corporate Social Responsibility unit. It started working in Rajasthan since its inception. In the initial years, it was engaged by the State Health Department in delivering emergency and non-emergency referral services. It also provided similar services in other Indian states. In 2010, the parent IT Company went into loss and the foundation stopped its functioning for almost two years. In 2013 the foundation was taken over by a leading pharmaceutical company in India and merged with its existing CSR unit. The foundation is engaged in installing water treatment plants in schools of selected districts in Rajasthan, where the water has arsenic or fluoride contamination. In addition to this; they run higher education institutions for engineering and training of nurses in the backward areas of Rajasthan along with some other states and operating MMU/ MMVs in five other states of India. The medical helpline service (commonly known as 104 services) of the foundation was discontinued in 2011, as funds for this initiative were not sanctioned under/in the NRHM Programme Implementation plans.

The organization's head office was in Hyderabad but it had state teams managing its project under CSR. The Rajasthan team comprising of 20 staff had three departments namely operations, accounts, and human

resources (HR) that were lead by a Vice President (VP). While staff in HR and accounts were based in the state capital, the operations team worked from their respective districts and reported directly to the VP. Daily functions of the organization were managed by the state team leads. However, final decisions on crucial matters were taken by the VP in consultation with the chief of CSR at the head office with subsequent permission from the board. One such decision was to discontinue the helpline 104 services after the state government's plan for it was not sanctioned by the central government (Box 5.3; Quote 1).

- The Trust

This organization was founded in 2000 by an Endocrinologist and Surgeon who had worked in Kuwait and London for more than 20 years. He is currently the Managing Trustee (henceforth MT). Since its inception, the Trust has been involved in providing health care in western Rajasthan, through its charitable hospital in Jodhpur district headquarter. Later, due to a lack of available human resources in the district, the hospital was shut down. During the interview, the MT informed about a Diagnostic Centre with all the latest diagnostic facilities that had been started by the Trust where service was provided at a cost much lesser than the market rate.

In 2007, the organization registered under the Foreign Contribution Regulation Act (FCRA) and was awarded projects from other international donor organizations. Besides, the organization was engaged in the Rajasthan Aids Control Society (RSACs) in its Targeted Intervention Project and also in Cataract Operation of the Blindness Control Programme. Currently, the organization is only implementing the Mobile Medical Unit/ Mobile Medical Van project of the Department of Health and Family Welfare, Rajasthan. The Trust also expanded its services beyond health care to skill training for rural youths as well as opened colleges to impart

technical education. While some centers were funded through government programmes, the organization also levied nominal fees from students. The Trust has more than 30 full-time employees which did not include the project-specific teams. Currently, there were three funding sources of the organization – (a) corpus funds, (b) long-term funding partners from mostly international donors/organizations, and (c) government projects. According to the MT, all decisions related to the activities of the organization were solely taken by him. He only sought the advice of the board of trustees when he felt the need for it (Box.5.3; Quote 2).

- NGO

The NGO was registered in 1998, by four local youths, under the Yuva Jyoti (Young Professional) Scheme, funded by the Council for Advancement of People's Action and Rural Technology (CAPART). As they belonged to the Jodhpur district of Rajasthan, they decided to start an NGO of their own after completing their tenure as Young Professionals in CAPART. They received a seed grant from CAPART. Initially, the NGO worked as a sister concern for a well-known organization in Jodhpur and received funding support from them. As the turnover increased, they also applied for independent projects. Apart from the health department, the NGO had worked with the Sarva Siksha Abhiyan, Tribal Development department, and NABARD. The NGO was not registered under the FCRA. It had a team of 10 regular employees and the rest were the project-based

staff. The decisions in the organization were taken by two of the partners (Box.5.3; Quote 3).

Box 5.3: Responses about the ownership of the private partners

1. "*Decisions regarding the day to day activities of the organization are taken by me and my state team. The board is involved only when there are major financial implications of the projects* [Interview with the state-head of the CSR Foundation, Jaipur, August 2016].
2. "*Although there is a board of trustee, all the decisions are taken by me. I always inform the board about these. For some critical problems, I also seek their advice.* [Interview with the head of the Trust, Jodhpur, July 2016].
3. "*Most of the organizational decisions are taken jontly by me and another partner.* [Interview with the head of the NGO, Dungarpur, April 2016].

2. Vision of the organization

According to the MT, it was a common practice among the Marwari community to do philanthropic work. Following this mandate, he started the organization to ensure, that health and education services should reach the underprivileged sections of the population who are deprived of these services (Box 5.4; Quote1). The Director of the NGO expressed that it was their goal to help deprived communities and also generate employment. The respondent from Foundation reiterated that it is not only because of the Indian Companies Act 2013 that the corporate has taken such measures. According to him, the leadership of the organization was concerned about the well-being of the people, hence the Foundation was established (Box 5.4; Quote 2). In short, all three private partners mentioned that their mandate was to help in the development of poor and marginalized sections, but none of them mentioned the empowerment of the communities.

Box 5.4: Responses about the vision of the private partners

1. *"After working for 20 years abroad, I had accumulated some wealth. I wanted to use it for the development of the villages. I spoke about the idea with my family members who had well established business and were keen to contribute."* [Interview with MT, the Trust, Jodhpur, July 2016]
2. *"The legal provision came in 2013, but the organization has been working since 2010. The Foundation was largely driven by the vision of the leaders of both the previous company as well as the current company to improve the lives of people*." [Interview with state-head of the Foundation, Jaipur, August 2016]

3. Source of funding

Based on the source of funding these three organizations could be classified into three categories – (a) corporate funding under a legal requirement, (b) international non-government agencies and (c) national non-government and government projects. While the main source of funds for the Foundation was largely from the parent corporate body, the Trust received funds from all three sources and the NGO was dependent on grants from governments. Besides, the Trust also generated resources from some individual contributions. According to the MT, some family members contribute to the Trust, but it is not regular.

During the interview, the respondents from the Trust and the NGO alluded that since the past couple of years, the funds from international agencies have reduced significantly, so their main donor was the national and state governments. The share of government funding in the turnover of the Trust and NGO was reported to be 70% to 80%. According to the MT, the funds received from the international donors helped in building the capacities of the organization alongside supporting the projects. This was not the case with the government, as the focus was on implementing the projects at a very low cost (Box 5.5; Quote 1).

According to the state-head of CSR, the government funds contribute to only 20%-30% of the organization's activities. However, he also mentioned that for government projects the contribution of the Foundation was minimal (Box 5.5; Quote 2). This information could not be cross-checked because none of these organizations were unwilling to share their annual reports as well as balance sheets with the researcher. The state government officials in charge of MMS also denied access to this information.

Box 5.5: Responses about the vision of the private partners

1. *"In the past we received funds from many international donors. Those were mostly long-term and not limited to projects alone. Funds were also given for building the organization's capacities. But now the situation has changed. With government as the donor the focus is only for implementing the projects. Despite this, we are compelled to seek the government funds because other donors have significantly reduced their functions in Rajasthan."* [Interview with MT, the Trust, Jodhpur, July 2016].
2. *"Most of our funds comes from the Corporate that we are a part of. We use these for the human resource cost at the state office and some district level staff to do activities sanctioned by the board. For government projects, we do not generally use the budget allotted under the guidelines. We prefer to keep these two accounts mutually exclusive."* [Interview with state-head of the Foundation, Jaipur, August 2016]

4. Profile specific to Mobile Medical Services

(i) Human Resources

All the partners reported that they have health teams comprising of doctors, nurses, paramedics, and drivers as per the RFP and memorandum of understanding. Most of the health team members met the essential qualification mentioned in the RFP. However, some of the doctors employed by these organizations were medical students who were doing their final year internships and yet to get their registration. According to the head of the Corporate Foundation, this decision was taken after due approval from the state and district officials due to the lack of available doctors in the districts. In some blocks, retired government

doctors and private practitioners who had local clinics were also employed. All staffs were on contract for the project. However, none of the organizations had a lady medical doctor or radiographer in any of the health teams.

One of the issues regarding staffing was the availability of doctors willing to devote significant time to the MMU/ MMV services. These doctors were primarily from the district headquarters and they had to travel to the respective blocks every day to attend the camps. As a result, many doctors did not prefer to take these jobs (Box 5.6; Quote 1). This was reported by all these private partners. The organization, especially the NGO, mentioned that staff attrition was high, particularly for doctors.

As a result, the private partner has been penalized a few times by the government. However, since they did not have the means to deal with this problem, they have jointly written to the health department to allow them to employ dentists when they do not get any suitable MBBS doctors (Box 5.6; Quote 2). Currently, this decision is pending at the state level. This was also verified by the state-level officer in charge of the scheme.

Box 5.6: Responses of the private partners about availability of doctors

1. "*Working in the MMU required them to either stay in the block or travel every day. Most of the doctors did not want to work in remote blocks*. [Interview with MT, the Trust, Jodhpur, July 2016]
2. *"The only alternative to the problem of attrition was employing dentistry graduate instead of MBBS."* [Interview with NGO representative, Dungarpur, April 2016]

The CSR had recruited an additional team comprising of Operation Executives (OE) headed by the District Manager (DM) to ensure effective implementation at the ground level. Each OE was in charge of 4 MMUs; for Udaipur, there were 3 OEs. Each DM was in charge of all MMU in three districts. The DM in Udaipur was in charge of Udaipur, Banswara, and Rajsamand. While the staff in health teams were assigned tasks as per the guidelines, the OE was responsible for maintaining the reports, ensuring

drug availability, and also solving any problems that the health team faced.

The trust had appointed a District Programme Manager, Pharmacist, and Administration Staff for each district besides the medical teams. However, it was found that the District Programme Manager for the Sirohi district was also responsible for the management of MMUs in the adjoining district. The Director of the NGO also mentioned that they have one manager for each district who reports to the head of programmes in the organization. However, like the Trust, the same manager was managing the project in more than one district. For both the Trust and the NGO, it was not possible to meet the manager during the field visits.

As per the RFP, the private partner had to calculate the actual number of staff in each category taking into account their work shifts, staff leave days, absenteeism and public holidays, to ensure that the Schedule of Services is not disrupted in any way. Private partners are also required to develop a network of the above-mentioned staff in the area, so that in the absence of any staff member backup may immediately be provided. While these organizations reported that they have a list of additional staff; they refused to share the list even after repeated requests. No such list was available with the district or state-level officials as well.

ii. Range of services

The RFP document for MMU in Rajasthan stated that the private partner should provide outpatient curative care, maternal and child health services, family planning services, referrals, emergency and epidemic management and diagnostic services. In addition to this, they have to conduct community mobilization activities through PRI, VHSNC and government staff working at the village level, as well as behaviour change activities including individual and group counseling.

As per the Govt. of India guidelines, the MMU/MMV should meet the technical and service standards for a PHC. The provider is expected to respect the dignity of the patients and maintain the confidentiality of the data. In the MOU and the Govt. of India guidelines, there is also scope to include special services based on the context and needs of the people.

In this context, it is important to note that as per the plan, each MMU is expected to spend five hours in the village to deliver all these services in addition to four hours of travel time. For villages with less than 1000 population or when the time taken to reach a village was less than four hours, the MMU is expected to cover at least two villages in a day.

In practice, all three organizations were providing only outpatient curative services and limited ANC services like Hb and urine sample testing. A variety of reasons was cited for not providing the range of services mentioned in the policy documents. These can be categorized into three broad categories –time, resources, and demand from the community. The mobile team, as well as the other staff in these organizations, reported that it was difficult to provide medical advice to 100 patients per day within five hours as mandated by the government's instructions (Box 5.7.1; Quote1). Sometimes the MMUs were expected to organize camps in more than one location, which increased the travel time and reduced the time available for providing services (Box 5.7.1; Quote 2).

Box 5.7.1: Responses of the private partners about time constraint

1. *"The government wants us to see 100 patients per day. It was humanly impossible, for one doctor in 4 hours, to do a thorough medical checkup and recommend treatment to so many patients.* [Interview with a doctor in medical camp, Foundation, Udaipur, August 2016]
2. *"Sometimes we are asked to do two camps in a day in two villages. Travel time between these villages ranges between 45 mins to an hour. As a result the camp is held only for two hours in each village. How can a team of three people provide different types of services? So we only deliver basic treatments.* [Interview with a pharmacist in medical camp, NGO, Dungarpur, April 2016]

Laboratory services, like urine tests and hemoglobin for pregnancy, were done in almost all camps but blood tests for the detection of malaria or sputum tests were mostly not done in the camps organized by the NGO and the Trust. This was because the reagents for conducting those tests were not available with the team (Box 5.7.2; Quote1). The managers also reported that due to a lack of radiographers in all MMUs, diagnostic services were not being provided. Inadequate availability of drugs in the camp was also a common problem, which adversely affected the types of services provided (Box 5.7.2; Quote 2). In such cases, the doctors asked patients to buy drugs from the market or referred them to the nearby block and district hospital where drugs were available for free. All these factors, in turn, limited the range of services provided.

Box 5.7.2: Responses of the private partners about resource constraint

1. *"Most of the tests is related to pregnancy only, so we have to refuse patients who come for other types of tests like sputum examination.* [Interview with a laboratory technician in the medical camp, Trust, Jodhpur, July 2016]
2. *"Although we give the requisition for drugs well in advance, the supply is lesser than what was indented. In such case we have to give smaller quantity to each patients. For some communicable diseases there is no supply at all. This discourages patients from utilizing the camp services* [Interview with a pharmacist in medical camp, NGO, April 2016]

iii. Frequency and duration of camps

The RFP states that the private sector should be functional for 20 days in a month conducting at least one camp per day or two in the case of villages with a population of less than 1000. The fixed-day approach was to be followed in organizing the camp to ensure continuity in health service provisioning. The camp timing was from 10 am to 5 pm. The

private partner was responsible for organizing the camp as per these conditions.

According to public and private partners, these conditions were mostly adhered to but some practical challenges emerged. First, identified villages were more than the number of working days. This made it impossible for MMU to return to a particular village on the same day every month. The health team following the 'fixed day approach' felt that this approach is an effective way of improving the utilization of MMS, otherwise, people do not remember the day for their camps.

Second, the users could not be informed about the dates of the camp in advance, although the RFP document mentioned that patients should be informed about the next visit date. The team across all categories of private providers were of an opinion that they were not aware of the schedule for upcoming months so they were unable to tell the dates to the community in advance (Box 5.8; Quote 1). In one district where the campsites did not change very frequently, the providers could tell patients the tentative dates when the camps will be conducted. Sometimes camps were even canceled because of the breakdown of the vehicles or the sudden absence of the doctor. These conditions were the responsibility of the private provider and were linked to penalty; hence in such cases, the camp was postponed to another day. However, no information was given to users about the rescheduled dates.

When this issue was discussed with the head of the organization, they shared that, a monthly plan was prepared after the 25th of the previous month by district officials. By then all camps were over, hence the team did not know about the next visit date to the same village. The MT further added that they had suggested the district officials about scheduling camps for each quarter, but this suggestion was not being followed regularly. The head of the Foundation mentioned that he had

written to the state-level officials on this issue but there was no positive change (Box 5.8; Quote 2).

Even when the camp is organized as per the schedule, the camp timings do not take into account the availability of the users. According to the team members of MMU/MMV that during the day villagers were either busy in their daily household chores, involved in agriculture, or out of the village. They felt that it was better to plan camps as per the convenience of the users to provide services to more people. However, this idea was not entertained by the head of the organization or district-level officers (Box 5.8; Quote 3). Many of the respondents reported that the government staff at the district treated MMS like any other routine medical service provided by the government. They reported government officials' resistance to change. As a result, organization leadership also did not take any efforts to convince them.

Box 5.8: Responses of the private partners about camp schedule

1. *"When patients ask us when the next camp will be organized in their village, we cannot provide them with any answer as we ourselves do not know."* [Interview with MMU team staff, NGO, Dungarpur, April 2016]
2. *"I have personally written about this to the state level officers, but no actions have been taken so far. It appears to me that they are hardly interested to improve the utilizations of MMS. So,over time, we have also become complacent."* [Interview with head of Foundation, August 2016]
3. *"I personally think that if we want better utilization of camps it should be organized in the afternoon, as in the morning people in the villages are very busy. Although I shared this point during our review meetings, it was not accepted. As a staff I cannot do more than this."* [Interview with MMU team staff, the Trust, July 2016]

iv. Demand generation for the service

As per the RFP, the proper and adequate Information Education and Communication (IEC) of the scheme is the responsibility of the private partner. For this additional staff has to be engaged in the designated areas

and coordinating with local communities for the uptake of services. Besides, posters have to be designed and after approval by district authorities, it has to be distributed at the campsite in advance, so that the maximum population can be aware of the future camps in the area. The private partners are also expected to do wall paintings at Anganwadi Centre or the nearest PHC/ sub-center and other prominent places about the camp schedule.

In none of the campsites, IEC material about the camps and their services were available. The health teams could not show any pamphlets that were prepared about the services. Hence the lack of awareness about the camp and the services was obvious. The head of the Foundation shared the pamphlets that had been printed and also showed an advertisement published in the local newspaper about the MMS, but a specific day and date were not mentioned in these materials. The cost was entirely borne by the Foundation. No such means for publicity was adopted by the NGO or the Trust. It was also observed that the health teams spread information using loudspeakers on the day of the camp.

According to the staff of medical teams, demand generation should be the role of the village level frontline health functionaries as well as the

Box 5.9: Responses of the private partners about demand generation

1. "*We come to these villages only once a month, while the ASHAs are always present in the village. If they were given the task to inform people about the camps it would be beneficial to more people. But, in reality they do not play much active role*." [Interview with staff of medical team, the NGO, Dungarpur April 2016]
2. "*To ensure that more people visit the camps we inform the ASHAs of the village about the visit dates, but most often when the camps reach the village they find that villagers did not know about the camp."* [Interview with Programme Managers, the Foundation, August 2016]
3. " When we get the schedule of the camps there no mention of which days there was a VHND on which village. This is the job of the block officials, who prepare the route plan, how else will we come to know?" [Interview with the staff of medical team, the Trust, July 2016]

elected representatives because they are well connected to the people of the village. However, in reality, their involvement was nominal (Box 5.9; Quote 1). The private sector respondent of the CSR Foundation, as the district, mentioned that they telephonically informed the frontline workers about the camps, but most often the actual task starts after the team reaches the village (Box 5.9; Quote 2). One of the camps, which the researcher attended, in Dungarpur although the medical camp was being held on the weekly Village Health and Sanitation Day the ANM or the ASHA were not aware of it. During the interview, the staff of the medical team shared that they seldom had updated information about the VHNDs (Box 5.8; Quote 3).

v. Location of the MMU camp

It was expected that the private provider will identify the Point of Service (POS) for organizing the camp. The RFP specified some basic requirements for the POS like; it should be accessible by all the sections of the society in a particular village or a cluster of villages, availability of waiting area and privacy for the patients. The decision of location was very context-specific, so it was largely left to the provider.

In practice, the site selected by the MMU health team was mostly at an Anganwadi Centre or any other community building. These sites were selected because they were commonly visited by the villagers and space for patients to sit while they were waiting was available (Box 5.10; Quote 1). In villages with poor road conditions, MMUs did not enter these villages because it was difficult for the bigger vehicle to move on *kaccha* roads. In such cases, the camps were held on the side of the main road near the village (Box 5.10; Quote 2). Although the team members recognized that the turnout of patients reduced, especially the elderly, women with small children, and those with any form of disabilities, when the camps are organized outside the village premise, they did not have any other options. It was also observed that none of the health teams had any map of the village. So, it was very difficult for these teams to identify an appropriate point to deliver service where all residents could congregate.

Box 5.10: Responses of the private partners about location of the camp

1. "*Mostly any government building in the village like school, Anganwadi Centre and Panchayat Bhavan are preferredbecause people can come easily and there is adequate space for sitting.*" [Interview with Programme Manager, CSR Foundation, August 2016]
2. "*For those villages that have kaccha roads we organise the camp near the main road outside the village. Though we are aware that it is difficult for some people to reach the camps, but we do not have much choice as these vehicles cannot move on such roads."* [Interview with driver of the medical team, NGO, April 2016]

- Motivation to join the partnership

All the private organizations chose to partake in the bid because they saw it as a means to promote their vision. However, there were other underlying reasons which were also reported (after probing). The state-level head of the Foundation explicitly stated that they intended to bid for the 108 Emergency Ambulances in the state. For which it was required that the bidder had the experience to manage a fleet of 100 vehicles. They considered bidding for MMS because it will increase their credibility as a potential bidder for the 108 scheme. They planned to operationalize the MMS in maximum numbers of districts to achieve that aim. The respondent also mentioned that to win the bid, they had reduced its operational cost by 50-60% and in few cases also waved it (Box 5.11; Quote 1). When probed about their motivation to partner for the '108' services he expressed that it improved the organization's profile, but did not elaborate on this point further.

Even after working for three years, when a new RFP was floated in 2018 this organization did not bid. The head of the CSR Foundation cited administrative challenges faced at the state and district levels, as a reason for not renewing the partnership. He also clarified that this decision was taken by the Executive Board of the Foundation (Box 5.11; Quote 1). The state official in charge, however, alluded to the change of eligibility criteria for the Emergency Ambulance RFP could be the reason why the organizations did not participate in the new bidding process (Box 5.11; Quote 2).

For the other two providers, this scheme was a potential funding source that they wanted to leverage, especially because the other sources had reduced considerably. Under such circumstances, it was being difficult to sustain the organization. The other reason cited was that working with the government enhanced the legitimacy of their organizations, which in turn

made them a stronger competitor for other government projects in other departments as well (Box 5.11; Quote 3).

Box 5.11: Responses of the private partners about motivation to join

1. "*Operationalizing MMU was a means to acquire the qualification required to bid for 108 services in the state. So, we bided for almost all districts. In some districts we did not include the operational cost in our proposal so that we could win the bid. After working for a long time we have understood that working with the government is very difficult, so the board decided to reduce all our engagements with the state health department."* [Interview with head of the Foundation, August 2016]
2. "*It is the choice of the organization to bid or not to, but I guess they opted out because they relied that even if they won the bids for all districts they will not be eligible to bid for the 108 Ambulance Service."*[Interview with official, state health department, Jaipur, May 2019]
3. *"Working with the government is an additional experience which increases our chance of getting bids with other government agencies and is also valued by other non-government donors."* [Interview with MT, the Trust, Jodhpur, July 2016]

4.1.2 Role of public sector

Several tiers of public sector staff were engaged in the designing and execution of MMS. This section focuses on the different roles of the public sector and the responsible authorities starting with the state followed by the district, block, PHC and frontline health workers.

- Capacity to perform the expected role

In this section, the capacities of the public sector officials at various levels are delineated according to the process of formulating and executing the PPP strategy for MMS. For each stage, first, the process is described in detail, then the required capacities are identified and finally, it is matched with the capacity of the cadres involved in that particular stage. This will enable in capturing the gaps in existing capacities as well as recognize those cadres who have better potential but are not being involved for various reasons.

1. Selection of the private partner

The selection process included three stages– pre-selection, selection, and award of contract. The pre-selection process starts with conceptualizing the scheme till the issuance of the tender. The second stage was the actual selection process of the private partner and the third stage was awarding the contract.

1.1 The pre-selection stage:

This stage starts with drafting the Expression of Interest (EoI) document. This was done only once when the project commenced in June 2007. A state-level consultant was assigned the task of preparing the EoI, publishing it in the local and national newspapers as well as on the health department's website, and later collating the responses. To expedite the process the Chief Medical Officers at the districts were also given the task of identifying potential private sector organizations and encourage them to apply for the scheme.

According to the state-level consultant, many of CMHOs did not complete this task properly. So, the higher officials, both bureaucrats, and technocrats in the health department assumed that the CMHOs across the state did not have the capacity. They decided to centralize the entire process of selecting the private operator. This had both advantages and disadvantages for the project implementation. By conducting this step at the state level it could be ensured that the quality of the organization was not compromised and the project could start simultaneously in all states. It also considerably reduced the workload of the district. The negative side was that the consultant had no prior experience or training in the tendering process. There were also not many officials in the department who had the capacity to prepare EoI at that time (Box 5.12.1).

Box 5.12.1: Responses of the public sector about pre-selection stage

"*Initially, when the task of identifying the potential private sector for delivering MMS was given to the CM&HOs, they were not able to identify capable NGOs. The Mission Director and the other directors in the department decided to centralize the processs. This helped the districts officials but it was challenging for me. I did not have any prior training or experience in the process. Also, there were not many officials in the department who were aware of the steps."* [Interview of ex-consultant in charge of MMS, state- level, health department, Jaipur, May 2016]

Based on the response to the EoI, the next step was to prepare the Request for Proposal (RFP) document. This task was delegated to the Rajasthan Health System Development Project (RHSDP) team, who then outsourced the drafting of the RFP to a private firm. According to the state consultant, this was done to expedite the process and also because there was no person to do this job available within the department. However, the consultant had to alter the RFP prepared by the external agency as per the suggestions of the top officials of the health department. The drafting of a suitable RFP took almost eight to nine months. Once approved by top officials of the department and the political leadership, the first RFP was published in August 2010 (Box 5.12.2).

All the subsequent RFPs have been based on that document although some revisions were made every project cycle. When the previous RFPs were reviewed there were differences in the assessment of bid documents submitted by the private players as well in the reporting structure and the payment modalities. Those are discussed in the later sections.

Box 5.12.2: Responses of the public sector about drafting RFP

"*The first draft of RFP was prepared by external consultants through RHSDP. This was done s othat the task could be completed quickly. Also it was difficult to do it at our level as there were no person in the department who had the required expertise. The draft contract shared by agency had te be changed as per the suggestions from various state level officials. This task took almost eight months. After that it was published in the newspapers.*" [Interview of ex-consultant in charge of MMS, state- level, health department, Jaipur, May 2016]

At the beginning of each phase of the tender process, the government organized a pre-bid conference with the prospective bidders. This meeting was chaired by the Mission Director and held in the Directorate of Health Services, Jaipur. The stated purpose of this meeting was to clarify issues raised by the bidders and also accommodate some changes that have been suggested. This step is essential for the partnership because in this exercise the private sector organizations could share their views.

The NGO representative shared that these meetings were not very useful as the queries of the private sector were seldom answered. There was also very little willingness to accept any changes or admit any lacunae on the part of the government (Box 5.12.3; Quote 1). One public sector official, contradicted by saying that most of the private sector's demands were about increasing the cost or reducing the workload, both of which were unacceptable. He also mentioned that when there were mutually beneficial suggestions, the higher officials always considered those (Box 5.12.3; Quote 2). After the meeting, the changes were incorporated after the approval of the Principal Health Secretary. However, there was no way to triangulate these views, as the minutes of the pre-bid meeting were not in the public domain.

Box 5.12.3: Responses of both sectors regarding pre-bid conference

1. "*The pre-bid conference is just a formality. The officials do not consider any of the suggestions given by the NGOs. They give the message that those who want to bid, will have to toe their line."* [Interview with head of the NGO, Dungapur, April 2016]
2. *"Most of these suggestions and comments are of the private party are not acceptable because it benefits them. Those, which are genuine and serves both parties is always considered."* [Interview with senior state-level offical, Health Department, Jaipur, May 2019]

1.2 Selection Stage

After the final RFP was published, the private players were given 15 days to submit their proposals. The selection stage started once the

submission period was over. The selection comprised of two steps – screening and vetting of the proposal.

Currently, the process of screening was done at the state level by the consultant in charge of the project. But, in the first three phases of the scheme, this task was given to the district level. According to a state-level officer-in-charge of MMS, this decision was taken to avoid delaying the process. She also hinted at the issue of the capacity of the district health officials because of their already busy schedules (Box 5.13.1; Quote 1). On one hand, the district officials reported that they were not aware of the reason for this revision of the selection process. An official from one of the study districts expressed his dissatisfaction with it. He also alluded to a sense of alienation between the state and district officials after the process got altered (Box 5.13.1; Quote 2).

Box 5.13.1: Responses of government officials about the selection

1. *"There was delay in shortlisting by many CM&HO because they have multiple responsibilities. In order to free those from this additional burden it was decided that the selection in done at the state level."*[Interview of state level consultant incharge of MMS, Health Department, Jaipur, April 2019]
2. "*I do not know exactly why the state government took the decision to exclude district officials from the selection process, but I do not agree to this. The saddest part is that they did not bother to seek our views*." [Interview of District Official, Dungarpur, April 2016]

The second activity in this stage was vetting the technical proposal of all eligible applicants by the district officials on the following parameters:

1. Duration of registration of the organization (in years)
2. Experience in the operationalization of MMUs/MMVs (in years)
3. Minimum annual turnover (in lac rupees)
4. Experience of successfully running (in number of vehicles)
5. Evaluation of Human Resource Function - Existence of a Formal HR Department headed by an HR manager, Training Dept., Recruitment process, Appraisal process, Statutory Compliance and Salary payment system

Scores were assigned to each of these parameters; only those agencies were supposed to be shortlisted which got the highest score. This was followed by an assessment of the financial bid. In the financial bid, the provider quotes the cost of running one MMU/MMV in the district, which includes the HR cost, vehicle maintenance, and awareness generation activities. Finally, the lowest bidder is selected. All these steps were done by a consultant at the state level.

While all the stages mentioned in the RFP were followed, there were some crucial loopholes. The first gap is that the process takes place without any field verification of the organization's work; hence there was a chance that the organization is not providing true and/or complete details in the parameters of the technical proposal. This point was not explicitly mentioned by any respondent. When the researcher posed it as a question the government officials accepted the possibility. However, they justified their approach to selecting private partners by stating that it was difficult to conduct physical verifications of all the private partners (Box 5.13.2; Quote 1).

The second problem was in the preference given to the lowest bidder. Hence the most private organization often quote much lesser than what might be necessary. As reported by a retired state official, sometimes the private providers quoted much less than the amount that would be required for meeting all requirements for the project and to remunerate the staff appropriately. However, he also hinted that they were bound by the government procurement norms to select the lowest bidder (Box 5.13.2; Quote 2). Besides, the consultant cited the limitation in cost per vehicle due to the amount approved in the PIP (Box 5.13.2; Quote 3).

Box 5.13.2: Responses of government officials about financial bid selection

1. *"There are 34 districts in the state and around 50 private partners applied. How can I alone verify all these partners? For that I need atleast a team of 10 professionals, but currently I have only a single operator working with me."* [Interview of state level consultant in charge of MMS, Health Department, Jaipur, May 2019]
2. "*Private providers have a tendency to submit bids with nominal rates in order to get the contract. Sometimes they do not allocate any operational cost in their proposed budget. Although service delivery becomes doubtful in those circumstances, but no government officials challenges it because there is fear of audit objections*." [Interview with retired Project Director (NRHM), Jaipur, May 2019]
3. " *There is a fixed budget for each vehicle in the PIP, we cannot overshoot that amount*." [Interview of state level consultant in charge of MMS, Health Department, Jaipur, May 2019]

The last and most important concern was the transparency of the process. Although the process of bid submission was online, very few people at the state level are involved in the actual selection. The documents related to bidding selection were not available for public scrutiny even under the RTI Act. As a result, the actual process followed could not be verified. The selected organization also refused to answer questions regarding the bidding process and the amount quoted by them. The state-level official mentioned that there was a confidentiality clause in the MOU prohibiting sharing the proposal (Box 5.13.3). The district teams also did not have much idea about the exact process, so in-depth information could not be gathered.

Box 5.13.3: Responses of government officials about financial bid selection

"*We do not share any details, regarding the bidding process and the details of the bidders, even under the RTI Act. It is always doubtful by someone is asking for that question. We are also bound by the confidentiality clause in the agreement*. [Interview with consultant for MMS at state level official, Health Department, Jaipur, April 2019]

1.3 Awarding Contract

After completion of the selection process, the contract was awarded to the private provider. A Memorandum of Understanding is signed between Chief Medical Officer at the district and the private provider who has been assigned to the district. This is followed by the handover and the takeover of the vehicles by the public and private partners respectively. The private provider is mandated to start operations within 15 days after the contract is awarded. All the respondents agreed that this clause was followed. This time was generally devoted to the selection of human resources for the project and also to repair the vehicles. While this period was important for an organization to get abreast of the areas where services shall be provided, in practice no such activity was conducted during this period. Hence, when they began working, they did not have much knowledge about the field areas.

2. Deployment of MMU

The first step towards operationalization was the identification of the villages without any functional facilities, followed by preparing a route map for the MMU. Although the CM&HO was responsible for operationalizing MMU as per the national as well as state guidelines, they did not have much authority in the deployment of the vehicles.[43]The district officials are left with the task of preparing the route plan. This was often delegated to the respective block official. According to the response of some block officials in the selected study districts, no clear mapping of inaccessible areas of the block was available. Sometimes, these villages did not match the eligibility requirement for hard-to-reach or medically underserved areas (Box 5.14; Quote 1 and 2). This was also observed in a few of the camps visited during data collection. Of the 6 villages (2 in each district)

[43]The reason for this is mentioned in the section 3 of this chapter.

visited in the course of the data collection, most of them had Anganwadi centers and a few were located on the highway within 10 km from the block headquarters.

Box 5.14: Responses of government officials about the deployment of vehicles

1. "*In the route plan we try to accommodate the under-served areas, but this list is not updated regularly. There might be some villages in the list which were earlier in this category because they did not have any facilities, but now they might have an Anganwadi Centre. There is also very little clarity on what is underserved.*" [Interview with a Block Medical Officer, Sirohi, July 2016]
2. "*All villages in my block are connected to some kind of public health facility, yet I have been given a MMU. So in the route plan I include the far of villages, but these are not necessarily underserved area in the real sense.*" [Interview with a Block Programme Officer, Dungarpur, April 2016]

3. Support the private providers under the MMS scheme

The Medical Officer (MO) in the nearest functional Primary Health Centre (PHC) and the ANMs of the health sub-center in the area are expected to provide support to MMU as per the MOU. They are expected to be present at the campsite, to support the health team of MMU. The frontline health workers and panchayat representatives have an important role in awareness generation and mobilizing the community so that people who need healthcare are informed about the MMU. The Village Health Sanitation and Nutrition Committee (VHSNC) and other community-based organization like SHGs should be actively involved in managing the delivery of services.

In reality, PHC MOs were not engaged in supporting private providers. In fact, at all the six field sites visited, the PHC staff reported that they were not aware of any MMU/ MMV that was operational in that area. Hence, they were not providing any form of support to the MMU/MMVs in their area (Box 5.15; Quote 1). An ANMs in a Sub-center in Abu Road block

of Sirohi reported that though they were aware of the camps, but did not have updated information about the exact dates on which these camps were held or about the location of these camps. She also shared that there were no such orders from their superiors to monitor these camps. Another ANM from the Mawli block of Udaipur shared that ANMs usually participated in the camps held on the Village Health and Nutrition Day (Box 5.15; Quote 2).

The only cadre who extended regular support to the medical teams were the community-level workers like the ASHAs and the AWWs. Most of them reported that they informed people and also accompanied pregnant women for an antenatal check-up. Few of the ASHAs also suggested that if they knew when the camps were to be held, they could help more. Some also alluded to the absence of role clarity and hence their inability to support the camp proceedings (Box 5.15; Quote 3).

Box 5.15: Responses about providing support to the medical teams of the private providers

1. "*In four years of my posting in this PHC I have never heard about the scheme in this area.So how can I provide any support?*" [Interview with a PHC MoIC, Udaipur]
2. "*I have taken part in few camps because they were organized on the VHND day at the Anganwadi Centre. Beside that we do not get regular information about these camps from our officers. We have never been instructed to visit the camp sites or support them in any way."* [Interview with ANM, Sirohi, July 2016]
3. "*Whenever I am present in the village I assistin organizing these camps. I bring all the pregnant women and also inform local people so that they can avail these services*. We could help in a better way if we knew what were our tasks during these camps." [Interview with ASHA, Dungarpur, August 2016]

4. Building a referral system

The guideline clearly states that MMU is not to be understood as a stand-alone service delivery option but a mode of delivering primary care in remote and inaccessible areas, in a way that links users with secondary

and tertiary level care. However, it does not mention how this will be established. It was reported by the private provider that this linkage is rarely established and the private partners mostly function as a stand-alone delivery point. The same was evident from the responses of the ANM and PHC doctors (Box 5.16; Quote 1). While the state and district level officials were aware of this, no measure was adopted to link private providers and public health facilities. As a result, on average only 10-15% of the patients are being referred to the CHC or PHC. This was confirmed by the state-level officer as well (Box 5.16; Quote 2).[44]

Box 5.16: Responses about building referral linkages.

1. *"We rarely receive patients who are referred by the MMU/MMV. Patients are either sent to CHC or not referred at all."* [Interview with PHC Medical Officer, Udaipur, August, 2016]
2. *"Only 10-15% of the total patients are being referred, per month across all MMUs."* [Interview with state monitoring officer, Health Department, Jaipur, September 2019]

5. Monitoring

The GoI guidelines mention that state officials are responsible for ensuring mechanisms for effective monitoring and better management of the providers. The indicators to be monitored were the regularity of these camps, the number and types of patients across social categories receiving services (it is important to ensure that the MMU was reaching those patients who otherwise are covered), and the services provided (including simple OPD as well as diagnostic tests).

As per the MOU, the functioning of MMUs/MMVs in a district should be monitored regularly and form an essential part of a review by the CEO of the Zilla Parishad/District Collector. There was software for online

[44]There was a tendency among most doctors in the MMU team to under-estimate the number of referrals as they felt that it reflected their poor performance. There was no accurade data available about the number of cases referred to validate the information.

reporting through which regular monitoring is possible. The data is collected in the following parameters for the online reporting system.

1. Human resource information
2. Inventory of medicines and other consumables.
3. Logbook of vehicles
4. Number of patients
5. Camp plans in advance

While some information was submitted by the private provider, district officials reported that they regularly monitored three indicators linked to a penalty in the RFP document (Box 5.17; Quote 1). Those were (i) the starting and ending time and (ii) the presence of a doctor in the camp, and (iii) the number of patients seen every month. For other indicators, the district officials reported that because of workload they were not able to do any filed verification; instead, this task was delegated to the block officials. The block officials mentioned that they visited the campsite whenever they were instructed to by the district or when they were in the vicinity of the camp. However, a block official also hinted that their visit was rare because they received a limited budget for field travel (Box 5.17; Quote 2).

Box 5.17: Responses of government officials about monitoring the private providers

1. "*The payment of the private operator is processed at the district level. We regularly monitor only those indicators that are linked to penalty clause because those are related to the amount payable to the private operator. We have also instructed the block officials to conduct field visits to check the services. It is difficult to monitor the MMUs at the block from the district level because we have shortage of human resources here and also some of the blocks are very far.*" [Interview with District Official, Udaipur, August 2016]
2. "*When we make any visit to the PHCs and SC, we also check the MMUs. Sometimes we receive instructions from the district officials to check the camps, the we have to go. There is very little scope for conducting any exit interviews of the patients due to time constraints, but we get the feedback from the ASHAs.*" [Interview with the block official, Dungarpur, April 2016]

6. Processing the payment

The GoI Guidelines state that there shall be a timely settlement of claims at the agreed terms, by provisions of the agreement, which must include parameters and norms for the imposition of liquidated damages/ compensation/ penalty concerning default in implementation of the project.

The financing norms, as well as the practice, were as follows:

i. For Human resources:

According to GoI guidelines (pp. 20) Rs. 95000 per month for 1 vehicle unit and Rs.1,20,000 per month for 2 vehicles can be approved. The cost is further subdivided as per the team members, such as Rs. 48000 per month for doctors, Rs. 15000 per month for ANM, Lab Technician and Pharmacist and Rs. 10000 for drivers. The cost is slightly higher for 2 vehicles as there are two drivers and an X-ray technician. In the PIP (2015, pp.16) by the state, allocations were reduced to Rs. 89500 and Rs. 73300 per month, for the two-vehicle and one vehicle unit respectively. Despite changes in the overall amount, the amount allocated for doctors by the state was according to the GoI guidelines. In the 2018 RFP, this breakup of the total cost was removed.

It was found that in these three districts, the staff was getting much lesser payment than what was mentioned in RFP. Besides, there was variation in salary among the same category of staff across and within the provider. As reported by a doctor who had worked with the CSR Foundation between 2016-18 and was currently working with the NGO reported that his salary was Rs 35,000 previously but now it is lesser. He also reported that some of the other doctors were getting more than that amount (Box 5.18.1; Quote 1). Since the MOU signed between Govt. and a particular provider was not shared, the agreed payment terms could not

be verified. The government officials at the district did not intervene in the matters of staff salaries as they considered it to be outside their roles, though they accepted that such practices had implications for the nature of the staff and also their services that they provided(Box 5.18.1; Quote 2).

Box 5.18.1: Responses of private and public sector staff about salaries of medical team

1. "*While I was working with the CSR Foundation my salary was Rs 35,00 but now the NGO gives me much less. I have also heard that some doctors are being paid more than what in this same organization."* [Interview with a Doctor, NGO, Dungarpur April, 2016]
2. "*It is not our role to check what salary the organization is paying its staff. It is entirely upto the private operator. But I personally feel that salary determines what kind of doctors are hired and also their approach to deliver services in the camp."* [Interview with district officials, Sirohi, July 2016]

On the part of the public sector, the major lacuna was the irregularity of payment. There are multiple factors associated with it. While some district officials revealed that there was a delay in the disbursal of the budget from the state government, others accepted that the delay was because of inadequate staff to handle the accounts at the district level. In one of the study districts, it was found that the accounts manager was on deputation to Jaipur and the post was vacant. The issue of inadequate funds due to late receipt of the budget from the state (Box 5.18.2; Quote 1).

While the official at State Programme Management Unit (SPMU) agreed that there were some delays, he attributed it to primarily two factors. On one hand, it was dependent on the receipt of funds from the state treasury and on the other hand, it was subject to the submission of Utilisation Certificate (UC) by the districts. The respondent also alluded to workload as another reason for the delay (Box 5.18.2; Quote 2).

Box 5.18.2: Responses of public sector staff about delayed payment to the private operator

1. "*We try out best to clear the dues of the private operators as soon as possible. However, there are some delays because of huge workload at the district and there was shortage of trained human resources. Many a time we do not have adequate funds because the state doesnot send budget on time*." [Interview with a district official, Dungarpur, April 2016]
2. " *The delay in disbursal of funds to the district was either because the state treasury did not release the required budget or due to late submission of UC by the district. The state level officials are also overworked*." [Interview with a state-level official incharge of Finance and Accounts, Health Department, April 2019]

ii. For Drugs and Laboratory Consumable:

The state did not allocate funds for medicines and laboratory reagents, in the MOU; instead, these items were supposed to be supplied from the district drug warehouse upon indent by the private providers. However, an inadequate supply of drugs and other consumables was raised on repeated occasions. It was difficult to ascertain the reason for this, as both the private partner and the district officials tend to hold the other party responsible for this lapse. On one hand, the public officials at the district refused that there was a delay or shortage in the supply of drugs and consumables which include laboratory supplies. Instead, they mentioned that the private operators did not submit their requisitions on time which could be the reason for the short supply (Box. 5.18.3; Quote 1). On the other hand, the staff from the private partner shared that they always indented at least a fortnight before the stock would get over, but they never received the required quantity (Box 5.18.3; Quote 2).

Box 5.18.3: Responses about drugs and consumables

1. "*We make sure that medicines and other consumables are adequately available with the MMU/MMV teams. But sometimes they submit their requisition so late that we cannot meet the requirements.*" [Interview with district warehouse official, Udaipur, August 2016]
2. "*We maintain a ledger for medicine and after every camp we submit that to the manager. He then collates all the requisition and submits to the district office once in every fiftteen days. Despite, we never receive as per our requirement.*" [Interview with a doctor, Trust Sirohi, July 2016]

During field visits, it was observed by the researcher that in some of the camps, especially those by NGOs, drugs closer to their expiry date were being distributed. When this issue was broached, all categories of respondents refused the possibility.

iii. Maintenance, fuel and other costs

According to the GoI guidelines, a sum of Rs. 35000 per month for fuel and maintenance. In the state RFP, the almost same amount was allocated but it included insurance of the vehicle. The private providers complained about the insufficiency of the amount, as more amount was being spent on maintenance of the vehicles owing to damages due to bad roads. They also alluded to the lack of trust expressed by district functionaries when the bills for the maintenance were raised, especially when the prior approval could not be taken (Box 5.19; Quote 1). The district-level officials voiced that private providers often used this money for unnecessary processes and also tended to claim more than the actual amount spent (Box 5.19; Quote 2).

As per the RFP, there was the budget for communication, postage, IEC material and overhead expenses, these budget heads were not there in the GoI guidelines. The sum allocated, annually, for this was Rs.19000 and Rs 18000 for MMU and MMV respectively. On one hand, the private providers reported that the amount was very less. On the other hand, the state officials opined that these norms were disclosed to the bidders to which they had agreed. On the contrary, state officials thought that, in a PPP, providers are also expected to generate their resources which the partners were not doing. They also accused the private providers of saving this amount for themselves or repaying penalties (Box 5.19, Quote 3).

Box 5.19: Responses about cost for fuel,mainteneous and miscellaneous

1. "*The amount allocated for mainetanance is very less. Moreover everytime we submit those bills, the district officials interrogates us. This is more when we undertake any repairing procedures without their approval of. It is a very frustrating experience."* [Interview with Manager, Foundation, Udaipur, August 2016]
2. "*The private providers have a tendency to spend the budget for maintenance on unnecessary procedures.They charge for changing one or the other part regularly which is difficult to trust."* [Interview with district officials, Dungapur, April 2016]
3. "*The private providers were expected to raise other source of funding which will help in enhance the quality of services delivered under the MMS. None of them are doing that, instead they try to save from the budget given to them for fuel and other miscellaneous activities."* [Interview with state-level official, Health Department, Jaipur, May 2019]

7. Charging Penalty

The latest RFP dated, April 7, 2016, clearly stated the different clauses of penalty that were applicable on the private provider (Annexure 3). Most of the providers reported that they had to pay a penalty regularly, even though sometimes the reasons were beyond their control. There were some cases where the public sector genuinely understood the problems of the private operator and so exempted the penalty (Box 5.19; Quote 1). During the field visit for data collection, some of the common gaps were an absence of all the staff, no proper IEC materials and the absence of a diagnostic vehicle. However, generally, a penalty was not being charged for these conditions. The district officials confirmed that a penalty was levied only when the doctor was not present in the camp and the number of patients treated in one month was less than 2000 (Box 5.19; Quote 2). One of the private providers emphasized that like a penalty is charged from the private sector, the government should also be penalized for the delay in payment (Box 5.19; Quote 3).

Box 5.19: Responses of private and public sector staff about penalty

1. "*Sometimes the vehicles are off-road for more than the stipulated number of days. In that case, we inform the CM&HO through a letter well in advance, so there is no deduction.*" [Interview with NGO representative, Dungarpur, August 2019]
2. *"We deduct penalty only when the two crucial conditions were not met, but for other conditions we just seek clarification."*[Interview with district official, Sirohi]
3. "*While any gap in the services is immediately highlighted and we are penalized, there is also delay in monthly payment by the government that we face constantly. Why is there no penalty charged for that*?" [Interview wi head of the Trust, July 2019]

However, actual data on the penalties charged was not made available to the researcher by the state or district officials. So, it is difficult to estimate the amount that was being charged from the private sector.

- Motivation to form a partnership

The state guideline is silent on the reason to engage the private sector in operationalizing the MMU. While the GoI guidelines mention that PPP is one of the modes to deliver MMS, it does not emphasize its benefits over a state-led model. As per the state official in charge of MMU, there has been some discussion on this issue with the higher officials. Based on their past experiences, it was unanimously refuted the idea of government doctors being sent for camps. The same has been verbally suggested by the national government, during the PIP finalization meetings initially. This decision was also one of the recommendations from RHSDP (Box 5.20; Quote 1).

Some officials cited the discouraging experience of the Mobile Surgical Unit which has been operational in the state for the past 40 years. These units were started to provide super specialty surgical care like neurosurgery or pediatric surgeries to people in backward districts where the district hospitals do not have the required expertise. Mobile Surgical Units were purchased and equipped with very sophisticated machinery but the public health system lacked experts (Box 5.20; Quote 2). The private

sector respondents responded that the government had chosen to engage the private sector for service delivery because they can get services delivered at a lower cost than what they would have to incur if it was done by the government cadre. One of the respondents added that the government preferred the non-profit organizations above the for-profit ones because the budget was too less (Box 5.20; Quote 3).[45]

When public sector officials were probed on their motivations in engaging the private sector for MMS, the views of the public sector officials across levels were very similar. Most of them shared that they were doing it as per the orders of the higher officials. Some of the officials also expressed their lack of motivation in managing the PPPs. Those at the state level felt discouraged because the selection of private partners was mostly based on the lowest bidder, which was not necessarily the best approach. The district-level officials mentioned a lack of motivation to monitor because they had no control over the selection of the private player.[46] Few officials added that when they strictly monitored the services and levied penalties according to the MOU, they were asked to be lenient by the state officials (Box 5.20; Quote 4).

[45] A total of Rs1.42 lakhs for MMU and Rs 1.15 lakhs for MMV was allocated as the upper limit for the financial proposal. however, it was found that the bid varied between 1 lakh to Rs. 1.30 lakh for 1 MMV per month and around Rs. 1.6 lakh for 1 MMU per month.

[46]Few officials indirectly hinted that there was collusion in selection process at the very high level. However there was no evidence for it. However, it did reveal a sense of caution that the public sector officials had in expressing their candid views about either the private sector or the state level public sector.

Box 5.20: Responses of the public sector officials about motivation to form partnership

1. "*The government has decided to form partnerships based on their learning from conducting health camps with the government doctors. The same has been informally suggested during the meeting with the central government officials as well as recommended by the experts in RHSDP project."* [Interview with state official, Health department, Jaipur, May 2019]
2. "*There is a special department in the state that run mobile surgical units using government doctors from different medical college-hospitals. Though it was a great idea with highly sophisticated equipment, it could not be properly implemented due to staff shortage. To address this gap, the state government decided to shift to a PPP mode of service delivery*." [Interview with retired director, Health department, Jaipur, June 2019]
3. *"The sole reason for engaging the private sector is to save money If the government had to deliver the mobile medical services on its own, it would cost much more that what they pay us. They prefer non-profit sector because the approved budget was too less which no for-profit private provider will sectorst cost now."* [Interview with the state head, Foundtaion, Jaipur, August 2016]
4. *"Monitoring is our responsibility so we do it. Since the state has started taking all decisions regarding the selection of private operators, I do not have much interest in monitoring because it does not really matter. In fact if we are a little strict, the state officials intervene. If we cannot take any decisions, why should we bother to monitor?"*[Interview with district official, Udaipur, August 2016]

4.2 Perception about inequity in access and the possible role of the partners in the MMS scheme

This section captures varied opinions of public sector officials and private providers across levels, regarding; factors causing inequities in access and the possible role of private partners in addressing them under the MMS scheme. The responses are presented according to the category of partners.

4.2.1 Private Sector

Representatives of all three organizations were of an opinion that inequity in access was mostly due to factors such as; lack of awareness among the rural people about the government schemes and ignorance about the severity of the health problems. Few respondents mentioned poverty and lack of education as the predominant factor (Box 5.21.1;

Quote 1). Most of the staff members, across other levels like managers and doctors in the MMU/MMV, also subscribed to similar views. While most of the respondents agreed that access in rural areas was worse than the urban areas, only a few of them alluded to the lack of adequate services in remote areas as a factor for that (Box 5.21.1; Quote 2). None of them mentioned other dimensions of equity, like caste or gender, as important determinants for access.

Box 5.21.1: Responses of the private sector regarding their perception of inequity

1. "*People in these areas do not have much information related to the health services of the government. Also, they are often ignorant about what are the causes and symptoms of different ailments*." [Interview with MT, Jodhpur, July 2016]
2. *"There are many reasons why people in rural areas access health services less frequently than their urban counterparts. One of the reasons is that many villages do not have any health facilities in the vicinity. Sometimes, the facilities do not have any doctors and these facilities also do not open regularly."* [Inetrview with a doctor, Foundation, August 2016]

The majority of the staff and leadership believed that engaging private providers in operationalizing MMU/MMV have helped to address the problem of availability of services in underserved areas. Some respondents added that because of the private sector, the range of services had increased and the service quality had improved. One doctor, from MMU managed by NGO, mentioned that in one village that he visited, people had gathered near the camp just to see a doctor for the first time (Box 5.21.2; Quote 1).

However, all the key respondents of the private organizations expressed that the scheme could be envisaged differently in which the private providers were given autonomy to design the services and the sanctioned budget was more flexible. The head of the Foundation especially mentioned that he had planned to include some special services like eye care for the elderly as well as malnutrition prevention and treatment for children in these districts, but this idea was not supported by the health department officials at the state as well as the district officials (Box 5.21.2; Quote 2).

The staffs directly involved in service delivery were of an opinion that MMU/MMV was addressing some of the immediate health concerns of the community. However, there was a consensus that such a form of service delivery was not adequate for an emergency as well as the regular health needs of the people (Box 5.21.2; Quote 1). There was a universal opinion among staff across different providers, that the MMS scheme should be according to the healthcare needs of villages to ensure better utilization. Although many of them agreed that the success of MMS requires an active role of community leaders for improving the MMS, they thought that it was the responsibility of the government (Box 5.21.2; Quote 3). They also agreed that the government's management capacity needs to be improved; especially of district-level officers responsible for financing (Box 5.21.2; Quote 2).

Box. 5.21.2: Response of the private sector about their in addressing the inequities

1. "*With NGOs* (sic.) *delivering these services, doctors are reaching the villages and people can also consult them for free. They are also getting medicines and diagnostic facilities at their doorsteps. I once went to a very remote village where a lot of people had come to the campsite. When I asked the local health worker about the rush, she said that it was because most of the villagers had not seen a 'real' doctor before. However, I do not think that this form of service delivery can address all the health needs of the people. For that, services have to be regular and also according to the specific health problems."* [Interview with a doctor, the NGO, Dungarpur, April 2016]

2. "*The services provided by the MMU can be much better if we had the autonomy to decide the kind of services. There should also be flexibility in the way the budget was allocated. We had planned to include other types of services like oral and eye care, but the government officials at the state and the district do not support us. Also, the capacities of the public sector officials need to be strengthened, especially at the district level for us to deliver services properly."* [Interview with the representative of the Foundation, Jaipur, August 2016]

3. "*If the government could ensure a more active role of the elected representatives, it could ensure better utilization by all sections of the village. As the staff of the private organization, we are not able to do that very well* because we do not have much rapport with the villagers. Even if we wanted, it will take a long time to achieve that." [Interview with MMU Staff, The Trust, Sirohi, July 2016]

4.2.2 Public Sector

Like the private sector respondents, many public sector officials attributed inequity in access to a lack of awareness among people due to poor educational status among people living in remote villages. They identified a range of health-seeking behaviours starting from ignoring health problems to seeking healthcare from the local healers for regular problems. According to few block-level officials, lack of awareness also hampered the uptake of preventive services like immunization and family planning. There was a tendency among some of the block and district functionaries to blame the local healers in the area for spreading wrong messages about the modern systems of medicines (Box 5.22.1; Quote 1).

The grassroots health functionaries, on the other hand, identified that certain sections of the population like women, tribals and those in the lower economic order were less likely to access formal health services unless the problem was acute and debilitating because of the uncompassionate attitude of the public providers and also the associated costs (Box 5.22.1; Quote 2). The lack of trained health service providers was also identified as a reason for inequities in access, by a few officials along with poor health infrastructure in those areas. When probed about the status after the NHM was launched, many respondents reluctantly agreed that the situations had improved while few believed that most of the changes were on paper with hardly any actual difference in the field (Box 5.22.1; Quote 3).

Box. 5.22.1: Response of the public sector regarding their perception of inequity

1. *"In my opinion, the biggest barrier in access to health services was the lack of awareness of the community about their health needs as well as about the needs for preventive services like immunization. The local healers who are not trained in any form of medicine also take advantage of their poor educational status and discourage the villagers from accessing formal health facilities."* [Interview with block-level official, Sirohi, July 2016]
2. *"Women, tribals and the very poor are least likely to go to any health facility when they are sick unless they are very unwell and cannot continue with their daily chores because of the illness. Besides money, the most important reason is that they do not like the attitude of the provider, both public and private, towards them. They often feel disrespected."* [Interview with ANM, Udaipur, August 2016]
3. *"New public facilities have been built in many areas after NHM was launched. But in most cases, these facilities are functional on paper because there is no human resource deployed. So, in terms of people's ability to access health services, there has been no significant improvement."* [Interview with retired director, Health Department, May 2019]

Respondents at the state level believed that improving access to health services needs more engagement of the community and the local leadership. They also emphasized the role of other sectors besides health in addressing the barriers to access. With respect to the strategy of operationalizing MMS through private sector partners, the opinions of the public sector officials varied. Some opposed the idea of MMS completely. According to them, the scheme was only providing services in a piecemeal manner so that it would not be able to meet the healthcare needs of people regularly (Box 5.22.2; Quote 1). For such services, they proposed fully functional health facilities in the underserved areas. Those who approved the idea of MMS but did not agree with the current model state that instead of contracting private institutions, doctors and staff should be hired on a contractual basis, by the government to ensure that services were accessible. They also suggested that the staff should be under the control of the block medical officer to ensure better implementation of the scheme (Box 5.22.2; Quote 2).

Finally, the public sector respondents, who agreed with the scheme, as well as the engagement of the private sector organization in its operationalization, alluded that the proper selection and management of

private partners could solve the problem of equitable access, albeit to some extent. They recommended that to ensure better service delivery from the private partners, the state officials should accord some power to the district officials during selection (Box 5.22.2; Quote 3).

Box. 5.22.2: Response of the public sector about their in addressing the inequities

1. "*The notion that primary health care can be delivered through health camps is not a good option. These camps can only be supportive service, but there has to be a proper health facility at the village level which is available all the year round so that people's regular health needs can be met.*" [Intervie ith retired director, Health Department, Jaipur, May 2019]
2. "*Engaging private sector organization has many limitations. Instead of that, the government should hire staff on a contractual basis. The staff and the vehicle should be handed over to the blocks for operationalization. Then we will have control over the implementation. At present, it is not at all in our control."* [Inteview with block official, Dungarpur, June 2016]
3. *"The private sector organizations have many advantages that can be harnessed to ensure that mobile health camps are more accessible. This should be followed by a strict mechanism to manage the functioning of the other sector. While the district officials are partly engaged in the management, they do not have any role in the selection. The state government should engage the district officials in both the steps to ensure better implementation of the project."* [Interview with a district official, Udaipur, January 2016],

Section 5: Discussion

The explicit purpose of the MMS scheme is to reduce inequities in access to healthcare by ensuring that primary-level health services reach those residing in the under-served areas. Therefore, two aspects of the scheme merit discussion. First, how the PPP strategy has approached the barriers in such areas. Besides, as the camp approach is adopted in the scheme, how partners have been able to overcome the problems associated with that approach. The second question is, what are the reasons inherent in the roles of the public and private sector that affect, either directly or indirectly, the successful functioning of the model. This section analytically summarises the empirical data from the study districts of

Rajasthan and the review of the contract document by reflecting on the abovementioned issues. To substantiate evidence of other states are also incorporated.

Barriers affecting access to health services in the under-served areas continue to persist in the PPP model

The two most important supply-side factors common to almost all under-served areas are the unavailability of human resources and poor condition or lack of health facilities. Both these are addressed in the design of the MMS scheme but there are many crevices in the implementation. For instance, in the design, it is clearly stated that the private player should form a medical team comprising of a doctor, laboratory technician, and pharmacist/ Nurse. There was also a need for an X-ray technician/ radiographer in some vehicles with the ultrasonography machine. In praxis, some private partners employed final year MBBS students, who were not registered to practice. This could be partly attributed to the availability of doctors, but it was also true that most private partners paid lesser salaries, as compared to what was mentioned in the guidelines, to the doctors This led to a high turnover of doctors. Besides, none of the camps had female doctors, the desired criterion as per the design. The problem of staff attrition, as well as the absence of female doctors and X-ray technicians, were also highlighted in other states (GoI, 2009; GoI, 2013; Kumar *et al.*, 2009; and Nandi *et al.*, 2017).

Poor road condition is one of the indirect causes for worse health outcomes in under-served areas. While this did not come directly under the purview of the health department's responsibility, they decided to operationalize the MMS scheme to rectify the situation. Initially, there were instances that the private sector employees did not conduct camps in remote villages. This was sorted after the government of Rajasthan installed GPS machines in all the vehicles. However, there were some instances when the camps were being held near the main road, outside

the village premise. This was partly because the approach road to the village was not in motorable condition, especially for a big vehicle. In such circumstances, only those who resided closer to the main road could avail of the services. Such locations did not have a proper sitting arrangement for users and lacked privacy. Thus the uptake of services by the elderly and women were hindered to a large extent.

For addressing the barriers in the underserved areas, one of the essential steps would be to set the criteria for the identification of those areas, followed by the deployment of vehicles according to that criteria. In Rajasthan, the decision regarding deployment of MMUs to under-served areas was taken by the political leadership at the state level and was often not based on data on health conditions or any other verifiable indicators. This aspect has also been recognized in the revised guidelines of the GoI (GoI, 2014).

Primary level healthcare cannot be delivered by health camps

Organizing health camps in the village is the approach adopted to deliver health services in the MMS schemes. The literature on health camps highlights that while the intervention got traction from many national and international organizations, it has its share of limitations, especially in rural areas. Citrin's (2010) ethnographic account of health camps in remote areas of Nepal identified some key problems with the way that the health camps were designed and implemented. Medicalization of health, limited engagement with the community, lack of follow-up, insufficient referral mechanism leading to fragmentation of health services, and ignoring the social determinants of diseases were identified as the key problems with this approach to deliver health services.

Health camps conducted under the scheme exhibited most of these flaws in varying degrees across all the study districts as well as in other states where the scheme was being implemented. Besides, there were

other operational challenges like the shortage of medical supplies for diagnostic tests and medicines in some of the locations. The services provided in these camps were only limited to common outpatient services and some basic antenatal care. None of the health camps delivered services under other national health programmes.

As per the design of the MMS scheme, the camp was supposed to be held on a particular day every month. While camps were being held according to the schedule, the dates for each village changed every month. Sometimes the list of villages to be covered was different from the previous month. This was found in those blocks where the number of villages was more than the number of days the MMU/MMVs were operational per month i.e 22 days. Moreover, the information on the revised schedule was not shared in advance with the community. The other problem with the schedule was that it was held in the morning hours when most people were busy with household chores or agriculture activities. All these factors adversely affected the uptake of services.

Also, these health camps did not take into account the epidemiological and felt needs of the area. There was no profiling of the people who availed of the services and those who did not. None of the health teams shared any information with the respective block officials or the nearby PHC about the kind of ailments treated. They only informed the district officials about the total number of cases that came to the camp.

Three inter-related factors lead to these gaps. First, the design of the health camps proposed in the MMU guidelines is highly focused on diagnosis and treatment. This fetish is explicit in the MOU between the public and private sector organizations. For instance, there is a clause that if the private provider (operator as per the MOU) does not provide some form of treatment to at least 100 patients per camp, a penalty will be charged. There is no such mandate to conduct awareness generation

activities in the community. The budget for conducting such activities was insufficient which indicates that the government also did not consider it important. The private sector partners therefore just followed the government contract and did not take any initiatives on their part to rectify the situation to some extent. Although the doctors and staff in the medical teams were able to identify issues related to the prevalence of diseases they were often discouraged from taking any initiatives; instead they were instructed to meet the minimum requirements.

While it is not possible to hold a single partner accountable for these problems, it is cannot be denied that the lowest bidder criterion applied in selecting the private partners might have excluded those organizations which had a better approach for operationalizing the scheme and hence had quoted a slightly higher amount.

Role of private and public sector partners in the scheme affected the outcome of the MMS.

While most of the above-mentioned problems were detected in all the study districts, there were some differences in the approach adopted by the different private players for managing the medical teams. The problem of staff attrition can be used to clarify this point. Unlike some other studies which also attributed attrition to low salary, in the study areas delayed payment was a common reason. For the NGO and the Trust, it varied between three to four months, but in the case of the Foundation delay in payment was maximum up to a month. This was because the latter used their own funds to pay the staff until they received the payment from the government whereas the former two could not afford to do so due to their financial constraints.

A range of underlying reasons was reported for this delay. On one hand, the private sector held the district officials responsible, while on the

other hand, the latter considered it as a fraudulent intention of the former. Besides, irregular disbursal of the budget from state to district was another explanation. In response, the state government either blamed the district officials for not meeting the financial requirements or attributed it to the delay in receiving funds from the state treasury. From these multiple strands of explanation, it is evident that the complicated financing mechanism is a definite roadblock for operationalizing the MMS scheme effectively.

The private sector, as the direct provider of services, also should be held accountable. There are two key aspects of their role that needs to be examined – capacity and motivation. The private sector organizations engaged in the project had the experience of managing small-scale projects with limited in-house expertise in managing a multi-district project. They also did not invest in training and supporting the new project staff under the scheme with any managerial and technical inputs. Besides, their implicit motivation was to sustain their organization and leverage more funding. This was true for all three partners. In other words, though the profile of these organizations differed the approaches were not significantly different. Despite these lacunae, they were selected under the scheme because the government's criterion was solely based on the lowest bidder.

Most of the problem in the role of the public sector was not directly because of the lack of capacity of the individual officials involved in the execution, it was related to the norms governing the overall system which restricted those working in it to perform to their best potential. There is also a tendency of the consultants to not exercise their knowledge and sensibilities because they knew that these will not be well received by the officials in the department.

Yet another factor that bears repetition is the inter-relationship between the public sector officials and the private sector organization as

well as among the different cadres of public sector officials. To begin with, there was a deliberate attempt of restricting the role of the district level officials, by those in the state level, during selection and of the block and PHC level officials, by their district higher up, in the monitoring. As a result, the plans of the health teams were not synchronized with the existing public health system in that area. This, in turn, strained relationships between the two sectors, especially at the block level as well as in certain districts. But, there were also districts where the situation was the opposite. A relationship of mutual trust was certainly beneficial for the project outcomes but the possibility of corruption was also high.

Besides the operational issues, these private partners and their respective staff seemed to have very little information about factors that contribute to inequities in access. Moreover, they believe that addressing this problem will require the active engagement of the community. It seemed that addressing inequities was not their primary agenda. To summarize, the data from the study of the MMS in the three districts revealed that by adopting the PPP strategy, the government has been able to shift the service delivery function to the private providers. However, there is no mechanism to ensure that the services were being delivered appropriately and that it was reaching all sections of the populations in the underserved areas.

Chapter VI: Discussion and Conclusion

"Scholarship that is indifferent to human suffering is immoral." [Richard Levins]

While working as a public health practitioner for over ten years in Rajasthan's health sector, directly with local NGOs, international donors, government, and indirectly with the private sector, the researcher had observed the lacunae of the government in delivering health services, especially in the rural areas. She had also been part of different pilot projects, designed and implemented by NGOs, for addressing the health needs of populations in backward regions. Many of those demonstrated encouraging results in improving access to health services. Based on these experiences she partly believed that an institutional arrangement between the public and private sector could ostensibly alter the service delivery characteristics of the public health system and in turn facilitate access to healthcare. However, the question that lingered was, *whether these arrangements could address all barriers to access faced by the vulnerable rural populations?* Hence, when she transitioned from a practitioner to a researcher, she chose to study the Public-Private Partnership model of the health service delivery system.

The decision to locate the thesis in the state of Rajasthan was partly because of the researcher's affinity with the government and NGOs in the state, but it was also pertinent for examining inequity. Rajasthan is one of the high focus states due to poor health indicators as compared to the national average. Within Rajasthan, the rural areas were more deprived, and within those, the need for health services was greater in the tribal belts. These multiple axes of inequalities are well-known factors for inequities in the provisioning as well as the utilization of health services.

The present study was designed to examine how the architecture of PPP projects under NHM addressed the supply-side barriers to access to

primary level care in the rural and tribal areas of Rajasthan. The overall objective was divided into two specific objectives. The first specific objective was to trace the development of both public and private sectors in Rajasthan, in the social development sector in general and health in particular. This was done to present the macro picture vis-à-vis the health system in the state. For this available published data on the public health system was reviewed, while for the private for-profit sector key informant interviews were conducted with representatives of the Indian Medical Association in Rajasthan and other senior public health officials who had worked on PPP projects in different capacities. Similar interviews were conducted with representatives of private non-profit organizations working in the field of public health.

The second specific objective was to examine two PPPs, at the primary level of care, under the National Health Mission. A three-stage process of selecting the cases was adopted. With the overall aim of inequity, in the first stage, 28 primary level care partnerships under the National Health Mission (as of 2015-16) were identified which were classified into two categories – service delivery and service purchase. This was followed by the mapping of these different partnerships in Rajasthan to identify the ones with a plurality of private partners. For the third step, those PPPs implemented in rural areas with a significant tribal population were selected. The districts were purposively selected based on earlier work experience as well as ease of gathering data. Three cases that matched the criterion were mobile medical services, institutional childbirth, and sterilization. The first case was for general health and the type of PPP model was service delivery, while the second and third cases were for reproductive health representing service purchase PPPs (See Table 6.1)

For analyzing the cases, a deductive approach was adopted by synthesizing three widely accepted conceptual frameworks. The first

framework was for assessing partnership using the Resource Dependency Institutional Cooperation model to examine the architecture of PPPs in terms of capacity and motivation of the public and private sector actors. With this, a new dimension of the perception of actors about the role of PPPs in addressing inequities in access was also added. The second framework is the Control Knobs framework used to assess the performance of the PPPs on three aspects - organization, financing, and regulation. One of the outcome indicators of this framework was access. To further define access, three of its dimensions – approachability, availability, and affordability were identified. The study focussed on the supply-side barriers to access.

Table 6.1: Details of the cases selected for the second objective

Typology of PPPs: Scope of service	Description of actors specific to each control knob		
	Organization	Financing	Regulation
Service Delivery: Mobile Medical Services	Corporate Foundation Trust Registered Society	State-level public sector	Primarily state and district level public sector, with a limited role of block-level public sector
Service Purchase: Institutional Childbirth	NGO Small Nursing homes	User	District and block-level public sector
Service Purchase: Sterilization	INGO Small Nursing homes Multi-specialty hospital	Part-payment by Public sector at district and block	District level public sector

Supply-side factors affecting inequities in access to health services in rural Rajasthan

Rajasthan, famous for its royal heritage and grandiose, is also one of the low-income states and the seventh most populous state in India. Although the state has made progress in reducing poverty the health

indicators continue to be lower than the national average (World Bank, 2016). It is one of the high focus states under the National Health Mission. There are also marked rural and urban differences in the health outcomes in Rajasthan. The districts with significant rural and tribal populations are the most vulnerable. To understand the supply-side factors associated with the inequities in health outcomes it is important to examine the three control knobs of the health system in the state.

The health system in Rajasthan is dominated by the public sector, but the private for-profit and non-profit organizations are also present. The organization of these three sectors has played a major role in exacerbating inequities. The state has a vast public health system, especially at the primary level (Sub Health Centres and Primary Health Centres) in rural areas. There is one SC and one PHC for three and 21 villages respectively in Rajasthan, while the national average is that of four villages per sub-center and 25 villages per PHC. However, the picture changes significantly when the numbers are disaggregated by districts. As per the recent data, 52% of the total rural PHCs cater to 26 districts, which had more than 50% rural population while the remaining seven districts were covered by 48 % of the rural PHCs. Among the rural districts, those that have more tribal populations do not have the mandated number of SC, PHC, and CHC as per the IPHS norms.

Another problem is that public health facilities in the rural areas are non-functional, at best partially functional, due to the lack of facilities like water, electricity, and other necessary equipment. The distribution of human resources is also uneven in rural and urban areas. As reported by the Central Bureau of Health Intelligence, in Rajasthan there is a single government doctor for more than 7000 population (GoI, 2019). Data reveals that doctor to patient ratio in the public sector was found to be lower for tribal and desert regions. The problem of absenteeism of doctors and other medical staff in tribal areas and lack of motivation among staff

to serve the vulnerable population contributed to poor access to health services.

The formal private sector in Rajasthan was insignificant until the 1990s with only 17% of the hospitals (Nandraj, 2001). However, according to the NSSO 67th round (2010-11), private providers contribute to 67. 29% of all health facilities in Rajasthan; out of these 78.67% are allopathic enterprises. This included both for-profit and non-profit enterprises consisting of solo practitioners, small nursing homes and hospitals, although numbers of non-profit enterprises were very less. There was a plurality of private sector institutions according to the qualification of doctors and other medical staff, number of beds, facilities available, and cost of care. Among those, ones owned by registered medical practitioners were mostly located where the public health facilities were robust. The evolution of the private sector in Rajasthan resembles the national picture (Kumar and Singh, 2016).

A similar observation has been made in a detailed study of private providers in Tonk, Bikaner, and Udaipur districts[47] (RHSDP, n.d.). The study highlighted many important issues concerning private sector health facilities; two of these are pertinent to this study. First, most of the private healthcare providers were sole proprietorship institutions working on a 'for-profit' basis. Second, there was a steep increase in the number of institutions after 2000. In these three districts, only 18 out of 105 did not have any profit motive.

As far as the private non-profit sector in Rajasthan is concerned, there are two generations of such organizations. The first generation of organizations, which emerged in the period of 1960s and 70s, had

[47] These three districts represented the plain, desert and tribal areas respectively. These are broadly the three geographical regions in the state. Although the data is dated, it merits attention. Similar exercises have not been undertaken in the recent past, hence no updated information was available.

contributed immensely towards development. The second generation emerged in the 1980s and 1990s, participated in projects funded by international organizations as well as those under government schemes launched during the 1990s. These organizations were only driven by the mandate of the donors and focused on preserving their highly professionalized structure; which adversely affected their relationships with the community.

Although according to the latest data Rajasthan is one of the top four states based on the number of PNP organizations working on health. Most of them are small in size with very limited financial and human resources. These organizations focused on preventive care (75 %) while an insignificant amount is for curative service (2.3%). Thus the capacity of these organizations is limited as far as the delivery of health services is concerned.

The next control knob of the health system is financing. For equitable access to health services, the government has to ensure that an adequate budget is allocated for the public health system so that the out-of-pocket expenditure (OOP) is less. In India, the funding has been inadequate since its independence. As per the current data, the government contribution to the Total Health Expenditure (THE), at the national level, is only 38% which amounts to 1.2% of the Gross Domestic Product. Most of the remaining amount is a household contribution (63.2%), which includes money directly paid during seeking healthcare and contribution to private health insurance. Compared to India, Rajasthan's government's health expenditure is 33% of THE (1.1% of Gross State Domestic Product) while the OOP is 56.7% (GoI, 2019).

Another problem concerning financing is the state and central share of funding. While the state government contributes more to the health sector, a significant proportion of the funds for the public health services,

especially at the primary level care are from the central government under the National Health Mission (NHM) as well as other centrally funded programmes. In the first phase of the NHM, the centre and state share were 90:10, which is currently 60:40. Despite the increase in the state's share, the state government decisions regarding NHM schemes are influenced by the guidelines of the central government. This was explicit from the interviews with the state government senior officials. Some retired officials alluded that this resource dependency is one of the key roadblocks in developing the capacities of the state government officials to manage the health sector.

Besides, service delivery and financing, the third control knob is regulation. This is predominantly the responsibility of the state government as health is a state subject. The state governments are supposed to regulate not only the public but the private sector providers. Although Rajasthan is one of the few states that have drafted the rules for the Clinical Establishment Act, there has not been much progress in its implementation that was corroborated by both the private and public sector respondents in this study. It was explicit from the responses of the private sector representatives, that they had opposed the implementation of this act because it challenged their authority.

Public-Private Partnership in health services in Rajasthan

The state government adopted the Public-Private Partnership (PPP) strategy to improve the situation of the public health system. These institutional arrangements were first introduced as a part of the different national health programmes in the 1990s. Later, in 2004, the state government also took similar initiatives under the Rajasthan Health System Development Project (RHSDP) World Bank funded which was intended to strengthen secondary level healthcare as well as for drugs and diagnostics at tertiary level. During this period, a PPP policy was prepared

in which one of the objectives is to enhance equity. Under that policy, the government has facilitated the private sector to set up health facilities. Many of these measures have increased the number of private providers of healthcare, but it did not translate into access to equitable health care by all sections of the people. As reported by most of the senior public health officials, the private sector was not interested in investing in those areas where the public health infrastructure was weak.

In 2015, the state government contracted out primary health centres to private non-profit organizations as well as private medical colleges. Although there is no systematic data available on its functioning, the scheme has been criticized because most of the PHCs that have been contracted out were near the urban areas (Pachauli and Gupta, 2015). Thus it doubts that such schemes will reduce the barriers to the availability of health services in rural areas. The scheme is also challenged because it allowed the private provider to introduce diagnostic services that are not included under the IPHS norms, and charge user fees for the same. This can be a threat to the affordability dimension of access. There were also newspaper articles highlighting the woes that the rural population continues to face in some PHC running in the PPP model in Rajasthan, which indicates that the approachability aspect of access has not been addressed adequately.

With this overall picture of the health system in Rajasthan, it is important to understand the specific roles that the public and private sectors play in the PPP projects. For that, the findings of the empirical study provide a first-hand account of the architecture of PPP in the state for providing primary level care in these areas. These PPP were started with the launch of the National Rural Health Mission. According to the Framework of Implementation, one of its goals was to “improve access of rural people to equitable, affordable, accountable, and effective primary health care” (GoI, 2005).

Case studies of Public-Private Partnership under National Health Mission in Rajasthan

The two cases selected for the detailed study belonged to two categories. One was for the public health goal of reproductive health while the other is for providing primary level care to the underserved population through mobile medical units/ vans. A qualitative comparative analysis methodology was used to examine the architecture and the roles of different partners in these PPPs. This information was collected through interviews of public sector officials at the state, district, block, and PHC levels. The functioning of PPPs was also observed which was helpful to triangulate the information gathered and also in framing the tools for the study. The data was collected in two periods – August 2015 to August 2016 and from March to September 2019 to update the information.

- *Architecture of Public-Private Partnership in Reproductive Health Services*

For the case of reproductive healthcare, two types of services were included, sterilization and institutional childbirth. Both these services are required for achieving the desired public health goals of population stabilization and reducing maternal mortality. Engagement of the private sector in the delivery of services for population control has been there since the initiation of the Family Planning Programme in the 1950s and later when the Reproductive and Child Health Programme was launched in the 1990s.

The utilization pattern of private facilities for these two services was very different. For the sterilization services majority (78%) of the population across India while in Rajasthan more than 90% population (including rural and urban areas) uses public health services (Mohanty et al, 2020). In institutional delivery, 69% of rural use public health services as opposed to 15% who use the private sector. Although there has been

an increase in the use of the private sector since 2004, the increase in the use of the public sector is much more. The number of institutional deliveries conducted by non-profit organizations was only 0.2% according to NFHS 4 (IIPS, 2017).

Despite that, the Government of Rajasthan adopted the PPP model to deliver these services. For sterilization services, the state reimbursed Rs.3500 per beneficiary to the private hospitals while in institutional childbirth, a sum of 500INR was payable to the provider by the user, but the users were entitled to get the incentives as per Janani Suraksha Yojana guidelines. The decision to engage the private sector in the delivery of sterilization and institutional childbirth services was taken under the directives issued by the Ministry of Health.

According to the state-level officials, the state was bound to implement such schemes because these were funded by the central government. As per the information shared by the state-level officials, there were 1320 private institutions across the state that were engaged in providing sterilization services, while only 216 for institutional childbirth. While the private sectors who had the capacity for sterilization could also provide institutional childbirth services, they were not keen to partner for the latter because there was no financial incentive from the government.

Besides their numbers, there were few concerns regarding the existing private sector partners. First, most of these providers were at the district headquarters and in those areas where the public sector institutions were strong. Second, out of these almost 70% were not very active. Third, there was no means to verify the number of users who availed of their services because the reporting by the private providers was irregular. Some other factors also emerged from the empirical study.

The private providers for reproductive health services include four kinds of organizations – state non-government organizations (SNGO),

national non-government organizations (NNGO), nursing homes(NH) and multi-specialty hospitals (MH). The human resources and infrastructure varied across these categories. Out of these, the MH had a maximum capacity of beds (100), followed by the NH (ranges between 10-20 beds). The SNGO engaged in the delivery of institutional childbirth services had 3 beds while the NNGO for sterilization initially had six beds and also managed a mobile van for delivering the service; later the in-patient facility was discontinued. Except for the SNGO and the NNGO, all other facilities were at the district and block headquarters.

All these organizations, except the NGO delivering institutional childbirth services, were owned and managed by allopathic doctors. The NGO was also headed by a doctor but the facility was managed by GNM. However, the number of doctors as well as other staff members varied which affected the caseload of these institutions. The NH and MH category were static facilities with hardly any outreach activities but were reported to be functional round the clock. The NGOs, on the other hand, conducted regular outreach, but the INGO involved in sterilization services held only day camps in different blocks.

Although the private providers are most responsible for the service delivery characteristics, the public sector's role in identifying the private partner with basic human resource and infrastructure requirements also warrants attention. However, as trained private providers were not available in remote areas the district officials of the health department were compelled to enlist those providers in the block and district headquarters. There was also a close association between the doctors in the private sector and the decision-making officials at the district level, which facilitated the selection process.

For examining the affordability dimension of access, different payment modalities merit attention. In the case of the institutional

childbirth services, the cost of care was to be borne by the users, while the public sector was responsible to pay the cash incentive to them as per the JSY guidelines. The cash incentive was the same as the public sector to ensure that the people were not seeking private healthcare. It was found that the out-of-pocket (OOP) expenditure for those who used private providers under the scheme was more. The private providers were partly responsible for this because almost all of them levied charges that were more than what was allowed under the contract. The other aspect of affordability was indirect cost due to travel to district or block headquarters. This was one of the known reasons for OOP in the public sector, which continued even after the private sector was engaged. Besides, there was a delay in paying the cash incentive to users who utilized private facilities.

In the case of sterilization, the services were free of cost for BPL families. The public sector was responsible for paying the private partner on a per case basis as well as incentives to the users. *Prima facie* these services were affordable for the poor, but the amount fixed by the central government under the scheme, for the private providers, was reported to be less and there was no scope for negotiations. Besides, the payment to the private provider was often delayed because of myriad reasons. These aspects of financing adversely affected the provision of services across all private providers. The only exception was the NNGO because it received the majority of funds from its parent body that was an international organization, working for population stabilization.

The travel cost incurred by the users to access the private providers was similar to that of institutional childbirth services. While the public sector did not provide any additional cost for this, one NH reported paying the travel costs to those who conducted sterilization in that facility. The other private institutions in this category shared that it was part of the government's agenda to provide sterilization care, so the money should

come from there. This was not a problem for the NNGO who provided outreach services in CHCs and PHCs; hence the travel cost was reduced.

There was no evident role of the public sector at the state and district level in enhancing approachability to services to the tribal and rural communities. The public sector officials did not take any measures to inform the community about the scheme as well as about the private providers. They also did not seek feedback from the users about the services they received and the cost they incurred. It was the role of the private partner to ensure better approachability because they were responsible for service delivery. Except for the SNGO, NNGO, and one NH in Udaipur, the remaining private sector institutions did not advertise their engagement in the scheme. This was, in reality, hinged on the motivation of the private provider in joining the partnership.

There was evidence of approachability being hindered, in the case of institutional childbirth services, when public and private sector staff at the grassroots had conflicting interests. On the other hand, in the case of sterilization services, public sector staff cooperated with private providers because it helped them in meeting their targets. One NH also paid these public health cadres additional incentives for referring cases to them. The district and block level officials were aware of this nexus, but they did not interfere as they thought that it was beneficial for achieving the overall goals.

- *Architecture of Public-Private Partnership for Mobile Medical Services*

Unlike the first case, PPP for mobile medical services was a new model of delivery. While there have been mobile dispensaries and health services delivered in a camp mode, in the past, those were mostly delivered by the public sector machinery. There is evidence from Rajasthan that these services were irregular. Hence PPP mode adopted to deliver mobile services under NRHM was adopted.

Rajasthan adopted a model of MMS in which the entire financing of the scheme was being done by the state, which includes both capital and operational expenditures, while the private sector was responsible for human resources as well as delivering the services. The selection of the private partner was through competitive bidding. Although technical and financial proposals were submitted in the process, the contract was awarded to the lowest bidder. The entire selection process was conducted at the state level, while the district level was responsible for the implementation of the scheme. The district official delegated the planning and monitoring of the private providers to the block. Thus all three levels of the public sector were engaged in the scheme in a different capacity.

In Rajasthan, there were two types of vehicles that are being used under the scheme - Mobile Medical Unit (MMU) and Mobile Medical Van (MMV). The Mobile Medical Unit (MMU) consisted of two types of vehicles, one vehicle for the movement of the health staff and the second vehicle was equipped with diagnostic facilities. Mobile Medical Van had a single vehicle, which carried staff and equipment with basic diagnostic facilities. The technical human resource in both these categories comprised an allopathic doctor, preferably a women, a laboratory technician, and Auxiliary Nurse-Midwives or Nurse Grade –II. The MMU also required an X-ray technician.

There were 208 vehicles in Rajasthan under the scheme; most of them are MMVs (150). According to the scheme's objectives, these were meant for the under-served areas but the distribution of the vehicles in the state did not follow that criterion strictly. In 17 out of 33 districts more than 70% of the blocks were allotted either an MMU or an MMV. As shared by a state-level officer, the political leadership decided about the deployment of the vehicles.

Different types of private providers were contracted for the scheme; most of them were non-profit. In this study, three types of private operators were included – a corporate foundation, a charitable trust, and a registered society. Other partners were private limited companies and private hospitals. In five districts, the respective Medicare Relief Society was running the scheme, which was not a private partner, but an autonomous government agency. While the three types of private providers selected in the study broadly belong to the category of PNP they differed in their status and also functioning.

The primary objective of MMS was that health services were available in the under-served areas. To do so, the public sector had laid down some essential requirements, which were also linked to the penalty clauses. First, a team of medical and paramedical staff had to be employed by the private sector. While all the private partners, included in the study, were able to do that, none of them had lady doctors, which was desired. There was also a dearth of X-ray technicians in most of the remote blocks. To ensure the availability of doctors the private partners all private organizations employed MBBS final year students from the medical colleges in the district or adjoining districts as well as private allopathic doctors. The availability of doctors was a constant concern because there was a very high turnover of doctors due to low remuneration.

Second, health camps were to be held once a month in selected villages according to a plan prepared by the block and district officials. As per the design, in each camp, 100 patients were supposed to be given services. All these conditions were fulfilled by the private sector, but there were some lacunae on their part as well. It was observed that when they did not get a required number of patients they conducted only routine height and weight checkups of school children in the village to avoid paying the penalty.

The third aspect of availability was related to vehicles, equipment, drugs, and laboratory supplies. The purchase of the vehicles and equipment was the responsibility of the public sector, while their maintenance was by the private sector except that of the X-ray machines. All the private partners reported that they followed monthly maintenance of the vehicle and the equipment. The drugs and laboratory reagents were supplied by the public sector, which was reported to be irregular as well as inadequate which adversely affected the range of services available in these camps. However, it was difficult to ascertain the reason for it, as both parties tend to blame the other. The reason cited by the public sector was a delay in receiving the indent from private providers while the private partner said that despite regular follow-ups, the drugs and laboratory supplies were not made available on time. They also reported the supply of drugs by the public sector, which was nearing the expiry date.

Some of these problems were more in the case of the Trust and the NGO, which had not employed adequate managerial staff to ensure that the medicine and other necessary supplies reached the field teams regularly. The teams managed by the Foundation did not report such problems. One of the reasons was that a managerial cadre was there at the district level. The salary of this cadre was borne by the Foundation. Such a cadre was not mandated in the contract; hence trust and NGO did not employ any such personnel.

By design, the MMS was free for all that most of the private providers maintained, as reported by both the public and private sector respondents. There were, however, no inbuilt mechanisms to ensure that user fees were not being illicitly charged. Some public sector staff at the field level shared that the doctor in the camp was reported to refer patients to their clinics in the block towns during the camp. When the same question was asked to the doctors in the teams and the representative of the private organizations, they denied that any such instances in their organizations,

although did not completely rule out the possibility in case of other private partners engaged in the scheme. According to the representatives of the private organization, they trusted teams on this issue, but no measures had been adopted to vindicate their claim.

All the private partners agreed that users had to incur out-of-pocket expenses for the diagnostic tests and medicine, which were not available in the camps. The doctors in MMU teams reported that they were instances when they were compelled to dispense drugs only for a week due to inadequate supply. They also reported that for many communicable as well as non-communicable diseases they recommended patients to visit nearby community health centers. Thus, despite the scheme people in these underserved areas continued to pay for the primary level care, which was supposed to be free.

The original mandate of MMS was to improve the approachability of health services. For that, the public sector at the block level prepared a list of underserved villages and the private sector organized camps in those villages. To ensure that the camps were held in the correct villages a GPS device was installed in all vehicles. The District Programme Manager was the designated officer to monitor the GPS data. However, this was not being done very regularly. It was reported in all three study districts that the DPM was busy with other components of NRHM, as a result, could not devote time to monitoring.

Even when the camps were organized as per the route plan, it was observed the camps were held at the Anganwadi Centre or any government buildings. Most of those were located in and around the houses of upper caste people of the village and generally far from the hamlets where tribal and scheduled caste people resided. Although prior information of the camp location, date, and time would improve the use of services by those communities, it was seldom given. In practice, this task was performed by

the ASHA, that too on the day of the camp. All these factors resulted in limited utilization of the MMS by the vulnerable population of these remote villages. As a service provider, this was the responsibility of the private agency, but it was not mandatory. None of the organizations involved in the scheme was adopting the required measures and the government officials were also not very vigilant about this aspect while supervising the campsites.

- *Perception about the role of PPPs in addressing inequities in access*

Irrespective of the services delivered and the ownership of the private partners in the PPP model, there were broadly three broad categories of perceptions about factors of inequity. The first was about the awareness and education of the users about the services. The private sector representatives identified users' lack of education and awareness about the need for services like sterilization and institutional childbirth as the main reason for the lower uptake of these services among certain social groups.

According to the organizations engaged in operating the MMU/MMV, people preferred to seek health services only when it was utmost necessary, not for minor ailments. The field teams, as well as the managerial staff, thought that because these camps provided only curative services for minor ailments, people were not interested in availing of those services. The public sector representatives identified some social groups which included the Scheduled Tribes (STs) and the Other Backward Castes (OBCs) in these villages who were the least motivated to seek the services mainly because these people were uneducated which affected their understanding of the need for these services.

The second factor for inequities in access was the distance between the villages and the facility. Most respondents from the NH and MH category whose facilities were located in the district headquarters

mentioned that communities residing in remote villages were less likely to avail their services. Those private sector representatives who were delivering services at the village level or nearby did not raise this as a concern. However, in their view, most people were seeking healthcare from their facilities, only a few were deprived. The private providers engaged in Mobile Medical Services (MMS) scheme also mentioned that distance impeded people availing the services, although these camps were held in the village premise. According to them, those villagers who resided in the hamlets were hardly availing of the services. The public sector respondents agreed that the location of facilities did contribute to access.

Trust was the third factor, which was mentioned for inequity in access. This was mostly stated by the staff in the medical camps as well as the managers of the MMS. According to them, villagers did not trust the providers because the services were only available once a month. The SNGO and NNGO also shared their initial challenges to convince the villagers to use their services. They identified that the problem of trust was more in lower social and economic sections of the communities. Distrust was not mentioned as a factor by the NH, MH as well as the public sector representatives.

In addition to all these population-related factors affecting inequities in access, private providers engaged in these PPPs also identified gaps in the availability of public health services as one of the key supply-side factors in access. The SNGO and NNGO also mentioned that there was differential treatment by grassroots public health cadres towards those in the lower socio-economic category, which discouraged these groups to seek healthcare. While the public health officials were reluctant to accept this as a problem, some agreed that the availability of staff adversely affected the coverage. They also mentioned that gaps in service delivery were also due to delayed fund transfers to the Sub-centres (SC) and PHC.

The issue of the cost incurred by the community was not included by most private-sector respondents, except the NNGO and the SNGO representatives who were working very closely with the community. According to them, people in the tribal areas were not only poor; they often did not have cash in their hands. There was also a strong belief that visiting any health facility had cost implications, which adversely affected their health-seeking behaviours. For the rest of the private providers, including the NH, MH and the private partners in the MMS financial constraint was identified as a factor only when a leading question was posed. They mentioned that some economically backward sections in the districts were not in a position to pay the fares to reach the hospitals and hence did not utilize this scheme.

On this issue, one NH representative under the PPP scheme for sterilization mentioned that when he started to reimburse the travel cost of the users, the uptake of services in his facility had increased. The respondents of the MH thought that people were willing to spend for a major illness or for the health services that they feel the need for, but not on sterilization. While the cost factor was not applicable for the MMS, the medical team of the private sector in the camp also expressed similar concerns.

The other dimension in this objective was about the perceptions of different actors about PPP strategy to address inequities in access. On this issue, most of the private providers mentioned that the government should play the main role in mitigating all the factors associated with poor uptake of services. According to them, their role was only limited to providing health services. While few private sector representatives, especially the NNGO and the SNGO agreed that they could support the government in their endeavour, while others said that it was not their primary objective. In this context, the public sector officials believed that the health sector alone cannot be responsible for mitigating the causes of inequity. Many of

the officials at the district and block level expressed the need for corrective actions in education, nutrition and employment creation, which were necessary for the overall development of the people. They did not agree with the views of the private sector representatives about their role in health service delivery. The public sector health officials expected that the private sector also played its part in reducing the cost of care so that health services become more affordable.

Responding to the question about the potential of the public health system in addressing the supply-side determinants of inequity of access, three broad themes emerged across the private and public sectors. First was resource capacity, availability of services for the rural communities was second, and third was the management of the services in the remote areas. Next, it was important to capture the potential of the PPP arrangement in reducing the inequities in access. At this juncture, it is important to mention that during framing this question, special attention was given to delink the particular private actor's role and probe for the overall role of the PPP strategy.

According to most of the institutions in the NH categories, lack of adequate human resources was one of the reasons for their inability to reach their services to the hinterlands. This was dependent on their financial status. On the other hand, while the MH had more human resources and the institutional setup, they did not consider that they had an important role in addressing inequities in access. The head of the MH shared voiced that due to the existing patient load they did not have the scope to conduct any additional activities in the remote locations.

The NNGO and SNGO delivering reproductive health services also had a similar view about the role of PPPs. Both these kinds of organizations reported that though they were striving to address the issue of inequity by providing health services at a cheaper rate yet better quality, they were

reaching only to those communities who lived closer to the point of service. They also had the limitation of infrastructure, staff as well as funds. Few respondents from the private sector added that the government's capacity to engage and regulate the private sector was also limited, so they were not able to address the barriers to access effectively.

Analysis

While India had registered improvements in the health indices like life expectancy, maternal mortality, infant mortality since independence, it is still below the other South Asian countries, including Bangladesh and Sri Lanka (Arora and Gumber, 2004). Despite rapid economic growth in the post-globalization era, India failed to meet the Millennium Development Goals related to health. To achieve the Sustainable Development Goal of *good health and well-being* by 2030, two of the targets are to achieve universal health coverage.[48]

While reducing inequities requires dealing with multiple factors associated with unequal outcomes, it is important to identify as well as rectify the changes in the Indian health system, espoused by the neo-liberal reforms; especially those that exacerbated inequities in access to health care. One of these is the commercialization of the health sector (Mackintosh, 2003)[49]. As the welfare ideologies were replaced by market-oriented principles, the nature of all organizations in the health sector also underwent certain irreversible changes. This was bound to influence the way the health system actors performed their respective functions.

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[48] Target 3.7: Ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.
Target 3.8Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.

[49] According to Mackintosh (2003), there is restructuring of internal hierarchies due to commercialization of health care which determines who receive treatment and who is excluded.

After the period of health sector reforms was officially completed, the Government of India as well as various state governments adopted different strategies to redress the demand-side barriers to access among poorer sections by introducing publicly funded insurance programmes for secondary and tertiary health services. For the primary level care, the National Health Mission was launched, in 2005, which envisaged addressing both supply and demand-side barriers. Initially, it focused on only rural areas, but since 2013 a sub-mission focusing on urban poor is also being implemented.

Although the Mission claimed to invoke architectural corrections towards strengthening the public health system, it endorsed some of the strategies that were introduced during the 1990s; with PPP being one of those. Besides, the mission continued with the vertical health programmes based model to deliver primary level care that existed since independence. Three problems with these types of programmes merit mention.

First, a vertical programme is antithetical to the comprehensive primary health care approach (CPHC) advocated in the Alma Ata Declaration to address health inequities. Later, the Health System Knowledge Network, under the aegis of the Commission on Social Determinants, also supported the need for CPHC to address inequities in access. Second, it reduced primary level care to a set of medico-centric services, which was devoid of a sound epidemiological rationale. Third, these programmes were mostly designed and funded by the central government and implemented at the state level; but there was hardly any scope or flexibility to alter the design according to local needs. These three points are sufficient to challenge the scope of the Mission to improve inequities in access, but in this thesis, the focus is on the strategy of PPP.

The primary question that the thesis aimed to answer is how the PPP strategy addressed inequities in access. The justification for

examining the PPP strategy through this lens is rooted in the claim of different policy and program documents, of the national and state governments, that this strategy will help to fill the gaps in the public health system as well as strengthen it. The High-Level Expert Group (HLEG) on Universal Health Coverage under the erstwhile Planning Commission also endorsed this strategy.

At this juncture, it is important to clarify that the purpose of this study was not to evaluate these different PPPs; instead, the goal was to describe the role of the private and public sector actors in translating the idea of equity into action. From the case studies of the two models of PPP in Rajasthan, mentioned in the previous section, it is evident that while the partnership model was able to reduce some barriers, none of them have been able to address all the dimensions of access in their respective catchment area. It was also explicit, that the experience of this strategy varied across the different types of private providers. Hence, the question that now arises is *why have the PPPs not being successful in addressing the inequities in access*.

As PPPs are nested in the health system, they can be examined using the Control Knob Framework.[50] In this study, three control knobs – organization, financing, and regulation were examined, which are aligned to three functions of the health system – service delivery, financing, and stewardship respectively. As the objective of this study is inequities in access, so primary level care in rural areas is the focus[51]. Further, the study is conducted in Rajasthan, one of the Indian states with poor health

[50] The Control Knobs Framework to assess health systems was proposed by Roberts, Hsiao, Berman and Reich (2003) in their book Getting Health Reforms Right: A guide to improving performance and equity. In this book the authors have identified five control knobs – financing, payment, organization, regulation and behaviour. In this thesis, the first two have been merged as financing. The behaviour component, although important, is not within the remit of the study. The Framework is also appropriate because it links to intermediate performance measures; one of which is access.

[51] According to the CSDH Report, in order to ensure equitable access to health care, health system should be designed around primary level which combines prevention, health promotion, treatment and rehabilitation. poorer in those areas as compared to the urban. See Gilson et al, 2007.

indicators compared to the national average and significant rural population. The analytical model incorporating the context and content has been used to arrive at a plausible explanation.[52]

The genesis of the idea of PPP can be traced back to the period starting from the 1980s. Various reforms in the social sector, led by the World Bank and other international financial organizations, took place in this period that were rooted in neo-liberal ideology; health was one of the sectors. All changes in the policies and the institutional structures were premised on the assumption that the public sector bureaucracies are inefficient and unresponsive and those market mechanisms will promote efficiency and ensure cost-effective, good quality services (Cassels, 1995).

To do so the private sector was engaged to deliver services, while the public sector's role was reduced to that of financer and enabler. This institutional arrangement was broadly referred to as PPP. While the model adopted was almost similar across the globe, the unfolding of health sector reforms is dependent on the health system of the country (*Ibid*).

For the delivery of health services in India, there were both public and private sector institutions since independence. The reform process started in India in the 1990s, but by then the public system had been rendered dysfunctional and the private sector had emerged as an important provider of health services. This had happened because of the plurality of reasons which are mentioned in detail in chapter two. There is a range of private health service providers in India. They have been broadly classified into formal and informal. Usually, the formal sector is divided into for-profit and non-profit. As there is no objective basis for this categorization, it can be at best viewed as a continuum based on the user fees charged. It is also important to recognize that these categories of

[52] The analytical model, proposed by Walt and Gilson (1994) helps to understand the process of health policy reforms and to plan effective implementation. It can be used both retrospectively and prospectively.

public and private and within private, the for-profit and non-profit, are not watertight.

While this is the situation of the overall health system, primary level care in India, especially in the rural areas as well as low-income settlements of the urban areas, is being provided by the public sector, but these are limited to specific diseases and reproductive and child health. To meet their healthcare needs community also uses services provided by informal providers who are easily available. Some non-profit organizations were also engaged in demand generation activities, but seldom in the actual delivery of services.

The delivery of health services is heavily dependent on the source of financing. There are three sources of financing for health services in India. The majority of expenditure in health is out of pocket (OOP), followed by the public sector and a very small portion by donations from national and international organizations. In India, the OOP is very high, which is an outcome of poor public health systems and the unregulated private as well as public sector providers.

One of the key aspects of the reforms was a reduction in public funding for the health sector. However, there was an increase in donations from international organizations that preferred to work with non-state actors, mostly the non-profit ones. The idea that these institutions, with better connections with the community, will help in improving the health status was based on the demonstrations of a few renowned ones, but these were not replicable. The state also actively engaged in promoting the private sector directly by purchasing services from them or indirectly through subsidies. This phenomenon is termed as 'informal commercialization of primary care' (Mackintosh, 2003).

Thus structural changes, garbed in the form of reform, not only compromised the public health system but also created an enabling

environment for the private sector institutions to prosper. There were also changes in the characteristics of these different actors. While most of the discussion on this matter is about the public sector institutions working like private firms, many civil society organizations also acquired a bureaucratic style of functioning.

There are a few theories that explain this transformation in the working style of organizations like the resource-dependency theory and institutional theory (Eikenberry and Kluver, 2004). One of these is DiMaggio and Powell's theory of institutional isomorphism. According to them, there is a tendency to homogenize organizations. They coined the term institutional isomorphism to explain this trend. According to the authors, the characteristics of organizations are "modified in the direction of increasing compatibility with environmental characteristics." They also identify three mechanisms for institutional isomorphic changes – coercive, mimetic, and normative (DiMaggio and Powell, 1983). Although there is evidence of all these mechanisms in the development of the health system of India, the changes in the nature of the organizations observed during the health sector reforms are mostly in the coercive category. According to DiMaggio and Powell, when one organization exerts formal or informal pressures on the other organization, some changes occur in the latter, this results in coercive isomorphism. The mechanism can also explain the functioning of the PPPs. This will be discussed in the later sections.

Another change espoused in the reform era was the emergence of the rights-based approach (RBA) to development. Although this is out of the purview of this study, it merits a mention that this approach has been criticized for being an instrument to uphold the neoliberal value of individual choice and efforts instead of addressing the structural issues which lead to deprivation. This approach also lends legitimacy to the interest of the powerful actors (Tewari, 2012). In the health sector, the notion of RBA was appropriated into demand generation for services. The

project funded by international organizations and implemented by most of the non-profit organizations was fashioned on this approach.

Like inadequate service delivery and insufficient financing, a lack of proper regulation has been a persistent problem in the Indian context. The government has failed to keep a check on both the public sector employees as well as on the private providers. Although the government intended to regulate the private sector by introducing legislation during the reform period the focus of the government was more on promotion rather than regulation. The cut in government spending also adversely affected the performance of the cadre of government staff mandated for regulation. Moreover, those from the private sector often headed the parastatal bodies constituted to regulate. The judiciary also failed to intervene in cases of violation of patient's rights (Sheikh, Saligram and Hort, 2015).

All these changes in service delivery, financing, and regulation were visible in the health system of Rajasthan as well but the magnitude was different. The public sector was the dominant provider of healthcare in the state and continues to be so, despite the existing lacunae. The presence of the private sector was limited to bigger cities and towns of the state and the rural population was largely dependent on the non-formal private providers. The state had some non-profit organizations, even before the reforms had started. This was mainly managed by philanthropy by the Marwari communities in these regions. There were also a few organizations, established by top echelons of the society, who were working for the emancipation of the marginalized communities.

There was a spurt in private healthcare providers as well as non-profit organizations in Rajasthan after the 1990s. Like in other parts of the country, these newly established healthcare facilities were mostly own account enterprises, with minimal resources and restricted to the more developed regions of the state. Most of the new non-profit organizations,

which spawned, were driven more by the donor's agenda rather than the felt need of the community. Hence, unlike their predecessors, they implemented a project, which was largely driven by the donors' interest. Most of them working in the health sector adopted the RBA and were engaged in demand generation for public health services.

The period of 2000 onwards has seen new trends in the Indian health sector. Realizing the adverse effect of health sector reforms on health outcomes and access, the national government decided to address the issue of equity. For that, the National Rural Health Mission adopted strategies to address both the supply and demand-side barriers to access, primarily in the hinterland. There was also a commitment to increase government funding for the health sector. Despite the mission, the OOP continues to be high and the government contributes about 1% of the GDP. The problem with poor service delivery in rural areas continues because of a shortage of trained personnel. There has been also an influx of public-funded insurance schemes, but those are only for secondary and tertiary inpatient care.

The PPP strategy has become an integral part of the public health system. Proponents of the Mission, as well as the subsequent committees, claimed that this institutional arrangement will be able to – (i) improve the effectiveness of the health services, (ii) support the state in delivering healthcare to attain public health goals, and (iii) fill the gaps in healthcare emerging due to shortage of resources with public systems (GoI, 2004). This strategy was also considered a suitable solution for regulating the private sector. Different schemes and programs have been launched to institutionalize PPPs for the delivery of health services at the primary, secondary and tertiary levels. Recognizing the scope of market failure at this level, the government decided to take the responsibility of financing. Hence the already reduced government funds were being utilized for purchasing services from both for-profit and non-profit private sectors.

Although a detailed discussion about the mode of PPPs in the Indian health sector is in the next section, it is important to highlight at this stage that the type of PPPs in the Mission did not change despite the changes that took place in the nature of the public and private sectors.

The private sector in India had also changed over time. The smaller nursing homes owned and managed by single doctors, especially those located in backward states and districts were facing problems of availability of doctors and other staff. One of the possible reasons is the rise of corporate hospitals, which employed medical and paramedical personnel. There were also complaints about the quality of services, cost, and accessibility (Bhate-Deosthali, Khatre, and Wagle, 2011). Some non-profit or trust hospitals also revamped themselves into multi-specialty hospitals with high user charges (Nundy, 2009). In the case of the non-profit sector, there has been a reduction in the availability of funds and increased competition because several restrictions were imposed by the government for receiving foreign funds (Sundar, 2020). To deal with the resource constraints, they have adopted market-oriented approaches and morphed into social enterprises (Eikenberry and Kluver, 2004).

The government has emerged as the key funder for the non-profit organizations alongside the corporate foundations; both these have influenced the role of these organizations. In the case of government funding, these organizations do not enjoy much flexibility and control in the implementation of the project. While the scope for garnering funds from the corporate sector has increased due to the law on corporate social responsibility, most of the corporates preferred to establish their foundations or contribute to the government's initiatives rather than to

donate to the non-profit organization (Sundar, 2020). Besides these philanthropic foundations have also evolved.[53]

The study found that the situation in Rajasthan had some similarities with the national picture. Reflecting on the key informant interviews it is evident that the for-profit sector in the state is largely unregulated, so much so that the health department officials at the state level did not have any updated information on the number of hospitals across the districts. The cost of care and quality of services in these facilities were seldom checked by the district officials. The state government attempted to promote the private sector in remote and under-served areas, under the Rajasthan Health Sector Development Project, but it failed because the private providers were non-responsive. Many for-profit organizations have taken up service delivery under government projects because that is the only source that is available to them. As a result, they have become a handmaiden of the government and have jettisoned their actual purpose of being an advocate for people's needs.

From the above-mentioned discussion, two interlinked points bear repetition. First, the changes in the public and private sector organizations towards a market-oriented ideology, which started in the 1990s, have amplified post-2000. Hence the partnership comprising both these sectors is also bound to behave similarly. Second, these changes negate the notion of equitable health services, even though the policies continue to claim that. Dovetailing both these two points, it can be inferred that the current PPP models do not have the required potential to address the factors associated with inequities in access.

[53] The non-profit sector has also been influenced by the new trend of philanthropy which applies principles of venture capitalism to social change. These new age philanthropists desire a way of donating which is consistent with their result oriented values. They seek return on investments in the form of social, financial and emotional returns. See Eikenberry and Kluver (2004).

The problems with the current health sector in India became heightened and explicit during the COVID-19 pandemic. On one hand, the public sector was ill-prepared to deal with the crises. There were inadequate public health facilities and human resources at all levels of care, but the gap in the primary level care was the main cause of distress because of which mass screening and contact tracing, the two important steps in the prevention of the disease became impossible to achieve (Baru, 2020). There was scope for involvement of non-profit organizations for some primary level measures but there was no adequate funding, neither by the government nor from the corporates (Sundar, 2020).

Although the disease had no cure, patients infected by the Coronavirus required medical intervention which was only available at the tertiary care hospitals. To match the emergency, the government had to requisition the private sector facilities, but it was not very successful. According to a report by the National Health Authority, titled *PMJAY under lockdown: Evidence on Utilization Trends*, there has been a steep decline in the average weekly claim in the 10 week lockdown period (March 25 to June 2) compared to the 12 weeks (January 1 to March 24) that preceded the lockdown. While a part of the reduction can be attributed to the thrust on COVID care in public health facilities, there is also evidence that claims submitted by private hospitals had reduced by 51 percent (Owen, Naib, Sehgal, and Chhabra, 2020). Besides numerous media accounts of the private sector discontinuing their services during this period revealed that the implementing authorities of PMJAY did not succeed in mandating private providers to deliver healthcare in this period of crisis.

According to media reports, the Rajasthan government had appealed to the non-profit organizations for participating in the management of the pandemic as well as engaged them to ensure that those people who have returned to the state gets employment under the provisions of the Mahatma Gandhi National Rural Employment Guarantee Act and in the

social audit of relief measures (PTI, 2020; Saini, 2020). Similar orders were issued by the health department to engage the private sector hospitals to participate in the treatment of the patients (Annexure 4). However, in effect only 44 private hospitals participated; but the majority of these were in three districts – Jaipur (10), Sikar (8), and Sri Ganganagar (5). Out of the remaining 30 districts, most of them had only one private hospital that was identified as a dedicated COVID Hospital and Health Centre (Annexure 5). Almost 65% of the private hospitals in the state had shut down outpatient services during the lockdown despite repeated orders from the government. A few of the hospitals that resumed functioning were charging exorbitantly (Singh, 2020).

While the context is necessary to understand the nature of the public and private sectors, it is not sufficient to explain the performance of PPPs. The content of the PPPs is the other important aspect that needs to be analyzed. There were three broad stages in the process of operationalizing PPP projects – decision to contract and the formulation of contract, selection of suitable partners, and implementation of the scheme. As was evident from the case studies, for the first two stages, the capacity of the public sector was more important than the private sector. However, in the last stage, the private sector became more prominent.

In most of the PPP projects, as well as those studied, the decision to contract was mostly taken by the central government, which was imposed upon the state government through the financing route. In other words, for the projects that were funded by the central government, even partially like NRHM, the state government had to follow the instructions. Most of these were in the form of guidelines, but sometimes we're also given verbally during the different meetings. Thus, although the PPP strategy was projected as an alternative to the over-centralized bureaucracy, the hierarchy of power between the center, and the state continues. This can pose challenges for the effectiveness of partnerships (Hunter et al, 2011).

For instance, the PPP model for institutional childbirth services. The government of Rajasthan, initially resisted the engagement of the private sector, however, because of the constant demands raised from the central government, the state initiated the process. The role of the central government was also similar in mobile medical services.

The other important decisions were about the selection of potential partners and location for implementing the PPP projects. In the two case studies, the authority rests with two different cadres of officials. For the reproductive health services, the district officials are responsible, while for the mobile medical services the state officials are only engaged. In both these cases, the local level officials, at the block or the PHC, are seldom consulted.

While it is difficult to ascertain the factors that determine which public sector cadre had the power to select the private partner and also an area of implementation, it was indicated that the cost of the project was a key aspect. Among the two cases of PPPs, the allocated budget for operationalizing the mobile medical service scheme (between 1.2 to 1.6 lakhs rupees per month) was much more than that incurred for reproductive health services (between 3000 to 4000 rupees per case for sterilization). Hence, the state government exercised maximum control in executing the first type of project. The state government, more specifically the political leadership, also took the decisions regarding the deployment of the vehicles.

This factor is especially important for equity, because, when decisions are being taken by higher-level officials, who are not aware of the people's need at the grassroots, the allocation of resources is not equitable. This was seen as a problem when the public sector was responsible for service delivery.

At this stage, the opinions of the private partners were not taken into account. Hence, in a PPP the public sector was the principal while the private sector is the agent. Many authors have questioned that the contracting model is not a partnership in the true sense. The power hierarchy between the actors is more when the public sector owns resources like in the case of mobile medical services. However, the power hierarchy shifts in favor of the private sector when they have the ownership of the resources like in the schemes for reproductive health services. However, this gets expressed only in the implementation stage.

The justification to engage private partners was that they delivered better services because of competition. However, studies on contracting from India, as well as in other countries reveal that true competition was not possible while forming the PPPs due to several factors. One of them was the lack of proper benchmarking of criteria in selecting the potential partners. In such a situation, the government awarded the contract to the lowest bidder. The same procedure was being followed in selecting the private partners for mobile medical services in Rajasthan.

Although it was reported that many private partners intentionally proposed a minimum budget, so that they could be selected, the onus was on the officials who were in charge of the selection to identify the most appropriate partner. While the public sector cadres understood the difficulties in delivering services at such a low cost, they seldom challenged the decisions due to the fear of audit objections.[54]

There are two ways that such a process impeded equitable delivery of services. First, the selected partners had to manage at a very low cost and hence they paid lower salaries to the medical teams, which

[54] The researcher wanted to analyze the technical proposals submitted during the bidding to differentiate between the selected partner and the other, it was not available for public scrutiny. The issue of lack of transparency in selection also raises doubt about the selection process.

demotivated the staff. They also employed less qualified medical professionals, especially doctors. It was also mentioned that these organizations did not take the necessary measures for spreading awareness. The other outcome was that organizations with experience in implementing similar projects either got sieved out because they quoted higher or did not take part in the bidding at all.

The discussion of the implementation stage should begin with the private sector organization's capacity because they are the service delivery organization. The capacity of the organization depends largely on the organization's culture. Most of the private organizations, across the two cases, were hierarchical structures with most of the decisions being taken by a single person or a few people who were the proprietor of the organizations. Therefore, the capacity of the organizations was dependent on the person(s) leading these organizations.

In the case of reproductive health services, out of the seven private partners, four belonged to the category of small nursing homes that were managed by a single doctor or a family of doctors. These doctors had some linkages with the public sector. For instance, three of these doctors had worked in the state health department in well-reputed positions. It was evident that most of these private partners were chosen because of their prior connections rather than based on their actual capacities, which was often insufficient. The owners of these facilities saw the PPP project, primarily, as an opportunity to increase the client load and also to get permission for conducting abortions. As these private providers mostly depended on the user fees, therefore joining the partnership was beneficial to them.

The other observation was that capacities were not sufficient to influence the performance of these actors. The best example of this was the multi-specialty hospital. Although the provider had all the required

institutional capacity, they were not proactive in delivering services under the project. This was because they did not think that the remuneration in the scheme was sufficient. As a result, the staff in the hospital also did not pay much attention to sterilization.

There were only two exceptions –state-level non-government organizations and national non-government organizations, who were delivering reproductive health services. Both these organizations had a decentralized organizational structure. The teams involved in delivering the services were well trained in counseling patients as well as technical aspects. These organizations were less dependent on government resources but their funding sources varied. While the national NGO was funded by an international organization mandated to promote family planning, the state NGO emphasized more on general health services and leveraged funds from national donors. The staff as well as the leaders of these organizations were self-motivated, but they joined the partnership because working with the government gave them legitimacy.

In the case of mobile medical services, all three organizations had a vertical structure, with most of the decisions being taken by the head of the organizations. The staff working in the medical teams had very little flexibility. This was because most of them were hired on a contractual basis hence were constantly apprehensive about the fear of losing their jobs. Besides, they had very little knowledge about the community and had received no training from the private organization or the public sector.[55] Also, all these organizations were largely dependent on government resources, hence they did not invest in any capacity-building activities of the staff because that was not budgeted in the proposal.

[55] In course of the data collection, the researcher was able to attend a meeting of the private partners with the district health department. Although this was meant to orient the team members about the different health programmes, the discussion in the meeting was centered around the modalities of service delivery.

Based on these two axes – capacity and motivation, the private partners could be arranged into three categories – (i) market-oriented, (ii) pro-poor, and (iii) in transition. This classification is not rigid; instead, it is best expressed as a continuum with the first two categories at either end. This indicates that an organization can change from one form to another. This form of classification of the private sector, based on structural, functional as well as ideological characteristics, instead of merely the binary of for-profit and non-profit, provides a nuanced explanation for the experiences of PPP projects.

In this classification, the first category had adequate resources to provide health services like the multi-specialty hospital. They were located in the urban areas but cater to the needs of the rural population provided the patient reached their facility. Their ultimate aim was to ensure a profit and also other benefits from the government, for that they entered into partnerships with the government. The organizations in the second category were small entities with limited resources that operate in areas having low economic status, both urban and rural. Their primary goal was to enhance the health conditions of the poor and for that, they partner with only those organizations that share the same goals. The staff in these organizations included people from diverse backgrounds and experiences. The decisions were taken in a participatory manner in consultation with the views of all cadres of work and keeping the overall goal in mind. The two non-profit organizations delivering reproductive health services belonged to this category. The third category fell in between the first two categories. Most of these organizations started as being pro-poor but over time they have adopted the market –model to sustain themselves. Hence they decided to engage in different kinds of activities, which supported attaining financial sustainability and improving legitimacy. Some small nursing homes, located in district and block town delivering reproductive

health services as well the private partners in the mobile medical service scheme can be clubbed in this category.

At the implementation stage, the regulation was an important function of the public sector, but in practice, it was conducted in an unstructured manner due to a variety of reasons. First, there was no clear parameter to regulate private partners. The only indicator was the number of patients who received services.[56]

Second, there was no clarity about the process of regulation as well as the cadre responsible for it. According to the state government officials, this was the responsibility of district-level officials because the payment was disbursed from the district while those in the district agreed that they have some role, but they also expressed that the state-level officials should be more active in the monitoring process. This *blame game* deterred the actual regulation. The private sector organizations also suggested that the monitoring was missing, as a result, the problems faced by them were never acknowledged. This was the status of regulation for mobile medical services.

The challenges in regulating the private sector in the case of reproductive health services were different. First, many of the key positions in the district health team were vacant and one person was responsible for many programmes. Hence they could not invest time in this. Second, the government officials were not too keen on actively monitoring because strict control may intimidate the few private sectors that were delivering services.

[56]According to the Memorandum of understanding, there are five parameters for the online reporting. These are human resources, inventory of drugs, medicines etc, logbook of vehicles, number of patients and camp plans. The researcher had included all these parameters and also included questions on the amount of penalty charged. However, when the researcher had approached the government, data on only the number of patients was made available. It indicated that the remaining data was not being collected on a regular basis.

As far as the capacity and motivation of the public sector cadres were concerned it is important to foreground two aspects. First, all public health cadres were not equally appraised about the PPP projects. Information about these projects was mostly with the state and district officials. This affected the motivation of the block and village level cadres towards the private partners as well as the partnership. Second, it also weakened the capacity of the public sector officials to frame contracts that met the real needs.

The reason for the lack of capacity in the public sector stemmed from the non-involvement of the block and locale cadre. This was due to the lack of trust between the different cadres of the public sector. In the case of mobile medical services, the state had full control over the selection process. Thus the private partner selected was often supported by the state-level officials. The district-level officials were asked to check some key indicators like the regularity of camps, the presence of doctors in those camps, and also the number of patients. In many situations, action taken at the district level was revoked by the state-level authorities. There was no handholding support from the state to the district in managing the partners.

In the case of reproductive health services, while the selection of the private sector was being done by the district, the guidelines were provided by the state. The state also put pressure on the district level to empanel more private partners, but they did not provide any additional support to ensure that the selection was as per the prescribed norms. Moreover, the state officials ignored some of the problems that the district officials raised in empaneling suitable partners; non-availability of such private facilities or the lack of willingness for the existing private sector were the most common ones.

The above discussion on the context and the architecture does provide sufficient insights about the reasons for its inability to address inequities in access to healthcare appropriately. To understand how these projects address inequities in access, the study analyzed the approaches adopted by the different public and private sector actors to ensure that services were reaching the under-served population. The next step was to understand why such approaches were adopted.

The perception of actors about factors leading to inequities in access was identified as the first reason. For this, the above-mentioned classification of the private sector can be applied. According to the organizations in the pro-market and transition categories, believed that the inequity of access was because the community lacked knowledge. They thought that it was the role of the government to address that gap. For them, the PPP model could only increase the availability of services to some extent. Only those organizations in the pro-poor category acknowledged the lack of service delivery institutions as one of the important determinants of inequities in access. While they claimed that they were able to deliver services to address some of the gaps, it was difficult for them to compensate for the role of the public sector.

The perception of the different cadres of public sector officials about factors affecting inequities in access and the role of PPP varied. Most of the state and district level officials blamed the community for not utilizing services while those working at the block and the village level also mentioned that as health services were not always available, people could not use them. They attributed it to the lack of human resources. Those officials who were directly involved in the selection of the private facilities felt that as a reputed and competent private sector was engaged it could improve access, but they were not sure that it would be equitable. In contrast, those who were not directly engaged felt that the selection of private facilities was erroneous and hence they exacerbated inequity

rather than reduce it. They suggested that the PPP strategy did not have the potential to fill the gaps in the public sector at the village level.

Research outcome

A study can be considered successful if it can generate new knowledge and also provoke more questions. As a practitioner cum researcher, I believe that research should also provide some recommendations to address the problem that the study engaged with. In this study, the core issue was inequities in access and the challenges faced in reducing them. Inequity is an outcome of several structural factors that are deeply entrenched and hence difficult to overcome. However, some factors are mutable; access to health services is one of them. Access is a multi-dimensional concept, which is affected by several determinants. These are broadly grouped into the supply and demand sides.

The literature on equity has emphasized the need to focus on both these determinants of primary-level care to reduce inequities in access. Historically, this level has been neglected by the public sector, especially in rural areas. The other two sectors, private for-profit and non-profit have extended their services, but they have not been very successful in addressing either the supply side or demand side determinants to access.

Most of these issues have been well researched and several suggestions have already been made by experts. These could be classified into broad categories – ideological and pragmatic. The recommendations by academic experts are in the first category. They challenge the pro-market attitude of the public health planners that have repeatedly shown to exacerbate inequity, not only in India but also in other countries. Therefore, strengthening the public health system is the only way out. This requires that the government increases finances for the health sector and undo all the changes that were adopted during the health sector reforms

era. One of these recommendations also calls for a stricter regulatory framework for all actors in the health sector.

While there is merit in these suggestions, there are some hurdles that cannot be negated. First, the current economic situation of India is in a pitiable state which means that there will be pruning off of government spending. Under such circumstances, it is less likely that more funds will be allocated for the health sector. Second, the government has failed to control the private sector. This has been evident in the management of the COVID-19 pandemic. Thus there is a need for a more pragmatic approach to address inequity.

The pragmatic approach has been largely promoted by practitioners in the field. They advocate in the favour of PPP because they believe that private sector resources can be utilized to support the public health system. However, the process by which this strategy is being executed needs overhauling. It can be done in many ways, depending on the state of the health system in a region and the requirements of the people. For this, projects need to be designed and implemented with the participation of all the cadres of the public system and the private counterpart. The selection of private agencies should be based on their organizational structure and the approach to deliver services. This may ensure that like-minded people and institutions are engaged. These projects need to be critically examined during the implementation as well as after completion to understand the changes in utilization across different axes of inequities.

This study, based on the case study of PPPs that are currently implemented and the overall situation of the health sector in Rajasthan, concludes that using the PPP strategy for addressing the inequities in access to health services has many problems. Most of these are related to the architecture of PPPs which comprise the capacities of the public and private sector organization. Besides, the motivations of the private sector

organizations also vary. Based on their capacity and motivation they decide on the approach to deliver health services; which are not appropriate or adequate to reduce the supply-side barriers.

In the public sector, the policymakers at the national and state level are keen to forge partnerships to increase coverage of health services without investing adequate resources but they are ignorant about the hurdles faced by their district and sub-districts counterparts in implementing the PPP strategy. The absence of scope for context-specific alterations demotivates the public sector officials in implementing it. Besides, the public and private sector actors, engaged in the partnership, do not bestow hopes regarding the role of this strategy in reducing inequities in access.

Under current circumstances, the PPP strategy may not play a significant role in improving service delivery. However, this does not mean that the private sector cannot contribute to the government's efforts in this direction. There is a need for both these sectors to consult each other in designing strategies that take into consideration the actual healthcare needs of the rural areas. This is possible only if both the actors have a shared goal as expected in a true partnership.

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Annexures

Annexure 1a: Interview Schedule for State Health Officials

This will include official in the state health department who are directly responsible for RNTCP, JSY and MMU. Interviews will also be conducted with Addl Director (Rural Health) and Director of Public Health for RNTCP and with Director RCH for MMU and JSY. Since it has been almost over a decade when the PPP model of service delivery was first launched, it is possible that the officials who were incharge in the initial period might have retired. An attempt will be made to interview the key officials who were responsible for initiating this process for the three selected programmes to cover the process of selection.

Hello I am Susrita Roy. I am a student of JNU, New Delhi pursuing my PhD on the topic of role of PPP in health service delivery. I am interested to know your views on the different PPP models which are currently functional in your programme. You are an important stakeholder involved with these PPPs therefore I would appreciate if you could spare your valuable time to respond to some of my questions pertaining role of PPP in health services. This work is conducted purely for academic purposes and your responses will be treated as confidential. However you may choose to skip any question or stop your participation at any time.

Designation:

Programme:

Period of Association with the PPPs in the programme (no. of years):

Please share the reason why this approach of service delivery was chosen?

Reminder: Was it decided based on some study at the state level/ was it as per the programme guidelines from the centre/ was it pursued by the donor partners?

When was the first PPP under this programme initiated? (Who was the Director PH/Director RCH that time)

Theme 1: Characteristic of the Public Partner- State

How much resources are dedicated for management of PPP (Reminder: Manpower, funds)

How much funds are allocated for each PPP in a year? (Reminder: What is the proportion to the total budget)

What approaches are adopted by the Govt. to ensure that the PPPs address inequities in access

Reminder: ensure that adequate and appropriate manpower is put in place, ensure that services are as per the guidelines, ensure that they conduct outreach activities, ensure that the staff is responsive to the needs of the community, ensure that the private do not charge extra money from the community)

Are these approaches of managing a private provider different from the approaches for managing the primary level public sector?

Theme 2: Role of Public Partner- State

Please describe your role after the MOU with private provider is done

Reminder- Role of the state and district teams

According to you how equipped is the public sector to play this role.

What are the problems that you face to perform this role

What is required to do the job better? (reminder: guidelines, capacity, authority)

According to you what does the Govt. expect from the private sector

According to you what does the private sector partners expect from the govt.

- In your opinion what is required to address inequities in access arises
- In your opinion how does the private sector provider different from public sector in addressing inequities in access?
- Strengths
- Weakness
- Opportunity
- Threats
- In your opinion is their mutual trust between the public and private sector
- In your opinion, how does coming into a partnership with the government change the private sector.

Theme 3: Power of Public Partner- State

Process of Partnership

Please describe the steps that were followed in selection of these PPP?

Reminder: EOI, Pre-bid meet, bidding process, criterion for selection of the provider- only financial or both technical and financial

Which official were involved?

Reminder: CM&HO from districts

- Which were the other organizations who entered the bidding process?
- In your opinion was the selection process fair and organization selected suitable for the job
- Please share your views about what process should be followed in order to ensure that the ideal private sectors get selected.
- Finally how many private players were selected (reminder- one per district/ more than 1per district/1for more than 1 district)
- Terms of partnership

How many current private partners in programme (Reminder: District-wise list)

- According to their MOU what is the key deliverable towards the people and towards the public sector (Reminder: Copy of a MOU)
- According to the MOU what should be the resources that the private sector needs to put in (reminder- manpower, funds, equipments
- According to the MOU what should be the resources that the public sector puts in

In your opinion are the current private player able to address inequities in access- please site the experience of the best private provider:

With respect to reaching services to the poor, women, tribals, far to reach areas and other vulnerable communities.

- With respect to infrastructure
- With respect to manpower employed- both quantity and quality
- With respect to cost of care
- With respect to their relationship with the users

According to you who is the more powerful partner in a PPP and why

As per MOU there is a clause for termination of contract, in reality is this possible?

Reminder: Please share any case when you have terminated a private partners

Please describe the channel of communication between community and public sector for services delivered by private player

Please share your views on should this approach to service delivery be continued the way it is or there is need for modification. (Reminder: what kind modification is necessary?)

Annexure 1b: Interview Schedule for District Health Officials

This will include questions for the CM&HO, Reproductive and Child Health Officer, the Deputy CM&HO Health and District Programme Manager (DPM) of NRHM at the District and who have some involvement in the management of PPPs in the district. This tool may be also used if there is a role of block level officials in case of any PPP.

Hello I am Susrita Roy. I am a student of JNU, New Delhi pursuing my PhD on the topic of role of PPP in health service delivery. I am interested to know your views on the different PPP models which are currently functional in your district. You are an important stakeholder involved with these PPPs therefore I would appreciate if you could spare your valuable time to respond to some of my questions pertaining role of PPP in health services. This work is conducted purely for academic purposes and your responses will be treated as confidential. However, you may choose to skip any question or stop your participation at any time.

Duration in the post:

Please share about the different PPPs in your district which are functional?

Reminders-

- RCH- Urban RCH, JSY
- RNTCP- Private Practitioners
- NRHM- MMU
- Blindness Control Programme- Cataract Surgery
- Any other- At Block CHC/PHC

Please explain your role in their management and how is it executed

Reminders-

- In selection
- In deciding on their location
- In their terms of service- like staff required, infrastructure, equipment as well as the approaches they follow to provide service
- In monitoring
- In releasing funds to the private provider
- In making course corrections/ punitive actions

Which are the other official at district and block levels who have a role in the management of PPPs?

Please describe the nature and frequency of interactions do you have with them.

Incase of any disagreement on any issue how is it resolved?

In your opinion how are these organizations able to address the inequities of access?

Reminders-

With respect to reaching services to the poor, women, tribal, far to reach areas and other vulnerable communities.

With respect to infrastructure

With respect to manpower employed- both quantity and quality

With respect to cost of care

With respect to their relationship with the users

It may be useful if specific examples are cited for all the above.

In all the different types of private partners, like individual private practitioners in RNTCP or NGOs in Urban RCH or empanelled hospitals in JSY that are involved do you find any difference in their approaches to address inequities of access?

Reminders-

- With respect to reaching services to the poor, women, tribal, far to reach areas and other vulnerable communities.
- With respect to infrastructure
- With respect to manpower employed- both quantity and quality
- With respect to cost of care
- With respect to their relationship with the users

In your opinion which PPP in your district is most effective in addressing inequities in access

Reminders-

- With respect to reaching services to the poor, women, tribal, far to reach areas and other vulnerable communities.
- With respect to infrastructure
- With respect to manpower employed- both quantity and quality
- With respect to cost of care
- With respect to their relationship with the users

What is the mechanism of community to report their views about the private provider to you?

Please share any instance from the recent past when a community member may have approached you with complain about the services being provided by the private.

Reminder-

- What was the issue?
- What was the response of the provider?
- How did you handle it?
- What is the status?

In your opinion how is the PPP led model of health service delivery more effective than the State led model for equitable access

Reminder-

- With respect to reaching services to the poor, women, tribal, far to reach areas and other vulnerable communities.
- With respect to infrastructure
- With respect to manpower employed- both quantity and quality
- With respect to cost of care
- With respect to their relationship with the users

Please share your views on the problems you face regarding the management of PPPs

Please share some solutions to these problem

Annexure 1c: Interview Schedule for Private Organization

This schedule will include the questions for the head of the organization as well as for the staff.

(Questions for the head of the organization/ project lead)

Name of the organization:

Year of registration:

Registered under which Act:

Working since:

Coverage of work:

Area covered under the government programme

Experience in Public Health Programme (Reminder: independent from govt. / as a partner with govt)

May I have a copy of your annual report

Vision and Mission of the organization

Annual turnover (earning and spending):

Theme 1: About the organization

What is the mandate/ purpose of the organization?

Please describe the services that your organization provides?

What are the additional services that are provided as a part of this partnership?

Please describe the approach that you follow to deliver those services (Reminder- outreach, timings, waiting time)

Please describe the organizational structure with qualification of the human resources at all levels

Process adopted in performing the role:

Identifying the target population

Need assessment

Design of services

How are they delivered

monitoring and supervision

Who are the key decision makers in the organization?

What is the process of decision making process in the organisation?

Funding pattern:

What is the primary source of funds

What are the heads in which fund is received?

Regularity and duration of funding?

What are the conditions for fund release? Are there any experience of funds not being released?

Is the fund received adequate for continuing the activities?

In your opinion what is the culture of the organization:

Attitude to Innovations and risk taking

Process of Decision taking

Patterns of communication

Orientation towards outcome or process

Focus on internal members/ community

Team work

Attitude to change

How have been the major changes in mandate, structure and function of the organization since it started working?

What according to you are the factors that lead to that change?

How did the partnership with the government influence the structure, function and overall culture of the organistaion

In your opinion what kind of changes may take place in the public health sectors and how do you think they will affect organizations like yours

Theme 2: About the partnership

According to you what is the purpose of this partnership

How did you enter the partnership?

Why did you enter into this partnership? (reminder: benefits)

What is the structure of this partnership- who are the stakeholders at the government, other funders and any community based organisations

What is the role of the organization in designing the terms of reference of this partnership?

According to you what is the current role of the Govt. and what should be the ideal role of the Govt. in this partnership to facilitate the outcomes?

Decisions about the project (strategies to be adopted, coverage area …)

Support

Monitoring

Reporting

Grievances and redressal

Funding

Accountability and responsibility

Sharing of risk and resources

Any other

What is the role that is expected from your organization you by the government as a part of the partnership? (Reminder is there any difference between the MOU and as in actuals)

According to you what is the role of your organization in this partnership

What are the key issues that affect the deliverable in the partnership

Please share your views about the terms of partnership (reminder- facilitative/ exploitative, control exercised by the government)

Describe the relationship that you share with Government – at the block, district and state level (formal and informal)

Theme 3: Equity

According to you what is the felt need of the community in your catchment/ service area (reminder- was there any study conducted?)

Are there any sections of the population who are vulnerable?

Which sections of population does majority of your client belong to? (age, sex, caste, religion, economic status, place of residence)

In your opinion why do public health services not reach all sections as per their need (reminder- why: quantity of staff, infrastructure, resources, skills, attitude of staff, attitude of people)

What approaches are being adopted by your organization to address these gaps

Distance from residence and time to reach

Better facility and treatment- includes manpower , quality of infrastructure and access to them, waiting time

Cost of care- Direct Cost- user charges, fees, medicine and other treatment related cost and Indirect Cost- Cost of travel, stay and loss of wages

Responsiveness of the staff- behavior of the staff providing clinical as well as non-clinical services

Trust on the provider

What are the additional steps taken to ensure that by your organization to ensure that vulnerable sections of the society can gain access to health care.

What is the nature of relationship with the community that is required to deliver services effectively

What is the nature of relationship you have

In your opinion how does this relationship affect your deliverables

In your opinion, is this better than other organizations working in this area (reminder Comparison with other service providers- who are the other health service providers? Where are the services provided? Quality of these services).

What do you expect from the community, do they match your expectation (reminder: anything that is not as per your expectation, how do you think it can be changed)

What does the community expect from you, how do you do to match their expectation

What is the course of action incase of grievances lodged by the community

Annexure 1d: Interview Schedule for Retired Government Officials from Health Department

Hello I am Susrita Roy. I am a student of JNU, New Delhi pursuing my PhD on the topic of role of PPP in health service delivery. I am interested to know your views on the different PPP models which are currently functional in your programme. You have been an important stakeholder involved with these PPPs therefore I would appreciate if you could spare your valuable time to respond to some of my questions pertaining role of PPP in health services. This work is conducted purely for academic purposes and your responses will be treated as confidential. However, you may choose to skip any question or stop your participation at any time.

Designation in the Health Dept (all posts before retirement)

Tenure in the Health Dept:

Design of PPP

- According to you, what is the history of private sector engagement in health care?
- When was the first PPP under this programme initiated?
- Please share the reason why a PPP mode of service delivery was chosen?
- In your experience of working with the state government which are the different PPP models that have been framed under your guidance?
- Please share the role that was played by the government in designing and implementing the PPPs
- In those PPP, what were the roles of the private sector?
- What measures were taken for management of these PPPs?
- In your opinion how are PPPs that were formed earlier different from those that are being formed now?
- In your opinion what do you think are the advantages for government and private partners in this mode of service delivery?
- In your opinion what do you think are the advantages for government and private partners in this mode of service delivery?

Equity

- In your opinion what is required to address inequities in access arises
- According to you how does the public sector ensures equity
- In your opinion is engaging the private sector a better approach to meet the marginalized population
- According to you, what are the measures that a private sector working in public health adopt that is not possible to be taken by the public sector

- Kindly share what are your views about the role of the state to ensure that the private player is delivering services equitously

Relationship

I know that some PPPs are executed at the state and some are done at the district. Please share your views about the nature of relationship between the government officials at the state and district with respect to execution of both these kinds of PPP

- Does the private sector behave differently with state and district level officials.
- According to you who is the more powerful partner in a PPP and why
- What are the modes in which the power is expressed?
- What according to you is the relationship of the Private provider and the community?
- How does the government official interact with community to understand their views about the private provider?
- What is the process followed if there is any complain from the community about a provider?

On the other hand, there are cases when health officials blacklist any private provider. In that case is the opinion of the community taken into account?

Thank you so much for your valuable insights and time. May I request you for some more time in case I need some clarification.

Annex 2: PPP Mode PHC In Rajasthan

S.N.	District	Sl.No.	PHC	Bidder Name
1	Alwar	1	Bhanokhar	St. Conard Shiksha Samiti
2		2	Damroli	Sprash Children Emencipation Society For Social Change & Action
3		3	Dabaravas	
4		4	Nangli Balaheer	
5	Banswara	5	Panchwara	Chtransh Education and Welfare Society
6	Baran	6	Badora	Vani Sanstha
7		7	Jaipala	Lords Education & Health Society
8	Barmer	8	Udasar	Navjeevan Seva Sansthan
9	Bharatpur	9	Kapuramaluka	Vani Sanstha
10		10	Andhwari	
11	Bhilwara	11	Chtamba	Parmatma Chand Bhandari Trust
12		12	Barudani	Jan Kalyan Rehibilation & Development Society
13		13	Kot	Parmatma Chand Bhandari Trust
14		14	Luharikaran	Jan Kalyan Rehibilation & Development Society
15	Bikaner	15	Kudsu	Bikaner Medical Relief Sociaety
16	Bundi	16	Jajawer	Lords Education & Health Society
17		17	Dugari	Lords Education & Health Society
18		18	Bamangaon	Lords Education & Health Society
19	Churu	19	Lala Sarbanirotan	Yuva Bharat Sansthan Bikaner
20		20	Losana Bara	Lords Education & Health Society
21		21	Khandwa Patta	Lords Education & Health Society
22		22	Sirsala	Lords Education & Health Society
23	Dausa	23	Sonad	Navjeevan Hospital
24	Dholpur	24	Gopalpura	Vani Sanstha

Annex 2: PPP Mode PHC In Rajasthan

S.N.	District	Sl.No.	PHC	Bidder Name
25		25	Samona	Vani Sanstha
26		26	Nagla Beedhora	Vani Sanstha
27	Dungarpur	27	Richha	Lords Education & Health Society/ WISH Foudation
28	Jaipur-1	28	Mandota	Jan Kalyan Rehibilation & Development Society
29		29	Rampura	
30	Jaipur-2	30	Ladera	Bikaner Medical Relief Sociaety
31		31	Sewa	Sparsh Hospital (A Unit of Scarlet Formulation Pvt. Ltd.)
32		32	Bagawas	Jankalyan Rehabilitaion & Development Socity
33	Jaisalmer	33	Bharewala	Navrang Ram Danyanand Dhukia Shikshan Sansthan
34		34	Madasar	
35	Jhalawar	35	Bhalta	Lords Education & Health Society/ WISH Foudation
36		36	Chachhlab	
37		37	Kanwara	
38	Jhunjhunu	38	Keru	Norang Ram Dayanand Dhukia Shikshan Sansthan
39		39	Nuniya Gothara	
40		40	Bagola	
41		41	Bajala	
42		42	Luna	
43		43	Sotwara	
44		44	Baloda	Naveen Bharat Jan Kalyan Trust
45		45	Dhanuri	Lords Education & Health Society/ WISH Foudation
46		46	Padampura	
47	Jodhpur	47	Beru	Parmatma Chand Bhandari Trust
48	Kota	48	Lakasaneeja	Lords Education & Health Society/ WISH Foudation
49		49	Kutradeep Singh	
50		50	Barod	
51	Nagaur	51	Gudhasalt	Parmatma Chand Bhandari Trust

Annex 2: PPP Mode PHC In Rajasthan

S.N.	District	Sl.No.	PHC	Bidder Name
52	Pali	52	Bhumbaliya	Navrang Ram Danyanand Dhukia Shikshan Sansthan
53		53	Kurkee	
54		54	Kot Kirana	
55	Pratapgarh	55	Achnera	Chitransh Education and Welfare Society
56		56	Rampuriya	
57		57	Ambirama	Lords Education & Health Society/ WISH Foudation
58	Rajsamand	58	Gajpur	Parmatma Chand Bhandari Trust
59		59	Sameecha	
60		60	Bardara	Lords Education & Health Society/ WISH Foudation
61		61	Odda	
62	Sawai Madhopur	62	Sukar	Navjeevan Hospital
63		63	Gurjar Bardod	
64		64	Lahsoda	Jan Kalyan Rehibilation & Development Society
65		65	Rawajna Chour	
66		66	Bhadoti	Lords Education & Health Society/ WISH Foudation
67	Sirohi	67	Manadar	Bikaner Medical Relief Sociaety
68		68	Bant	
69		69	Alpa	
70		70	Varada	
71	Tonk	71	Kalmanda	Jan Kalyan Rehibilation & Development Society
72	Udaipur	72	Chansada	Matra Darshan shiksha Samiti
73		73	Loonada	Geetanjali Medical college and Hospital Udaipur
74		74	Savina	
75		75	Kun	
76		76	Sagatra	
77		77	Malwa Ka Chora	
78		78	Mandwa	Lords Education & Health Society/ WISH Foudation
79		79	Bikarani	

Annexure 3

Reasons for Penalty	Amount
1. Delay in commencement of the service – after 45 days from the signing of the agreement.	Rs. 3,000/- per vehicle per day after 45 days from the signing of the agreement.
2. Organization of fewer than 20 camps in a month	Proportionate deductions from claims plus penalty @ Rs. 5,000/- per camp.
3. 2000 patient a month @ 100 patients for 20 camps	Proportionate penalty plan with a maximum of Rs. 25,000 and a minimum of Rs. 5,000/-
4. Absenteeism of staff	Rs. 1,000 if any staff apart from the doctor is absent. A camp where the doctor was not present was considered as camp not held (deduction as per 2).
5. Diagnostic Vehicle is not present in the camp.	It will be taken as camp not held (deduction as per 2).
6. Not submission of daily reports and off-road vehicle	Rs. 1000 per day and proportionate deduction for the off-road vehicles
7. Proper IEC of the camp well before 7 days.	There was no fixed amount, but it was linked to the number of patients in the camp
8. If the vehicles are not found in the camp for the scheduled time as per the camp plan	Based on the GPS control room data, if the camp does not start and end as per the time mentioned in the camp plan it is considered as camp not done unless the provider gives adequate justification.

Annexure 4

	राजस्थान राज-पत्र विशेषांक	RAJASTHAN GAZETTE Extraordinary
सत्यमेव जयते	साअधिकार प्रकाशित	*Published by Authority*
	चैत्र 2, रविवार शाके 1942- मार्च 22, 2020	
	Chaitra 2, Sunday , Saka 1942- March 22, 2020	

भाग 1 (ख)

महत्वपूर्ण सरकारी आज्ञायें।

चिकित्सा एवं स्वास्थ्य विभाग

अधिसूचना

जयपुर मार्च 21, 2020

संख्या प.1(1)चिस्वा/ग्रुप-2/2020 :-विश्व स्वास्थ्य संगठन तथा संयुक्त राष्ट्र द्वारा कोरोना वायरस (COVID-19) संक्रमण को Pandemic घोषित करने तथा इस संदर्भ में उत्पन्न स्थिति के परिप्रेक्ष्य में राजस्थान एपिडेमिक डिजीजेज एक्ट, 1957 की धारा (2) में प्रदत्त शक्तियों का प्रयोग करते हुए कोरोना वायरस (COVID-19) के संक्रमण को फैलने से रोकने के लिए राज्य में स्थित ऐसे निजी अस्पताल एवं निजी मेडिकल कॉलेज जिनकी बैड क्षमता 100 या 100 से अधिक है, को निर्देशित किया जाता है कि उनके यहां उपलब्ध बैड क्षमता के 25 प्रतिशत बैडों को कोरोना वायरस (COVID-19) से संक्रमित/संदिग्ध रोगियों के ईलाज/भर्ती के लिए आइसोलेशन वार्ड के लिए आरक्षित रखें।

इसके अतिरिक्त कोरोना वायरस (COVID-19) से संक्रमित मरीजों के ईलाज हेतु आपके यहां उपलब्ध आई. सी. यू. में भी 25 प्रतिशत बैड आरक्षित रखे तथा समस्त आवश्यक उपकरण एवं औषधियों की उपलब्धता सुनिश्चित करें।

रोहित कुमार सिंह,
अतिरिक्त मुख्य सचिव

3177

राज्य केन्द्रीय मुद्रणालय,जयपुर।

Annexure 5

राजस्थान सरकार
चिकित्सा एवं स्वास्थ्य विभाग

कमांकः प.1(1)चिस्वा/ग्रुप–2/2020 जयपुर, दिनांक : 05.04.2020

अधिसूचना

विश्व स्वास्थ्य संगठन, तथा संयुक्त राष्ट्र द्वारा कोरोना वायरस (COVID-19) संक्रमण को Pandemic घोषित करने से उत्पन्न स्थिति के परिप्रेक्ष्य में राजस्थान एपिडेमिक डिजीजेज एक्ट, 1957 की धारा (2) में प्रदत्त शक्तियों का प्रयोग करते हुए कोरोना वायरस (COVID-19) संक्रमण से बचाव, रोकथाम एवं प्रबन्धन के लिए राज्य के निम्न राजकीय एवं निजी अस्पतालों को तुरन्त प्रभाव से (COVID-19) संक्रमण से बचाव, रोकथाम एवं प्रबन्धन के लिए पूर्णतः समर्पित (Fully dedicated) अस्पताल आगामी आदेशों तक अधिसूचित किया जाता है:–

S. No.	District Name	Name of the State HeadQuarter/ District Hospitals	Category of Health facility	Total number of isolation beds available
1	State Designated Hospital at Jaipur	SMS, Hospital	State Govt. Medical College	950
2	State Designated Hospital at Jaipur	RUHS, Hospital	State Govt. Medical College	500
3	JODHPUR	MATHURADAS MATHUR HOSPITAL JODHPUR	State Govt. Medical College	550
4	BIKANER	MCH Wing PBM Hospital	State Govt. Medical College	150
5	KARAULI	Saurabh Hospital Kheda Hindaun Road karauli	Private Hospital	100
6	AJMER	JLN Medical College, Ajmer (Old Section)	State Govt. Medical College	504
7	AJMER	Mittal Hospital & Research Center	Private Hospital	150
8	ALWAR	Sant Sukhdev Hospital Alwar	Private Hospital	60
9	ALWAR	Lords Hospital Alwar	Private Hospital	259
10	ALWAR	RAJIV GANDHI GENERAL HOSPITAL	State Govt. Hospital	200
11	SIKAR	SHRI RAM TRAUMA AND SUPER SPECIALITY HOSPITAL	Private Hospital	50
12	SIKAR	SHRI DHANWANTRI HOSPITAL	Private Hospital	40
13	SIKAR	Kalyan Arogya Sadan, Sanwali, Sikar	Private Hospital	350
14	SIKAR	Dhayal Hospital & Reasearch Centere, Reeengus	Private Hospital	100
15	JALORE	Govt. Bhandari General Hospital Jalore	State Govt. Hospital	84
16	JAISALMER	Maheshwari hospital and research center jaisalmer	Private Hospital	50
17	JAISALMER	Golden city hospital jaisalmer	Private Hospital	30

18	JAISALMER	New Rajasthan Hospital & Fertility Center Jaisalmer	Private Hospital	25
19	JAISALMER	R.L. Memorial hospital jaisalmer	Private Hospital	25
20	RAJSAMAND	R.K. District Hospital Rajsamand	State Govt. Hospital	150
21	CHITTORGARH	SSG Govt Hospital	State Govt. Hospital	250
22	UDAIPUR	SUPER SPECIALITY BUILDING,MBGH	State Govt. Medical College	500
23	BARMER	PMO Barmer(DH)	State Govt. Hospital	300
24	NAGAUR	JLN HOSPITAL NAGAUR	State Govt. Hospital	200
25	HANUMANGARH	MAHATMA GANDHI MEMORIAL HOSPITAL HANUMANGARH TOWN	State Govt. Hospital	200
26	HANUMANGARH	HISSARIA MULTISPECIALITY HOSPITAL, HANUMANGARH TOWN	Private Hospital	50
27	HANUMANGARH	CHC RAWATSAR	State Govt. Hospital	75
28	HANUMANGARH	VIVEKANAND SWASTHAY SEWA SAMITI HOSPITAL, BHADRA	Private Hospital	100
29	KOTA	NMCH HOSPITAL KOTA	MEDICAL COLLEGE	969
30	TONK	DH TONK	State Govt. Hospital	150
31	BARAN	PRIYA HOSPITAL, BARAN	Private Hospital	100
32	JHALAWAR	SANJEEVANI VYAS HOSPITAL ANUSANDHAN KENDRA PVT LTD	Private Hospital	60
33	SAWAI MADHOPUR	RANTHAMBORE SEWIKA HOSPITAL	Private Hospital	60
34	BUNDI	ANURAG NURSING HOME	Private Hospital	50
35	BUNDI	BUNDI HOSPITAL AND RESEACH CENTER	Private Hospital	75
36	BHILWARA	DH BHILWARA	State Govt. Medical College	427
37	SIROHI	DISTRICT HOSPITAL SIROHI	State Govt. Hospital	100
38	BHARATPUR	Jindal Nursing Home	Private Hospital	90
39	DAUSA	Shri Ramkaran Joshi District Hospital Dausa	State Govt. Hospital	90
40	CHURU	D.B. Hospital churu	State Govt. Hospital	300
41	JHUNJHUNU	CKRD hospital Jhunjhunu	Private Hospital	100
42	PALI	Community Health Centre, Sadari	State Govt. Hospital	50
43	PALI	Nanesh P.G. Hospital, Pipaliya Kalan, Raipur	Private Hospital	155
44	PALI	Bhagwan Mahaveer Hospital, Sumerpur	Private Hospital	150

45	PALI	Sub Divisional Hospital, Sojat City	State Govt. Hospital	150
46	PALI	Govt. Bangur Hospital, Pali	State Govt. Hospital	200
47	PALI	Dr. Vyas Hospital and MRC, Falna	Private Hospital	40
48	PALI	Vijay Vallabh Hospital, Sadari	Private Hospital	30
49	GANGANAGAR	jan sewa Hospital tantia Univeraity	Private Hospital	200
50	GANGANAGAR	District Hospital	State Govt. Hospital	250
51	PRATAPGARH	Sky lifeline multispeciality Hospital	Private Hospital	30
52	PRATAPGARH	DISTRICT HOSPITAL PRATAPGARH	State Govt. Hospital	200
53	BANSWARA	MAHATMA GANDHI HOSPITAL, BANSWARA	State Govt. Hospital	160
54	DUNGARPUR	District Hospital Dungarpur	State Govt. Hospital	250
55	DHOLPUR	DH DHOLPUR Dedicated Block	State Govt. Hospital	140
TOTAL				10578

(रोहित कुमार सिंह)
अतिरिक्त मुख्य सचिव

प्रतिलिपि निम्न को सूचनार्थ एवं आवश्यक कार्यवाही हेतु प्रेषित है:–

1. निजी सचिव, मा. मुख्यमंत्री महोदय।
2. निजी सचिव, मा. मुख्य सचिव महोदय।
3. विशिष्ठ सहायक, मा. चिकित्सा मंत्री महोदय/मा. चिकित्सा राज्य मंत्री महोदय
4. निजी सचिव, अतिरिक्त मुख्य सचिव, चिकित्सा एवं स्वास्थ्य विभाग।
5. मिशन निदेशक, राष्ट्रीय स्वास्थ्य मिशन, राज. जयपुर।
6. समस्त संभागीय आयुक्त, राज.
7. समस्त जिला कलक्टर, राज.
8. निदेशक, सूचना एवं जन सम्पर्क विभाग
9. निदेशक, केन्द्रीय मुद्रणालय, जयपुर को भेजकर लेख है कि उक्त अधिसूचना (मय साफ्ट प्रति) को जारी होने की तिथि से राजस्थान राजपत्र में असाधारण गजट में आज ही प्रकाशित करने का श्रम करें।
10. समस्त प्रधानाचार्य एवं नियंत्रक, मेडिकल कॉलेज एवं अस्पताल, राजस्थान
11. समस्त निदेशक, चिकित्सा एवं स्वास्थ्य सेवाये राज. जयपुर
12. समस्त प्रमुख चिकित्सा अधिकारी, राज.
13. समस्त मुख्य चिकित्सा एवं स्वास्थ्य अधिकारी, राज.
14. जन सम्पर्क अधिकारी, चिकित्सा एवं स्वास्थ्य सेवाऐं, राज. जयपुर।
15. संबंधित अस्पताल
16. निजी /रक्षित पत्रावली

(संजय कुमार)
शासन उप सचिव