PUBLIC PRIVATE PARTNERSHIP IN PRIMARY HEALTH CARE: A CASE STUDY OF PPPS IN PRIMARY HEALTH CENTRES IN RAJASTHAN

A Dissertation submitted to the Panjab University, Chandigarh for the award of Master of Philosophy in Social Sciences, in partial fulfillment of the requirement for the 44th Advanced Professional Programme in Public Administration (APPPA)

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44th ADVANCEDPROFESSIONAL PROGRAMME IN PUBLIC ADMINISTRATION

INDIAN INSTITUTE OF PUBLIC ADMINISTRATION
NEW DELHI

(2018-19)

CERTIFICATE

I have the pleasure to certify that Ms. Archana Mayaram has pursued her research work and prepared the present dissertation titled "Public Private Partnership in Primary Health Care: A Case Study of PPPs in Primary Health Centres in Rajasthan" under my guidance and supervision. The dissertation is the result of her own research and hard work. This is being submitted to the Panjab University, Chandigarh for the purpose of Master of Philosophy in Social Sciences in partial fulfillment of the requirement for the Advanced Professional Programme in Public Administration of the Indian Institute of Public Administration (IIPA), New Delhi.

I recommend that the dissertation of Ms. Archana Mayaram is worthy of consideration for the award of M.Phil. degree of Panjab University, Chandigarh.

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ACKNOWLEDGEMENTS

This Thesis has become a reality because of the constant support and guidance of Associate Professor Dr. (Ms.) Neetu Jain who had immense faith in my capacity to complete the work.

I am grateful to the Course Directors Professor Ashok Vishandaas and Dr. (Ms.) Kusum Lata for their understanding and encouragement. I also express my thanks to the staff of APPPA office who silently worked behind the scenes throughout the Programme and were always keen to help the participants.

I am grateful to Dr. Arvind Mayaram, former Finance Secretary to the Government of India and an internationally acknowledged PPP Expert for his incisive comments which enabled me to sharpen the thesis.

I am grateful to Ms. Veenu Gupta, Additional Chief Secretary, PWD and former Additional Chief Secretary, Department of Medical, Health and Family Welfare, Rajasthan for providing me insights into which PPPs in PHCs have evolved in the state.

I also thank Dr. Hemlata, Consultant with National Health Mission, Rajasthan looking after Urban PHCs and Dr. Ramniwas Meena, Joint Director, Directorate of Medical & Health Services, Rajasthan for providing data support, organizing field visits and helping me in understanding the manner in which these PHCs have been functioning. Thanks are also due to Dr. Samit Sharma, Director, National Health Mission for providing me support in my field visits.

This work would not have been possible without my family's support and the grace of Almighty.

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Acronyms and Abbreviations

A.N.M	Auxiliary Nurse Midwifery
B.C.M. O	Block Chief Medical Officer
CA	Chartered Accountant
CGHS	Central Government Health Scheme
CHC	Central Health Centre
DCA	Draft Concession Agreement
DPR	Detailed Project Report
EAG	Empowered Action Group
EoI	Expression of Interest
GDP	Gross Domestic Product
G.N.M	General Nursery Midwifery
G.o.I	Government of India
IIHMR	Indian Institute of Health Management Research
IMR	Infant Mortality Rate
INR	Indian National Rupee
IPD	In-Patient Delivery
IRR	Internal Rate of Return
KPIs	Key Performance Indicators
L.H. V	Ladies Health Visitor
L.T	Lab Technician

MDGs	Millennium Development Goals
MoU	Memorandum of Understanding
MMR	Maternal Mortality Rate
NITI Aayog	National Institute for Transforming India
NPV	Net Present Value
NFHS	National Family Health Survey
NGO	Non- Government Organization
OPD	Out-Patient Delivery
PHC	Primary Health Centre
PPI	Private Participation in Infrastructure
PPIAF	Public Private Infrastructure Advisory Facility
PPPs	Public Private Partnerships
QCBS	Quality and Cost Based Selection
RfP	Request for Proposal
RfQ	Request for Qualification
SDGs	Sustainable Development Goals
SLA	Service Legal Agreement
SoE	Statement of Expenditure
TFR	Total Fertility Rate
UNDP	United Nations Development Programme
USD	United States Dollar

UN	United Nations
U5MR	Under 5 (years) Mortality Rate
UPHC	Urban Public Health Centre
USAID	United States Agency for International Development
UT	Union Territory
VGF	Viability Gap Funding
WHO	World Health Organization

CHAPTER I

INTRODUCTION

1.1 Background

1.1.1 It is globally acknowledged that investment in infrastructure is necessary for economic growth and development. It also improves quality of life, be it investment in roads, railways, telecommunications, power, ports and airports. In a highly globalized and networked world, which is being rapidly transformed on account of technology, the definition of infrastructure is undergoing change, which also poses several challenges. While the requirement of investment in infrastructure is well documented, it is acknowledged that globally there is a large infrastructure deficit, afflicting developed and developing countries alike. While the developing countries are facing the problem of sourcing long term finance for their infrastructure needs, the advanced economies are facing the challenge of renewal of graying infrastructure which is no longer economical to maintain. There are different estimates for resource requirement globally to meet the infrastructure challenge. One of the more conservative estimates, taking into consideration investment needs across 56 countries and 7 sectors (Energy, Telecommunication, Airport, Ports, Rail, Road and Water) and five regions is USD94 trillion till 2040, whereas the current investment is to the tune of USD79 trillion, leaving the infrastructure deficit of USD15 trillion.[1] In developing countries, annual infrastructure financing needs have been estimated in the range of USD1.2 trillion to USD1.5 trillion per annum.[2]

[1] Website of Global Infrastructure Hub (https://outlook.gihub.org/)
[2] Ibid

1.1.2 As per Global Infrastructure Outlook Report (July, 2017), India needs USD4.5 trillion investment in infrastructure. With the current investment level of USD3.9 trillion, there is an estimated investment gap of USD600 million. Once other sectors, including social sectors like education and health are added, the gap increases significantly. The fast pace of economic growth in the recent years has placed an increasing stress on physical infrastructure which suffers from a substantial deficit in terms of capacity as well as efficiency. The pattern of inclusive growth averaging 9 per cent a year can be achieved only if this infrastructure deficit is overcome and adequate investment takes place to support higher growth and an improved quality of life for both rural and urban communities.

1.2 **Public Private Partnerships**

1.2.1 Infrastructure is funded largely through public investment. However, pressures on budgetary resources limit the ability of public funding to finance the growing requirements of infrastructure. As a result, financing the targeted levels of investments require strategic participation from the private sector, through adoption of innovative ways of financing. Public Private Partnerships (PPPs) have emerged globally as an efficient mechanism to harness private sector participation.

1.2.2 Private sector involvement in the delivery of public services is not a new concept; PPPs have been used globally for more than three decades. "Initially focusing on economic infrastructure, PPPs have evolved to include the procurement of social infrastructure assets and associated non-core services. In Asia, countries like China, Malaysia and Thailand started a few projects with private participation in mid 1980s. This trend

caught on and in the 1990s, most of the countries in the region began to involve private sector in the provision of infrastructure facilities".[3]

1.3 Public Private Partnership is not privatization

1.3.1 PPPs are often misconstrued as privatization. However, PPPs involve a partnership with the government and it does not reduce the responsibility and accountability of the government in the outcomes expected from the partnership. In PPPs there is a long-term contract between the government and the private partner for delivery of public services where the service standards are set by the government. Whereas, in case of privatization the infrastructure assets' ownership is transferred to the private sector to largely operate in free market conditions, with freedom, in most cases to set prices. The private party also bears the complete risk of the project. In PPPs the infrastructure assets are transferred to the private party only for a specified period ("concession period") of time through a risk sharing contract in which the risk gets transferred to the party (government or the private party) that can best manage it. Further, in case of PPPs the government plays the role of a facilitator whereas the private sector is expected to bring in its operational efficiencies and deliver the services as per the preset standards and prices set by the government. Therefore, role of the government in the partnership remains critical throughout the contract period for a PPP to be successful.

1.4 Public Private Partnership in India

1.4.1 India in the recent years has emerged as one of the leading PPP markets in the world, because of several policy and regulatory initiatives taken by the Central Government. According to the Word Bank,[4] India is second in terms of the number of PPP

[3] http://shodhganga.inflibnet.ac.in/bitstream/10603/50293/6/06_chapter%201.pdf
[4] http://ppi.worldbank.org

projects and the Private Participation in Infrastructure (PPI) amongst the developing countries.

1.4.2 According to the erstwhile Planning Commission, the share of private investment in infrastructure increased from 22 per cent in the Tenth Five Year Plan to 38 per cent in the Eleventh Five Year Plan. It was expected to be about 48 per cent during the Twelfth Five Year Plan (2012-17). However, actual infrastructure investment is less than the targets set by the 12th Five Year Plan. This fall in investment is attributed to several factors such as global financial crisis, stressed balance sheets of large corporates, issues of bank financing etc. PPPs in India have also been plagued by the downturn in the economy since the global economic meltdown in 2008, and the steep learning curve for both the public and the private sector to manage a new kind of partnership. As India has already emerged as one of the leading markets for PPPs, the challenge is to redefine the PPP framework and evolve new and innovative models of PPPs that can play a more critical role in the development of infrastructure in the country.

1.5 Public Private Partnership in Social Sectors

1.5.1 PPPs have been widely used in core infrastructure projects such as roads, ports, airports, telecommunication networks, power etc. and have been tried only sporadically in the social sector projects in commercial format. This has been the case as social or welfare services, such as education, health, water and sanitation etc., have traditionally been the responsibility of the public sector. This is also because of the fact that private investment is driven by profit motive, whereas social sector projects are not commercial in nature. It is only recently that serious effort has been made to develop new models of PPPs in the social sectors to develop infrastructure and services in Sustainable Development Goals (SDGs) related projects which combine profit motive and public good in equal measure. It is, therefore, important to examine how robust the new models are, whether

they would be cost effective and efficient in delivery of critical services like health care, and whether PPP based public services are inclusive and serve the interest of the poor and the marginalized.

1.5.2 Whereas, public resource constraint inhibits adequate public investment in social sector projects, in the developing countries including India, public services have also come to be associated with inefficiency, delays, poor staffing etc. resulting in general dissatisfaction amongst the users. As a result, private investment is also sought to bring in private sector efficiencies and greater accountability in the delivery of public services.

1.5.3 In India, PPPs in various forms in social sector projects are approximately a decade old phenomenon and are still at a nascent stage. While making social sector public services "commercially viable" to attract private investment and ensure long term sustainability, governments strive to maintain affordability (to cover a large segment of unserved and under-served population) and reliability. PPPs in social sector are governed by both central and state government policies and regulations, and often state governments follow different approaches for governing, regulating, de-risking and incentivizing PPP projects. The tendency at the operational level to adopt an integrated 'one size fits all' approach for PPPs across all sectors is dysfunctional for social sector projects. Monitoring of social sector PPPs also poses a challenge due to difficulties in accurate demand assessment forecasting and meeting of service level standards. Coupled with the possibility of severe repercussions in case of failure to ensure quality service in sectors like health and education, this sometimes becomes a deterrent. There are also issues regarding the fixation of user charges. Private sector does not have an appetite to take high risks involved in social sector PPPs as most projects are not commercially viable without substantial government support, a factor seen as a sovereign risk.

1.5.4 It is also pertinent to mention that social sector projects are premised on 'Value for People' rather than 'Value for Money,' requiring a completely different set of protocols for implementation and operation. Therefore, there is an urgent need to develop a regulatory framework, including legal documents, which would be suitable for social sector PPPs. There are a few success stories of successful PPP projects in the social sector in India and this has been possible as these projects have been treated differently in design from the core sector PPPs. Noteworthy, are the following projects: (I) Emergency Response Service and Alandur Sewerage Project in the State of Tamil Nadu (II) Mobile Clinics (III) Diagnostic Services.

1.6. PPPs in Primary Health Centres in Rajasthan

1.6.1 With the intention of improving primary health services in the state, the Government of Rajasthan (the government), sought interest of the private sector to partner with the government. Private sector participation was initially invited for Primary Health Centres (PHCs) in the rural areas and later extended to the Urban Health Centres. There are 2092 rural PHCs in Rajasthan out of which presently 83 PHCs are running on PPP mode. The list of rural PHCs running on PPP mode is at Annexure -I. In the case of urban PHCs, there are 245 PHCs, out of which 34 PHCs are currently running on PPP mode, list of the same is at Annexure-II.

1.7 Statement of the Problem

Public primary health care system is not delivering the quality of services people expect and deserve. Primary Health Centres (PHCs), which are the unit of primary health care delivery in general have poor physical infrastructure and inadequate diagnostic aides, and are poorly staffed. State governments are short on resources and find it difficult to enforce discipline on the government staff. New models of implementing PPPs are being attempted to obtain a better bid response and financial closure for the projects, which could pro-

vide an optimal risk matrix of the projects. The study intends to analyze the PPP model adopted by the state government and try to identify areas where improvements can be made to make the model more efficient and result oriented. It also suggests policy recommendations to improve the delivery of services, allowing for greater spread of PPPs within and outside the state.

1.8 Research Objectives

The following are the objectives of this study:

(i) Study the implementation of PPP model in primary health care in the state of Rajasthan to ascertain whether the model can improve the delivery of primary health services.

(ii) Examine the factors that have a bearing on such PPPs and the extent to which these facilitate or hinder the functioning of the PPPs in PHCs.

(iii) Examine the risk matrix of the model used by the State Government to ascertain whether these risks have been properly identified, mitigated and assigned in the project design.

(iv) Make policy recommendations to make the model scalable and replicable.

1.9 Research Design

The Research Design would consist of the following:

(i) Descriptive analysis of PPPs in PHCs in Rajasthan.

(ii) Exploratory research to determine factors that have a bearing on such PPP models.

(iii) Qualitative assessment of the risk matrix of the PPP model.

1.10 Research Questions

(i) What are the factors which make primary health care delivery inadequate and of poor quality?

(ii) Are PPPs a robust model to follow in primary health care?

(iii) What are the salient features of PPPs for PHCs in Rajasthan?

(iv) To what extent risks have been identified and mitigated in the model?

(v) What are the strengths and weaknesses of the PPP model?

(vi) What are the changes necessary to make the model scalable and replicable?

1.11 Limitations of the Study

One of the major limitations of the study was paucity of time and resources. Therefore, the analysis has been primarily based on secondary data sources. However, this has been supplemented by observation for validation by visits to a few PHCs both in rural and urban areas and also several discussions undertaken with the state government officials who have been and are presently associated with this project, doctors and staff of the PHCs and "users of services" by using the technique of simple random sampling. Discussions have also been held with private sector partners to obtain the private sector perspective.

1.12 Literature Review

There are several books, reports and papers available on infrastructure development and also on PPPs. However, specific books and literature on PPPs in social sector projects are limited. Some studies that have been reviewed are as follows:

(i) "Public-Private Partnerships in Infrastructure - Managing the Challenges", (Pratap and Chakrabarti, 2017), is a book that examines PPPs in infrastructure in detail. It covers a wide range of issues, such as what we mean by infrastructure, its characteristics, PPPs and financing of infrastructure, including some important case studies in some of the core infrastructure sectors, challenges and the way forward. The book does not cover PPPs in social sector in much detail but touches upon the subject briefly where three social sector issues, viz., education, health and prisons have been discussed. This section of the book highlights the need for PPPs in social infrastructure and also states that the private sector

often finds social infrastructure projects more challenging as financial rewards are smaller and the operational demands more complex.

(ii) "What Drives Private Sector exit from Infrastructure", (Harris and Pratap, 2009) an article in which the authors examine the premature exit of the private sector from PPP projects and the factors influencing this. The authors carried out their analysis by using information from the World Bank – private participation in infrastructure project database[5] which collects and disseminates information on infrastructure projects with private participation in low- and middle-income countries. The article looks at the cancellation of projects in the water and sewerage sector and concludes that the projects in this sector are most prone to cancellations as the water sector has the lowest levels of revenue recovery among the infrastructure sectors. Further, through an econometric analysis, it has been shown that occurrence of macroeconomic shocks can double the rate of such cancellations. The other reasons for cancellation of projects are the presence of a foreign sponsor and larger projects which are politically riskier. As the global financial crisis has pushed the costs of the projects upward, the number of project cancellations could grow. It has been observed that the financing of infrastructure projects has been hampered globally due to the lack of funds and liquidity and this has also led to a rise in the cancellation of PPP projects.

(iii) "Department of Economic Affairs (2015): "Report of the Committee on revisiting and revitalizing Public Private Partnership model of Infrastructure" is an important source of reference as it identifies the challenges faced by PPPs in India as those of a "maturing PPP market" and gives recommendations encompassing a number of areas. The report also identifies major gaps in both policy and regulations, and in the legal documents

[5] Public-Private Infrastructure Advisory Facility (PPIAF)

governing PPPs thereby setting the context for studying the challenges being faced by PPPs not only in the core infrastructure projects but also those in the social sectors.

(iv) "Public Private Partnerships", (Ramesh G,Nagadevara V, Naik G, Suraj B, 2010) is a book that deals with the issues related with PPPs at large. However, there is one chapter titled PPPs in delivery of "Elementary Education: Present, Imperfect, Future Alternatives." In this chapter, there is an important finding that both the formation of PPPs and their performance should be subject to scrutiny within a larger framework of public policy on PPPs which can address different areas of public service delivery. It also raises questions that have immediate implications for policies in PPPs in education and also for PPPs in general.

(v) In the Economic and Political Weekly article titled "User Fees and Political and Regulatory Risks in Indian Public-Private Partnerships" (Pratap, 2015), the issue of users' resistance to payment of user charges, challenges of under pricing and political difficulties in enforcing user-pay principle have been elucidated. The author emphasizes the importance of users paying for services and suggests that either users should pay or the government should pay in lieu of the users through explicit subsidies. In the absence of this the existence of PPPs in the country would be endangered. The article makes a reference to the private water and sewerage projects that have failed across the developing world as there was opposition to periodic price increases and also on opposition to the private sector providing these "essential services.''

(vi) According to the erstwhile Planning Commissions report of the PPP Sub - Group on Social Sector (2004), "Initially focusing on economic infrastructure, PPPs have now evolved to include the procurement of social infrastructure assets and associated non-core services. PPPs have extended to housing, health, energy, water and waste treatment. PPP policy has also evolved globally as public sectors develop the necessary skill base to

procure infrastructure by way of PPP, including the capacity to create and maintain a regulatory framework. The private sector has also become increasingly innovative in several experienced countries, thereby adding significant value to public procurement." The report also elucidates the budgetary support that is provided by the Government of India and also covers several schemes of the Government in the social sector which are running on PPP mode.

(vii) Cook Jacques, in a paper titled, "PPPs in the social sector: Health and Education", examines some of the international experience to date in these sectors and discusses some of the issues which should inform the policies being developed to promote the wider application of PPPs in the key social sectors. The paper also describes key features of the PPP models that are currently applied in each of these sectors and the key issues facing these projects in achieving sustainability.

1.13 **Research Methods and Data Sources**

The analysis is primarily based on secondary data sources, which includes the following:

(a) Government documents and websites of Planning Department and Department of Medical, Health and Family Welfare, Government of Rajasthan

(b) Discussion with the officers of the Department of Medical, Health and Family Welfare, Government of Rajasthan

(c) Studies /Surveys conducted by Government/Non –Government agencies

(d) Anecdotal validation through site visits and discussions with stakeholders including the PHC staff, patients and the private sector partners

Chapter-2

PPPs in social sector and the case for Rajasthan

2.1 Sustainable Development Goals

2.1.1 At the United Nations Sustainable Development Summit on September 25, 2015, more than 150 world leaders adopted the 2030 Agenda for sustainable development, including Sustainable Development Goals (SDGs). The United Nations Development Programme (UNDP) will support governments around the world in tackling the new agenda and taking it forward over the next 15 years. The seventeen (17) new SDGs, also known as Global Goals, aim to end poverty, hunger, inequality, take action on climate change and environment, improve access to health and education, build strong institutions and partnerships and more. [6]

2.1.2 The SDGs have built on and replaced the Millennium Development Goals (MDGs). For 15 years, the MDGs drove progress in several important areas such as reducing income poverty, access to water and sanitation, reducing child mortality and improving maternal health. [7] The SDGs have a more ambitious agenda, seeking to eliminate rather than reduce poverty, and include more demanding targets on health, education and gender equality.

2.1.3 Goal 17 of the SDG's recognizes the fact that resources required to meet the SDG goals cannot be mobilized without forging strong partnerships. Therefore, this goal talks about encouraging and promoting "effective public, public-private and civil society partnerships that mobilize and share knowledge, expertise, technology and financial resources

[6] undp.org

[7] UNDP, "Background to the Goals"; http://www.undp.org/content/undp/en/home/sustainable-development-goals/background.html

to support the achievement of the SDG's in all countries, particularly in developing countries". [8] This would require public policies to be framed in such a manner that it permits such partnerships to be forged and provides an enabling regulatory environment that would bring together all the stakeholders for common purpose.

2.1.4 In this context, PPPs have emerged as a viable option for providing of infrastructure and public services in both developed and developing countries. As meeting SDGs requires huge amount of resources, and considering the fact that government budgets are limited, it would be critical to allow PPPs to flourish both in the core and non-core sectors. The Financing for Development (FfD) framework must help direct large-scale resources, perhaps USD2-3 trillion per year of incremental private and public saving, towards new investment programs directed at the critical sustainable development challenges. Most of these funds will flow through private intermediaries rather than governments and official institutions. Still they will have to be directed and mobilized with supportive public policies, including market signals and regulations. The incremental investment needs are high, but are still manageable. They constitute roughly 2-3 percent of global GDP, 9-14 percent of the roughly USD22 trillion in global annual saving, or 0.9-1.4 percent of the stock of global financial assets, which has been recently estimated at USD218 trillion (UN 2014).[9]

2.1.5 An important aspect of meeting the SDGs also relates to investment in the social sector projects. The Government of India has been supplementing the efforts of the state governments in this direction by providing budgetary allocation for the 'social sector' schemes. According to the latest World Bank data India spends 3.8 per cent of GDP on education and 1.4 per cent of GDP on health which is below the world average of 4.4 per

[8] www.sdgfund.org/goal17-partnerships-goals

[9] Guido Schmidt-Traub and Jeffrey D. Sachs.Financing Sustainable Development: Implementing the SDGs through Effective Investment Strategies and Partnerships, 2015.

cent and 6 per cent respectively. Also, according to the Human Development Report–2015 published by UNDP, India's Human Development Rank is 130. The following table shows the cross-country public expenditure on education & health.[10]

Country	**Education (%) Latest available period (2011-12)**	**Health (%) 2014**	**HDI Ranking**
India	3.8	1.4	130
Singapore	3.1	2.1	11
Sri Lanka	1.5	2.0	73
China	-NA-	3.1	90
Brazil	5.9	3.8	75
United States	5.2	8.3	8
Japan	3.8	8.6	20
Sweden	7.7	10.0	14
Canada	5.3	7.4	9
World	4.4	6.0	-NA-

Table 1: Public Expenditure as percentage of GDP

From the table it is evident that increasing public expenditure on social sector including health and education is critical to improve Human Development Index rank of the country and also attain SDGs, of which India has been a strong proponent.

2.1.6 Incentivizing PPPs in social sector, particularly in health and education can make significant contribution in exploring new ways for providing these services, as a

[10]Kumar Alok, NemaAjay, Hazarika Jagat, Sachdeva Himani, "Social Sector Expenditure of States,Pre& Post Fourteenth Finance Commission (2014-15 & 2015-16)", NITI Aayog

supplement to the public sector in making these services available to the under- served and unserved segments of the society. The quality of services provided by the public sector in these areas has been mostly unsatisfactory as most public sector managed projects are plagued with inefficiencies and ineffectiveness. This results in dissatisfaction amongst the users. Those who can afford turn to the private service providers, therefore, public services get restricted to only the poor and the marginalized resulting in moral questions like equity.

2.1.7 PPPs in social sector is also not a very new phenomenon as several government run schemes are being implemented in the PPP mode. Some of these are Mid-Day Meal Scheme, National Aids Control Programme and Central Government Health Scheme (CGHS)[11]. However, recent times have seen more innovation in designing PPPs and greater willingness on the part of the private sector and civil society to contribute their bit and partner with the government in providing services in the social sector. For instance, Tamil Nadu, has entered into a MoU with a private organization to provide Integrated Emergency Response Management Services bringing together the Departments of Medical, Health and Family Welfare, Police and Fire Prevention. This model has now been replicated in several other states, including Rajasthan. Others are Timarpur Waste to Energy Plant in New Delhi, Alandur Sewerage Project in Tamil Nadu etc. However, one of the leading questions on the minds of policymakers in both the developed and the developing countries is how to structure financially sustainable PPP projects in social sectors. To understand how social sector PPPs work, we need to look at the specific characteristics which guide such partnerships in these sectors and the challenges faced by them.

[11]Government of India, Planning Commission 2004, *Report of the PPP Sub-Group on Social Sector*, New Delhi.

2.2 Challenges of PPPs in social sector

2.2.1 PPPs have characteristics that do not easily fit into traditional governance structures. This poses challenges for sponsoring authorities. Some of these are:

(i) Social sector PPPs vs commercial PPPs: First and foremost is to differentiate the social sector PPPs from the commercial or economic PPPs as social sector projects are premised more on "value for people" than "value for money", requiring a completely different set of protocols for implementation and operation. Considering that predominantly financial viability parameter underlies the framework used for core sector PPPs, it is necessary to evolve new framework for social sector PPPs. Developing a sector specific or a project specific framework will ensure successful implementation of PPP social sector projects.

(ii) Financing of PPPs: In social sectors financing of PPPs is weak and the funding largely comes from the government. The reimbursements are made to the private sector if the targets and the standards set by the government are met. There are also restrictions on determining the 'user fees' and this impacts the financing streams of the project. Therefore, PPPs in social sectors can only succeed through government subsidy or the annuity payments being released by the government. The experience in social sector PPPs shows that the bidders often tend to bid lower than the financial viability of the project to bag the project, mostly because data availability for proper financial structuring is inadequate. Once the project is in construction or operational phase and revenue gaps appear, the bidders clamour for re-negotiating the terms of the contract. More than 25 social sector PPP projects have been granted additional funding under the VGF scheme during December, 2005 to August, 2017 period. Therefore, monitoring, which is complex for social sector PPPs, is critical to ensure that the beneficiaries are receiving the prescribed quality of care required under the contracts throughout the lifecycle of the project.

(iii) Allocation of risks: Risks related to social sector PPPs are more complex and require a different approach, with public partner taking a larger share of risk for these to succeed. There is also a need to continuously re-appraise the project contours in the light of better availability of data and the changing ground realities. One of the major reasons for private sector losing interest in a social sector PPP is because "service delivery price is set by the public sector while demand risk is borne by the private sector". For instance, tariff for water supply is set by the government. Over-optimistic demand projections lead to unrealistic revenue expectations and poor project appraisal. The disconnect between cash flows expected to reach the desired level of financial viability and achieved cash flows, has not been addressed fully. There is need for the public sector to equally bear the risk by guaranteeing a minimum number of users for a particular service or by bearing the financial burden if the required targets/ numbers are not achieved.

(iv) Benchmarking: While developing the social sector PPP framework, it is critical to develop Public Sector Comparator, which will give the sponsoring authority to be satisfied that private sector bids are reasonable and that the proposed PPP would give "value for money". No effort has been made to develop such comparators for the social sector PPPs as yet, for instance in the area of health services and education. Once such comparators are available, it would be easy to widen the scope of PPPs in more complex social sector projects.

(v) Absence of Single Window Clearance mechanism: One of the most relevant factors for the success of PPPs in social sectors is obtaining timely approvals and clearances. In the absence of a real single window clearance system the private partner is required to connect with different agencies which is time consuming and costly. As the financial viability in most cases is slim, delay in regulatory or administrative approvals adds to the cost, adversely affecting viability.

(vi) Dispute Resolution: Social sector PPP projects often lack financial viability and in the long run are more prone to disputes between public and private parties. This arises from conflict of interest in the case of the government, which is both the regulator and the service provider (partner), making the partnership unequal. It is further compounded by the unwillingness of the public (users) to pay and the over-estimation of demand by both the public and the private partners.

2.2.2 The Paper by Cook Jacques [12] describes the challenges that impact the implementation of PPPs in social sector. It states that social sectors present a unique set of problems for PPPs that distinguish them from conventional PPPs in the economic sectors. Understanding and dealing with the special challenges facing policymakers in the social sectors is vital to developing and planning viable social sector PPP programmes and projects. The main factors to be considered are the following:

(a) Segmentation of beneficiary class: As noted in the preceding paras, this paper highlights that the services in social sectors, such as, health and education are structurally segmented. It is the people at the bottom of the pyramid, who largely avail of these public services, due to affordability issues. This makes PPPs in social sector politically sensitive as people using these services are also the voters. In general, PPPs are seen as 'privatization' and with that comes the perception of exploitation and higher user charges, with little understanding that PPPs involve full retention of responsibility by the government for providing the services. Under the PPP format, the government role gets redefined as one of facilitator and enabler, while the private partner plays the role of financier, builder, and operator of the service or facility. PPPs aim to combine the skills, expertise and experience of both the public and private sectors to

[12]Cook Jacques, "PPPs in the social sectors: education and health", Public Private Partnerships, White Paper Series, Institute of Public Private Partnerships (IP3)

deliver higher standard of services to customers or citizens. The public sector contributes assurance in terms of stable governance, citizens support, adequate financing and also assumes social, environmental, and political risks. The private sector brings along operational efficiencies, innovative technologies, managerial effectiveness, access to additional finances, and construction and commercial risk sharing. This means that PPPs are critically dependent on sustained and explicit support of the sponsoring government. To deal with these procedural complexities and potential pitfalls of PPPs, governments need to be clear, committed, and technically capable to handle the legal, regulatory, policy, and governance issues.

(b) Performance indicators: In the social sectors, measuring the performance of the PPP against realistic performance indicators is complicated and critical. Auditing contract performance in these sectors is more complex because of the difficulty of establishing clear benchmarks and measuring the key performance indicators. Therefore, it is important that the monitoring is either done by a Government agency or a Third Party to ensure that the service level standards set by the government are being met by the private partner.

(c) Regulatory risks. Economic regulation in the infrastructure sectors is an integral part of the PPP process. The usual approach in PPPs is for the private sector to develop and operate facilities while the public sector focuses on supervision through regulatory agencies. Only a very few comparable regulatory frameworks and institutions exist in the social sectors. In the absence of these regulatory institutions, alternative independent monitoring mechanisms must be developed to fill that gap.

2.2.3 The other challenges mentioned in the paper, such as bankability of the project, stakeholder involvement etc. have already been covered in the above paragraphs.

2.2.4 The Government of India has acknowledged the role of the private sector as a partner in improving and expanding health services in the country. The National Health Policy, 2017 advocates a positive and proactive engagement with the private sector for critical gap filling towards achieving national goals. It envisages private sector collaboration for strategic purchasing, capacity building, skill development programmes, awareness generation, developing sustainable networks for community to strengthen mental health services, and disaster management. The policy also advocates financial and non-financial incentives for encouraging the private sector participation.

2.3 Case for Rajasthan

2.3.1 The National Family Health Survey, 2015-16 (NFHS-4), provides information on population, health and nutrition for India and for each State/Union Territory (UT). NFHS-4 for the first time provided district wise estimates for important indicators. The last survey was conducted ten years ago, i.e, in 2005-06. The key observations as per NFHS-4 for Rajasthan were as under[13]:

(i) NFHS-4 for Rajasthan was conducted from January 23 to July 21, 2016 by the Indian Institute of Health Management Research (IIHMR), which gathered information from 34,915 households (41,965 women and 5,892 men).

(ii) Infant Mortality Rate (IMR) took a dip from 65 per 1,000 live births to 41 per 1,000 live births in the previous ten years.

(iii) NFHS-4 observed large difference in IMR in rural and urban areas. In rural areas, IMR is 44 deaths per 1,000 live births and in urban areas, it is 31 deaths per 1,000 live births.

(iv) Under age 5 Mortality Rate (U5MR) also witnessed a dip of 34 points in the state in the past ten years from 85 per 1,000 live births to 51 per 1,000 live births.

[13] https://www.rajras.in/index.php/national-family-health-survey-nfhs-4-rajasthan/

(v) As per the Survey, higher percentage of women in urban areas received maternal and child care in comparison to their rural counterparts. The difference between urban and rural women getting maternal treatment indicated that the latter are yet to get the same kind of health facilities which the urban women were getting.

(vi) Percentage of children in urban areas receiving vaccination against diseases was higher in comparison to children in rural areas. NFHS-4 showed that 53.1 per cent of children (12-23 months) in rural areas were fully immunized whereas 60.9 per cent of children in urban areas had received vaccination.

(vii) There was also a decline in the percentage of women suffering from anemia. Ten years ago, 52.6 per cent non-pregnant women and 61.7 per cent of pregnant women were anemic but as per the Survey, it reduced to 46.8 per cent among non-pregnant women and 46.6 per cent among pregnant women.

(viii) As far as access to healthcare facilities is concerned, more women had access to institutional health care. In 2005-06, 29.6 per cent of the total childbirths were institutional. This had increased to 84 per cent in 2015-16. Additionally, 86.6 per cent of births were assisted by doctor, nurse or other trained personnel in comparison to only 41 per cent a decade ago.

(ix) The state witnessed a sharp decline in the Total Fertility Rate (TFR) over the past ten years. Rajasthan's TFR had come down to 2.4, which was still higher than 2.1 - the goal for achieving a stable population growth according to the WHO.

2.4 NITI Aayog's Health Index

2.4.1 As economic growth witnessed in India is yet to translate in improving the health indicators in our country, NITI Aayog has spearheaded the Health Index initiative, to measure the annual performance of states and Union Territories (UTs), and rank states on the basis of incremental change, while also providing an overall status of states' per-

formance and helping identify specific areas of improvement. Multiple stakeholders were involved in the development of this Index, such as the World Bank, Ministry of Health and Family Welfare, United States Agency for International Development (USAID) etc.

2.4.2 States and UTs have been ranked on a composite Health Index in three categories (larger states, smaller states and UTs) to ensure comparison among similar entities[14]: With a focus on outcomes, outputs and critical inputs, the main criteria for inclusion of indicators was the availability of reliable data for the states and UTs, with annual frequency. The Index is a weighted composite Index based on indicators in three domains: (a) health outcomes; (b) governance and information; and (c) key inputs/processes, with each domain assigned a weight based on its importance. The indicator values are standardized (scaled 0 to 100) and used in generating composite index scores and overall performance rankings for base year (2014-15) and reference year (2015-16). The annual incremental progress made by the states and UTs from base year to reference year is used to generate incremental ranks.

2.4.3 The top five performing States in the reference year based on the composite index score are Kerala (76.55), Punjab (65.21), Tamil Nadu (63.38), Gujarat (61.99), and Himachal Pradesh (61.20). On the other end of the spectrum, Uttar Pradesh (33.69) scored the lowest and ranks at the bottom preceded by Rajasthan (36.79), Bihar (38.46), Odisha (39.43), and Madhya Pradesh (40.09). The Empowered Action Group (EAG) states (except Chhattisgarh) and Assam lie at the tail end of the distribution, ranking between 14th and 21st positions.

2.4.4 Among the 21 larger states, only five States improved their position from base to reference year. These States are Punjab, Andhra Pradesh, Jammu & Kashmir, Chhattisgarh and Jharkhand. The most significant progress was observed in Jharkhand and

[14] http://social.niti.gov.in/uploads/sample/health_index_report.pdf

Jammu & Kashmir. Both States moved up by four positions in the ranking. Meanwhile, Punjab improved its performance in the ranking by three positions. Andhra Pradesh and Chhattisgarh have shown modest improvement – both up by one position. Despite increases in the composite Health Index scores, the rankings of Maharashtra, Madhya Pradesh, Bihar, Rajasthan, and Uttar Pradesh did not change between base and reference years. Kerala continued to be at the top position and the remaining states fell in ranking by 1-2 positions.[15]

2.4.5 Therefore, Rajasthan was chosen as the state to study the implementation of PPPs in PHCs and whether it has been beneficial to the people of the state in contributing towards betterment in the provisioning of health services.

[15] Ibid

Chapter 3

Contracting Primary Health Centres under PPP mode in Rajasthan - Case of Rural PHCs

3.1. Model adopted by the State Government

3.1.1 **Project and its objectives:** The PPP policy of the government was drafted in the year 2008[16]. The objective of the policy was to leverage the large pool of private capital as well as to introduce private sector-based efficiencies. A closer partnership between the public and private sectors can support sustainable development, reduce poverty and ultimately achieve greater prosperity. The government sought interest of the private sector to partner with the government to improve the availability and the quality of primary healthcare with a view to utilize technical, financial and managerial resources of the private sector for reducing existing gaps in public healthcare institutions and systems. To provide and facilitate increasing role of PPPs in managing existing public assets, the initial proposal was designed to invite suitable parties for operation and management of 300 Primary Health Centres (PHCs). However, after assessing the resistance to the idea amongst public representatives and community leaders against transferring the management of the PHCs to PPPs, 87 PHCs were subsequently excluded from the bid, reducing the number to 213. Later on, 30 more PHCs were added to the list taking the number to 243. However, looking at the process and also the RfP which had weaknesses, response from the private sector hospitals, medical colleges and NGO's was not very encouraging and in the final count only 41 PHCs were transferred for operation and management to qualified private parties across 19 districts.

[16] Planning Department. 2008.Public-Private Partnership Policy. Government of Rajasthan.

Approximately 10 poorly performing PHCs were selected from each district based on criteria such as poor institutional delivery, status of immunisation, number of families covered under family welfare measures, and number of In-patient and Out-patient Delivery (IPD/ OPD) in relation to eligible women. The bidders who qualified for managing these PHCs in PPP mode in the technical bid were then selected on the "lowest" (L1) financial bid.

The following PHCs were transferred to the private partners in 2015:

Sl No	Name of the private partner	Number of PHCs awarded
1	WISH Foundation	**22**
2	Geetanjali Medical College	**5**
3	Navrangram Dayaram Dukiya Sekshen Sansthan	**3**
4	Individual doctors	**11 (1 each)**

Table 2: Names of the private partners and the number of PHCs awarded

Source: Department of Medical, Health and Family Welfare, Government of Rajasthan

3.1.2 **Type of project envisaged:** The government invited private parties and NGOs for the operation, maintenance and management of 41 PHCs in the state as service and management contract PPPs. The period of the contract was to be for a maximum duration of five years. A two-stage selection process was followed: stage 1 -Technical Proposal for Qualification and stage 2 - Financial Proposal. Technical proposal for qualification was to contain a write up by the bidder with details of costs and contact details of the ongoing and completed projects of similar nature. The financial proposal was required to

indicate the per month expenditure for running a PHC in a given format. The applicant could be a Not for Profit or for profit legal entity, individuals with minimum qualification of MBBS (Bachelor of Medicine/Bachelor of Surgery) or a consortium thereof. The criteria for evaluation in the Request for Proposal (RfP) of 2015 were as follows:

Parameter	Marks	Maximum marks
Type of organization		
A Not-for-Profit Agency/ Group of Doctors' (with minimum qualification of MBBS each)/ an individual MBBS doctor/Private Limited/Company Ltd	20	**20**
A consortium	15	
Experience in government sector		
Experience of running government hospital (document to be attached in support of experience)	10	**10**
Agency having experience of running more than 10 bedded hospital (other than government hospital)	5	
Experience of operations and management of project		
Experience of managing more than 10 bedded hospital or government hospital-PHC/CHC for 1 year	M.O*-10 M.O.P.G*-15	**15**
Financial details		
Average annual turnover of up to INR10 million for the last 3 years	10	**15**
INR10 million or more	15	
Quality of technical proposal as assessed by evaluation team	20	**20**
MBBS and entrepreneur	10	**10**
High Priority District (HPD)	10	**10**
	Total	**100**

***M.O : Medical Officer; M.O.P.G-Medical Officer with Post Graduate Degree**

Table 3: Parameters for Technical Evaluation

Source: RfPof 2015

3.1.3 Manpower requirement in each PHC and sub Centres to be provided by the private partner as per RfP of 2015 was as given below:

Sl No	Designation	Minimum recommendation
1	Medical Officer	1
2	Grade II Nurse	2
3	Pharmacist	1
4	Lab Technician	1
5	Ladies Health Visitor (L.H.V)	1
6	M.P.W A.N.M (Female)	1
7	Data Entry Operator	1
8	Ward Boy	2
9	Sweeper	1
10	Total	11
	Sub Centre	
11	A.N.M	According to number of sub-centres under PHC
12	Total	16

Table 4: Manpower Requirement for running a PHC and Sub Centres

Source: RfP of 2015

3.1.4 Key Performance Indicators as per RfP (2015): Since health is a state subject, it is the responsibility of the state government to provide a list of performance indicators with threshold limits to measure the performance of the PHCs. Performance of the PHCs was to be treated as satisfactory if the assessment criteria of KPIs as given in Annexure III (Provision 5). were met. There were 11 KPIs with a total of 16 sub-parameters against which the minimum expected level of performance was to be measured. Criteria weight of work was to be determined on percentile basis. The performance assessment was to be

done on a quarterly basis by the Block Chief Medical Officer (B.C.M.O) based on data maintained by the PHCs. The KPIs took into consideration critical health indicators such as registration of pregnant mothers with the PHCs under KPI 3, which measures safe motherhood. This indicator required at least 95 per cent registration in the first year and after third year 100 per cent achievement was required. If successful, it would help the state in achieving the objective of reducing Maternal Mortality Ratio (MMR), which was 244 against the national average of 167 during 2011-13[17]. Similarly, the state through the PPP projects is encouraging cases of normal deliveries by striving to increase the number of institutional births to 200 in the first year and after third year 300 per year. Indicator 6.1 was kept in line with the state's goal of attaining the Total Fertility Rate (TFR) of 2.1 as given by the World Health Organization at the end of 4th year of operation of the PHC. The present TFR of Rajasthan stands at 2.7[18]. In KPIs 1 and 2, the criteria for assessment were average outpatients or inpatients per month including deliveries. Expected minimum level was kept to register all patients coming to OPD or IPD, which could be avoided by not registering some cases who come to the PHC. Government has the data of patients visiting each of these PHCs. An increase in percentage terms over the years could become measurable criteria in addition to stipulating that all patients should be attended to. KPI 7-1 described a minimum of fifteen types of lab tests that should be available in the PHCs. KPI-9 merely stated that there should be zero death due to negligence. As these PHCs are being run on the PPP mode, any death due to negligence on the part of the private sector partner could result in a huge liability to the government. Safeguards such as insurance cover or sharing of such liability on pre-determined criteria needed to be incorporated in the document.

[17] MMR per 100,000 live births. NITI Aayog, Government of India, 2017.
[18] http://niti.gov.in/content/total-fertility-rate-tfr-birth-woman

3.1.5 Request for Proposal (RfP) of 2017: Although the RfP issued by the government in 2017 was an improvement over the one issued earlier in 2015, it still remains a very elementary document. The evaluation criteria were revised significantly and weightage assigned to the kind of organization, experience and financial details was altered. The same is listed below:

Parameter	**Marks**	**Maximum Marks**
Type of organization		
A Not for profit Agency / Pvt. Ltd. Company/ Consortium	20	40
An individual MBBS Doctor/Group of doctors' (with minimum qualification of MBBS each)	40	
Experience		
Agency having experience of running Government hospital for more than one year (document has to be attached in support of evidence)	25	40
Agency having experience of running more than 10 bedded hospital for more than one year (Other than the Government hospital)	20	
Financial Detail		
Average annual turnover for the last three financial years (2013-14, 2014-15,2015-16) below 10 Million (assessment will be based on certificate issued by the CA) Individual doctor will have to submit 3 assessment year Income Tax Returns (ITRs) (2014-15, 2015-16, 2016-17)	10	20
INR 10 million or more attested by the CA	20	
	Total	**100**

Table 5: Parameters for Technical Evaluation

Source: RfP of 2017

3.1.6 Manpower requirement in each PHC and sub Centres to be provided by the private partner, as per RfP of 2017 is given as below:

Sl No	Designation	Minimum recommendation
1	Medical Officer	1
2	Grade II Nurse	2
3	Pharmacist	1
4	Lab Technician	1
5	Ladies Health Visitor (L.H.V)	1
6	A.N.M (Female)	1
7	Data Entry Operator	1
8	Ward Boy	2
9	Sweeper	1
10	Total	11
	Sub Centres	
11	A.N.M	**According to number of one A.N.M for each sub Centres under PHC**
12	Total	16

Table 6: Manpower Requirement for running a PHC and Sub Centres

Source: RfP of 2017

3.1.7 Further, in the RfP of 2017, in addition to only specifying the working hours, penalties for absenteeism were also specified. These deductions were to be made from the

monthly payments in case the absence was beyond paid weekly offs. These are enumerated below:

Name/post of staff	**Amount of deductions per day (Rs)**
Doctor	1500/-
Para - medical staff (GNM,L.H.V,A.N.M,L.T,Pharmacist and Data Entry Operator	500/- per person
Ward Boy and Sweeper	250/- per person

Table 7: Penalties for absenteeism

Source: RfP of 2017

3.1.8 The Key performance Indicators in RfP of 2017 were made more realistic as compared to the KPIs listed in RfP of 2017. The targets were moderately reduced as compared to the RfP of 2015 as can be observed from the list of KPIs as given at Annexure-IV.

3.1.9 The RfP of 2017 also listed several statutory requirements to be complied by the private partner, for example, implementation of the Minimum Wages Act, requirement of biomedical waste management, adherence to bio-safety etc. It also gave more control to the government in terms of specification of the clauses relating to (i) termination of the contract (ii) arbitration and (iii) application of law and jurisdiction of court. It addressed the process of payment to be followed by the government and the service provider in clause 8 of the RfP making it at the same time more predictable.

3.1.10 Analysis of main provisions of RfP's of 2015 and 2017 is as tabulated below:

Sl No	Salient features of RfP (2015)	Salient features of RfP (2017)	Remarks
1.	The evaluation of the technical proposal was kept simple and objective, except for the parameter on quality of the proposal to be evaluated by a team, which carried 20 marks and could be subjective.	This provision was removed from the RfP issued in the year 2017.	The revised RfP (2017) was an improvement over the earlier RfP as the weights for the technical parameters were refined considerably.
2.	The financial detail asking for a turnover of up to INR 10million or more being the minimum threshold for qualification was uniform for all areas, i.e., rural and semi-rural	-same as given in Col I-	There should have been some differentiation between these areas to capture real costs.
3.	The names of the High Priority Districts were not disclosed upfront for entities to make a choice at the time of the bidding.	The details of the PHCs and attached sub Centres along with the names of the districts were incorporated in the document.	RfP of 2017 was an improvement and was more transparent as it ruled out the possibility of all applicants getting the same score irrespective of their other qualifications.

4.	There was no specific provision in the KPIs to measure quality of service being provided by the private partner. The RfP document merely stated that the services should conform to the Indian Public Health Standards (IPHS)	-same as given in Column I-	It is important to develop a proper monitoring mechanism to assess the progress and also keep a vigil on the quality of services being provided by the private partner. IPHS standards are not easily verifiable.
5.	The document contained a provision for providing additional services at the rates agreed between government and private partner. However, it was not stated clearly as to what these additional services would be.	No such provision was kept in the RfP of 2017	The revised RfP did not contain this clause and reduced the speculation and ambiguity surrounding what was meant by these 'additional services.'
6.	It is stated in the RfP that District Health Society (DHS) would be the monitoring and funding body, which would monitor and evaluate the functioning of the PHC and attached sub Centres periodically. Third Party Evaluation will be conducted annually through empaneled Chartered Accountant audit and government audit.	-same as in Column I-	The manner in which monitoring is to be done or the parameters on which the inspections would take place does not adequately capture the quality aspect of the service.

3.1.12 There is no clearly stated risk sharing between the public and the private partner in the RfP issued by the government in 2015 as well as in 2017. This has been summarized in the following table:

Sl No	Government	Private Sector/Concessionaire
1.	**In both the RFPs, Scope of work given under section 2b states that the existing infrastructure of the PHCs, which include equipment, furniture, drug inventory, medical records and so on are to be handed over to the concessionaire.** **The manner of handing/ taking over has not been prescribed.**	The condition of the available infrastructure should have been ascertained and brought up to at least working condition level.
2.	**Services to be provided include minimum 15 types of lab tests** **There is no procedure to assess that the lab tests were done in all cases, when necessary.**	There is no commitment on the part of the government for providing reagents and consumables. The RfP merely states that the "Money granted from GoI such as untied fund, annual maintenance fund, corpus grant fund is to be given to the service provider, which will then be adjusted for payments to be made by the Department of Medical, Health and Family Welfare."

3.	**While a minimum number of personnel in each PHC was prescribed, the qualification of each personnel has not been prescribed for each category.**	The qualifications of recruited staff should be commensurate with the qualifications required for similar staff in government managed PHCs
4.	**In the RFP of 2017, government has prescribed the private partners to abide by several statutory provisions, such as, adherence/ compliance with all provisions of Minimum Wages Act, biomedical waste management, bio-safety, environmental safety and firefighting system.**	It is difficult for private partner to identify all the provisions of different acts that govern the waste disposal and safety aspects. Government should have converted the statutory provisions into service level standards for greater clarity and more effective monitoring.
5.	**The financial bid in both the RfPs has been designed on benchmark costing of the average expenditure incurred by the government on running of the PHC. However, the bid parameter was the lowest bid offered below the benchmark cost.**	This has serious implications on quality of services offered as the private parties offering the bid would be tempted to offer low bids by cutting expenditure on salaries etc. and by hiring staff which may be less qualified and experienced.

6.	**The qualified bidders have been selected on the basis of their lowest financial bid. In other words, the government is to pay the agreed bid amount on satisfactory performance of the tasks each month. The payment mechanism prescribes submissions of deliverables and Statement of Expenditure (SOE) for the release of payments. No useful purpose would be served in comparing the SOE with what was submitted as the financial bid**	The financial bids are to be submitted on the basis of estimated expenses on salaries for prescribed number of personnel, administrative expenses, maintenance expenses and miscellaneous expenses. In the absence of details of infrastructure to be provided by the government, it would be difficult to estimate the maintenance costs. Again, in the absence of details on number of patients, both OPD and IPD, to be attended to by the PHC and the availability of the equipment and machinery in the PHC, it would be difficult for the bidder to estimate other costs such as administrative, maintenance and miscellaneous expenses. No penalties have been fixed for delays in payment by the Government.
7.	**This is a PHC run by the private sector. Any act of negligence will entail a huge cost on the exchequer, and therefore there is substantial contingent liability from the first day of PPP operations. Merely stating that this is the responsibility of the service provider is a weak legal formulation.**	On paper, the liability is on the private partner, but as the ultimate responsibility for delivering the services lies with the government, contingent liability of the latter can be substantial.

8.	**No provision has been kept for continuous verification that patients are not diverted to private clinics/hospitals/unqualified persons.**	
9.	**No provision has been kept where private partner is given incentives in case the performance exceeds the predetermined targets, whereas, penalties have been incorporated in the RfP in case of absence of staff beyond the stipulated period of holidays.**	
10.	**The RfP does not make any distinction in the provisions for serving in remote and inaccessible areas where operational difficulties for private partner would be greater than those in the semi-rural areas.**	
11.	**No turnaround time, i.e., time for attaining stability has been specified in the RfP, after the PHC is handed over to the private sector.**	The process of handing/taking over is not always smooth and therefore it would be appropriate to build this provision into the RfP.

12.	**Concessionaire may resort to borrowings; for which the risk is to be fully borne by the concessionaire as the government would pay the contracted amount based on satisfactory outcomes. However, there is no provision for government paying the debt due in case of its default under the contract, leaving financial risk uncovered.**	This would make accessing institutional finance difficult.
13	**No provision of any escalation of costs over the concession period owing to inflation has been factored in the RfP.**	

3.1.13 Whereas the objective of harnessing private sector efficiencies in improving primary health services is laudable, the structure of PPPs designed for PHCs in Rajasthan needs improvement by factoring in the various shortcomings that have been listed above. PPPs cannot succeed unless the financial structure in the design is thought through and takes into account detailed costs, both capital and revenue, and the sources of revenues which would plug the gap. Assumptions without underlying credible data also lead to faulty design.

Chapter-4

Contracting Primary Health Centres under PPP mode in Rajasthan - Case of Urban PHCs:

4.1.1. Model adopted by the State Government: In 2017, the government proposed bidding for 50 Urban PHCs (UPHCs) on PPP basis. The Expression of Interest (EoI)[19] and Service Level Agreement (SLA)[20] were published in June 29, 2017 which were improvements over those issued for rural PHCs. The EoI and SLA were for operationalization and maintenance of Urban Primary Health Centres (UPHCs) and attached health kiosks under PPP mode. The EoI and SLA are placed at Annexure-V and Annexure-VI respectively.

4.1.2 Ordinarily in PPP projects, an EoI or RfQ is issued first, which qualifies candidates for the next stage where RfP along with Draft Concession Agreement (DCA) is issued to the shortlisted entities. In the instant case the EoI and SLA, akin to the DCA, were issued on the same date. As stated in the EoI, "the proposed PPP was seen as a measure towards facilitating and building capacity of the state to manage UPHCs through active community engagement".

4.1.3 The EoI, inter-alia, states that government views the arrangement as Public Private Partnership in the Public Health System and such a partnership is seen as a step towards strengthening the public health system and as a measure towards facilitating and building the capacity of the state to manage such facilities by demonstrating models for comprehensive UPHC, with emphasis on active community engagement. It also states that

[19]Department of Medical, Health and Family Welfare. 2017. Invitation for Expression of Interest for PPP Project for Improvement of the Health Delivery System in Urban Areas of Rajasthan. Government of Rajasthan.

[20] Department of Medical, Health and Family Welfare. 2017. Service Level Agreement. Government of Rajasthan.

spirit of such partnership is essentially to share risks and rewards in such a manner so that comprehensive primary health care can be provided to those who need these services. Government recognizes that such partnerships with organizations that have competence and credibility offers the government avenues to leverage the knowledge and expertise of such organizations to improve the management and delivery of comprehensive primary health services. Thus, at least on paper, i.e. in the EoI, the private sector has been identified as a 'partner' and not 'vendor'. In the document (EoI), it has also been clearly stated that "such partnership should not be seen as a measure of the government abdicating its responsibility to provide public health services, but rather as a transitional measure towards facilitating the state to be able to manage such facilities after the term of the partnership ceases.''

4.1.4. Further, as per the EoI, the selection methodology entailed:

- Formation of a technical committee of experts with 5 members comprising both internal and external experts. The number of external experts was kept at (at least) two.
- Evaluation on five criteria such as organizational work in clinical areas, range of services provided, outreach/community-based services, staffing and undertaking community level public health interventions, with 20 points or marks for each criterion.
- The technical committee was to meet before opening of the bid to review the criteria and assign weightage based on which the proposals would be ranked.
- The technical committee was to rank the proposals based on the criteria decided beforehand by awarding a score for each criterion. The first three ranked proposals were to be shortlisted for field appraisal and the technical committee was also required to devise a scoring system for field appraisal.

- Final ranking was to be done by adding the rank and field appraisal scores.

4.2. Scope for improvement in the EoI

As per the model RfP document of the Government of India, the bidding process for selection of the private partner for undertaking a PPP project is divided into two stages. The first stage is referred to as Request for Qualification (RfQ) and is aimed at pre-qualification and short-listing of eligible bidders for the second stage of the process which is referred to as the Request for Proposals (RfP). The RfP process is aimed at obtaining financial offers from bidders who have been short-listed at the RfQ stage. In the instant case, this two-stage bidding process was not followed and hence the method was not completely transparent and left scope for subjectivity in assignment of scores and weights which were not disclosed upfront.

4.2.2. As in the case of rural PHCs, in this case also, the financial bid had been designed based on the benchmark costing of the average expenditure incurred by the government on running of the PHC. Although, there was no financial bid but if financial bids were to be invited with the same set of information and documentation, the government may have gained if bids for sums lower than what has been indicated by the government were received. The government could always reject the bids if these were for amounts far higher than government's own estimates or too low to inspire confidence in the bidder's capability to deliver. However, more pertinent question is on 'costing' and 'effectiveness' which has not been taken into account while formulating the RfP's for both the rural PHCs and EoI issued for UPHCs and that the approach of the government is limited to the 'savings' which could accrue to the exchequer by handing over PHCs to the private partner.

4.2.3. It is also stated in the model RfP document of the GoI that the selection of the private partner holds the key to the success of a PPP project since the cost and quality of service to users over a long period would depend on the performance of the private

partner. A flawed selection process could, therefore, jeopardize the entire project. However, Clause 1.9 of the EoI flies in the face of the logic of private participation. It would either attract only philanthropic organizations thereby reducing the possibility of scaling up the model or encourage private sector to dishonestly make profits through creative accounting.

4.2.4. It is important that the RfP document is fair, predictable and competitive as it ensures that the perils inherent in selection through negotiations or limited competition are eliminated and the public exchequer and users are assured of paying a competitive price for quality services. However, the EoI leaves room for unpredictability as the government reserves the right to decide on the number of facilities for which concession to operate and maintain will be awarded to any concessionaire.

4.2.5. As per clause 1.6, the partnership is initially for a period of three years and extendable for another two years, subject to review and confirmation of arrangement after one year. The length of concession period is an important factor in the PPP contracts, especially in commercial sector PPPs. In case of the commercial sector PPPs, there are several approaches, such as Net Present Value (NPV), Internal Rate of Return (IRR) etc. to ascertain the benefits that could accrue to the government and the concessionaire over the concession period. The purpose is to allow the private sector partner to earn a reasonable rate of return on its investment and also to adequately share the risks. Although, these principles do not fully apply in the instant case of a social sector PPP, the limitation is that the concession period is too short and may not encourage the private partner to invest in the project adequately.

4.2.6. There are several other problems associated with this EoI which are similar in nature to the RfPs issued by the government in case of rural PHCs and these are: (i) the private partner has not been allowed to earn any return on its investment (ii) costing has

been determined by the government (iii) user charges cannot be levied (iv) risks have not been adequately shared between the government and the private partner (v) there is no provision of any incentive , in case the targets as specified by the government are met/ exceeded (vi) there is no provision of any escalation in the costs over the concession period owing to inflation.

4.3. **Salient features of the Service Level Agreement (SLA):**

- Aim of the agreement was to enhance health and well-being of the people by providing high quality services, innovation and development and to meet identified needs within the resources available to both the parties.
- The services to be provided would include comprehensive health care package encompassing community outreach, behavioural change, communication for promoting positive health, clinical and public health services.
- The concessionaire was to establish a Rogi Kalyan Samiti (RKS) / Rajasthan Medicare Relief Society (RMRS) within the UPHC as mandated in the guidelines and in the manner similar to that being run by the state government for a similar level of facility.
- The concessionaire was also expected to establish a transparent and "open to public" grievance redressal system within the facility and grievance was to be addressed within 24 hours.
- The concessionaire was to agree that the concession granted will not be treated as a business venture and would not be used to make profits.
- The SLA provided for transitional arrangements for handover/ takeover of the infrastructure facilities on an as-is-where-is basis.
- As regards the financial arrangements, the fixed budget earmarked for each PHC and Health Kiosk (if any) was to be paid in four advance installments

at three-month interval against equivalent bank guarantee. Advance amount was to be kept in a separate account opened exclusively for this concession.

- Quality and hygiene standards were to be at par with the National Quality Assurance Programme and even hospital waste disposal had to conform to norms as specified by the state pollution control board.
- Monitoring mechanism comprised UPHC level management committee with representative of the state government which was mandated to meet at least once in a quarter. There was also a provision for monitoring by a steering committee at the state level, although the periodicity was not clearly stated.
- Evaluation of performance by the government was to be done through the assessment of KPIs.
- Payment of INR25,000/- for each default communicated to the concessionaire and the termination for failure to fulfill its obligations provided in the SLA were stated clearly as penalties. The government was however free to recover any loss it may have incurred due to the sudden termination of the agreement. This was an open-ended contingent liability on the concessionaire. The concessionaire could also terminate the agreement by giving three months' notice and stating its reasons for seeking termination.
- Annexure F of the SLA captured the performance indicators including details of personnel availability, the key to the service level achieved by the concessionaire.
- The SLA also attempted to encourage innovative measures and information technology to improve quality of service.

4.4. Scope for improvement/shortcomings in the SLA

- The private partner was expected to provide a lot more services in running of the PHCs and health kiosks whereas the total funding specified in Annexure D of the EoI didn't take into account the cost of these additional services which the private sector partner is expected to provide.
- In clause 2.14 of the SLA, it was specified that wherever required the UPHC could be run in a rented building but who would pay the rent was not clearly specified.
- The risks had not been allocated adequately between the government and the private sector and even though private partner does not have an appetite to take on higher risks in social sector PPPs as these cannot be run profitably, the government had assigned too many risks to the private partner.
- Annexure D of the SLA gave the break up and details of total funding cost of each PHC at INR 2.16 million including INR1.89 million as personnel cost. Hence no financial bids were to be invited. There was no provision for escalating this cost, to adjust for inflation, over the contract period except for increasing staff salaries by a maximum of 5 per cent based on satisfactory performance in the previous year.
- The issue of contingent liability of the government for negligence of the concessionaire had also not been addressed in the SLA.
- No penalty on the government for default of its obligations had been specified which gave the government machinery leeway to delay the processes relating to payment to the private partner for the services rendered.

Chapter -5

Filed Visits and validation of analysis of secondary data sources

5.1 Field Visits

5.1.1 To understand and validate the analysis based on secondary data on how PPPs in PHCs are working in the state, field visits were undertaken at 3 PHCs - two in rural areas and one in an urban area. Interaction with state government officials, medical officers and staff of the PHCs, representatives of the private sector partners and also with the beneficiaries was undertaken. General view of the officials who have been associated with the project and of the people at large in all these PHCs is that PPPs are working well in the state despite low political acceptability and resistance from local leaders and government staff who is moved out of the PHCs after the private partner takes over.The antagonism towards PPPs is also because of the lack of understanding about the nature of partnership arrangement with the private sector. PPP is often viewed as 'privatization' by the local political leadership and private 'partner' is treated as a 'vendor' by officials of the Department of Medical, Health and Family Welfare. Not enough effort has gone into advocacy and public education to convey that that PPP is not privatization and that these are long term contracts between private parties and government agency, for providing public service, in which the private party bears significant risk and management responsibility and remuneration is linked to performance but the service level standards are set by the government and the infrastructure also belong to the government and that the ultimate responsibility for providing health services still remains with the government.

5.1.2 PPPs are also seen as a source of extra-budgetary resources for the government resulting in savings that can be utilized for expanding services. The efficiency gains that come through private partner are not acknowledged or captured in the official narra-

tive. The emphasis on cost cutting (as captured in the lowest financial bid parameter) puts the private partner at a disadvantage as they are expected to cut costs while providing better services. There is also no benchmark in terms of Public Sector Comparator which could determine the baseline for the costing which could be used at the time of the RfP /award of the project.

5.2 Visit to Rural PHC in Rampura Dabri , District Jaipur

5.2.1 The private partner for the PHC concerned is Jankalyan Rehabilitation and Development Society. It is operating and managing 8 PHCs, viz. in Barundi and Luharikaran in Bhilwara district, Mandota and Rampura Dabri in Jaipur -1 and Bagawas in Jaipur 2, Lahsoda and Rawajna in Sawai Madhopur district and Kalmanda in Tonk district. The staff strength of the PHC is that of eleven (11) which was in full attendance on the day of the visit. The Medical officer employed by the private partner was a retired government doctor. Interaction with patients present at the time revealed that they were very satisfied with the services being provided by the PHC. However, they were not aware that the PHC was being run on the PPP mode. Further, they had no understanding of what PPP means. Their interest was in the quality of service and not in who was running the PHC. The beneficiaries believedthat the improvement in services was on account of strict action by the government resulting in regular availability of the doctor and the staff at the PHC. However, there was some concern about the condition of infrastructure. This PHC was put on PPP mode in 2016, prior to which it was a sub centre. The upgradation of the sub centre to PHC has not led to any improvement in the infrastructure of the hospital. The OPD has seen significant improvement and on an average 70-80 patients avail of this service every day. Patients also come from the other adjoining areas to the PHC despite the fact that there is a CHC in Chomu which is only 7 kilometers from this location. We were told that fifteen lab tests, such as blood sugar, blood grouping, urine etc were being conducted at

the PHC in accordance with the RfP requirements. It was noted that the lab technician needed training on the disposal of the bio-medical waste as he was unaware of the protocol to be followed for this purpose.

5.3 Visit to Kalmanda PHC in Tonk district

5.3.1 A surprise visit was undertaken to this PHC which appeared not to be functioning so well as the private partner was found to be grappling with several issues, the foremost was that of retaining the doctor itself who is looking for better job opportunities. There were a large number of staff which was on leave that day, while the doctor in-charge was away to Jaipur for taking an exam. The staff at the PHC informed that the handing/taking over of the PHC only materialized six months earlier after a lot of resistance from the government staff who was being moved out. Response of the beneficiaries was mixed as some of them were of the opinion that the PHC was functioning in a better manner when it was with the government and some others felt that the services being rendered now were better. The local politicians also seemed to be against the move to handover the PHC to the PPP partner. It was evident that there was a concerted effort to destabilize the PPP. During the visit, a group of motivated young boys came to the PHC to protest against the staff. They complained that the services that were rendered by the government staff when the PHC was run by the government were superior to the ones being provided by the PPP partner. There were other issues also. For instance, no training was given to the staff of the PHC for segregation and disposal of the bio-medical waste. Due to connectivity issues, there is no system for collection of bio-medical waste from the PHC which is dumped in a pit in the open. This may result in a health hazard for the residents of the nearby villages in future. However, it must be noted that this problem would be generic for all PHCs and is not specific to this PHC being run in the PPP mode.

5.4 Visit to Urban PHC in Raghuvihar, Jaipur

5.4.1 This PHC is newly constructed and was inaugurated in February, 2018. It is being run by Apollo Hospital as the private partner. The staff was in full attendance, except for a lab technician, whose post is lying vacant amidst the ongoing shortage of lab technicians across the country. Although the visit was deliberately conducted during the evening OPD timings (4:00 pm to 6:00 pm). The OPD at the PHC varies from about 40-50 patients per day, which is below the target of 70-75 patients a day. The Medical officer and the staff stated that one of the reasons for the relatively low OPD is that the entire team, including the Medical officer were occupied with the field visits for conducting the survey on swine flu, which had affected the state.

5.4.2 Most impressive of the lot were the A.N.M workers whose enthusiasm is laudable. Despite the meager salary of around Rs 6300 per month, the motivation level of these A.N.M workers was impressive. There is also a provision of specialist doctors like gynecologist, pediatrician, dermatologist and ENT doctors visiting the PHC every Thursday. The state government pays the visiting doctors Rs 2000/- per visit. The pharmacy at the PHC was also in a good condition and no shortage in the supply of the medicines was noticed. The medicines prescribed by the doctor are entered in the E-Aushudhi portal of the state government which then reflects the status of the medicines issued and available with the PHC. Positive feedback was received from a few beneficiaries who were satisfied with the services being provided, however, the grudge was that the tests cannot be conducted at the PHC as the Lab Technician has not been appointed.

5.5 Interaction with senior officers of the state government

5.5.1 It helped in putting things in perspective. There is acceptability of the fact that there is lack of capacity and understanding within the state government officials about PPPs. As a result, the RfP, EoI and other documents had a design flaw when they were first introduced. Based on the feedback of the private sector partners, the RfP issued in

2017 (both for rural and urban PHCs) was improved upon but a large number of gaps still remain and need to be plugged. It also emerged from the discussions that perhaps it was not the right decision to transfer PHCs to PPP partners in easily accessible areas as government staff tends to gravitate towards such PHCs and there is resentment when private partner takes over. There is also a greater competition from private hospitals that tend to be located in easily accessible areas. Positive results have been observed in the PHCs located in the remote areas, where government staff is generally absent and people do not have access to other medical facilities. It is seen that the success of PPPs primarily depends on the private sector partner and their experience in the health sector, and that lowest financial bid principle mostly results in selection of wrong private sector partners who bag the project by bidding at low rates but later find it difficult to deliver the services as per defined standards.

5.5.2 From the interactions, it also appears that there is resistance from the staff within the Department of Medical, Health & Family Welfare against the PPPs, which are not seen as 'partnerships. These are seen as 'outsourcing' of activities to reduce the financial burden on the state exchequer. As a result, the attitude is negative and that is also one of the factors that often leads to unnecessary objections in processing expenditure claims of the private sector partners resulting in delayed payments, sometimes up to a period of 4-5 months. Unless, regular monitoring takes place at a fairly senior level, this issue can go unaddressed which would then demoralize the private partner.

5.5.3 The discussion also corroborated the view expressed by the other players that the biggest impediment to this process are the local politicians, community leaders and the government staff who fear being transferred after the takeover of the management by the private sector partner and they then engage in politicking and bring pressure to end PPPs. Therefore, there is a need to create awareness amongst people that PPP does not

mean ‘privatization’ and that the control and responsibility still rests with the government. There are success stories that clearly establish the utility of PPP PHCs and these have also been part of the discourse at the highest levels of policy making. For instance, in a place called Richha in Dungarpur district, institutional delivery took place after 40 years since the opening of the PHC only after it was assigned to a PPP partner. It is also being acknowledged that it is challenging for both the public and the private sector to appoint full time staff in the remote areas but as private sector is held accountable more vigorously, they still manage to do a better job in the appointment and placement of staff as compared to the public sector.

5.6 Interaction with the private sector partners

5.6.1 Discussions were held with representatives of two private sector partners, viz, WISH Foundation and Chitraansh Education and Welfare Society. The issues which emerged were several and diverse and ranged from lack of understanding of the concept of PPPs to focus on ‘savings’ by the government rather than bringing in ‘efficiencies’ of the private sector. Costing of running a project is not taken into consideration while deciding the benchmark rates for running the PHC. Further, treatment of the private partner as a contractual vendor by the government officials also work to the disadvantage of the private partner as providing services in the remote areas is in any case very difficult and requires a much closer partnership between the two. The private partners also feel that the RfP did not offer any ‘incentive’ in case the performance exceeds the defined standards, whereas, there are a large number of penalties listed in the document for things that are sometimes beyond their control. Erratic fund flow to the private partner also results in deterioration in services. Representative of WISH Foundation stated that since they get funds from the owner who is based in the United States of America, they can still manage to run the show. They also have the advantage of having assisted Delhi government in setting up

Mohalla clinics and have presence in five other states, viz, Andhra Pradesh, Karnataka, Delhi, Assam and Uttar Pradesh where the foundation is providing technical support to these governments in improving health services, which gives them an advantage of vast experience. In this context, the RfP for the urban PHCs has a clause which mentions that the fixed budget earmarked for each urban PHC and health kiosk in the state would be paid in four advance installments at three months interval against equivalent bank guarantee. This allows the private partner to continue to function even if reimbursement of costs gets delayed. They also felt that monitoring at the district level needs to improve. The government has not encouraged third party evaluation till now. Policy uncertainty also plays on the mind of the private partner and is a demotivating factor.

5.6.2 There is also a surfeit of reports that need to be filed on a daily, weekly and monthly basis. In all, it was stated that a total of 58 reports have to filed by each private partner. Whilst this may also be true for the government run PHCs, the method of costing does not allow the private party to book the additional cost of manpower required for this purpose.

5.7 Evaluation of the functioning of PHCs is at a nascent stage and there is no conclusive evidence on the success rate of PPPs in PHCs. However, the officials of the National Health Mission who are associated with the rural and the urban PHCs which are being run on the PPP mode estimate that about two third PHCs in rural areas are being run efficiently and one third PHCs are not doing so well. In case of rural PHCs, the data available with the Department of Medical, Health and Family Welfare for the period June, 2016 - June, 2017 shows that in the 41 PHCs which went on PPP mode in 2015, the number of patients in OPD increased by 1.90 times or from an actual number of 3, 21,844 patients to 6, 11,096 patients. In case of the IPD, increase was that by 4.46 times as the number of patients in IPD was increased from 6,207 patients to 27,689 patients. The state gov-

ernment officials also were of the view that the urban PHCs are more successful than those in the rural areas. The reason attributed for non -performing PHCs is the lack of adequate resources, including man-power.

Chapter -6

Recommendations

6.1 Based on the analysis of the documents related to PPPs in PHCs in the state, field visits to a few PHCs - both rural and urban, detailed discussions with officers who are and have been associated with this project, officials of Department of Medical, Health & Family Welfare, representatives of private partners and the beneficiaries ("patients"), the following are the suggestions and policy recommendations which may be useful for the state government to improve the design of the EoI/RfQ, RfP and other related documents and also in structuring the PPP projects in a better manner which may improve the private sector participation and result in better delivery of services bringing greater gains for all the stakeholders:

(i) **Capacity Building:** Whilst this is one of the most significant aspects for the success of PPPs, it is largely ignored. Investment and effort in developing capacities in public functionaries, technical personnel and private partners is necessary for any PPP project to succeed. For this the PPP cell in the state government should be strengthened and strategic partnerships with training institutions, both public and private, should be entered into for designing and managing capacity building programmes in areas such as contract management on a regular basis. The courses must also lay special emphasis on developing right attitude in the public officials in their dealings with the private sector in a partnership.

(ii) **Project Design Development:** As PPPs are complex, the ab initio designing of the project is critical for the future success of the projects. The capacity within the public agencies for designing complex PPP projects, including the Detailed Project Report (DPR), financial structuring, writing legal documents, concession agreement, developing

Service Level Standards, should be commensurate with the best practices followed by the industry and it requires specialized domain knowledge. It is, therefore, advisable to hire a qualified Transaction Advisor, to assist the government agency in designing the project. In the case of Rajasthan, the state government has created a company as a Joint Venture with a private partner called Project Development Company of Rajasthan (PDCOR) for this purpose. It is advisable to use the services of this company for development of project design and assisting the agency to undertake PPP contracting for future PPPs in PHCs.

(iii) **Managing political risks throughout out the life cycle of the PPP project-** PPP projects in the social sector are politically sensitive and hence it is important to manage the political risks throughout the life cycle of the project to create an enabling environment and to reduce the uncertainty and doubt in the minds of the private sector partner. This entails continuous interaction with the local politicians and opinion makers and also the private partners to ensure on-going communication to minimize the risk of discontent and opposition to private operation of the PHCs.

(iv) **Costing of the project and setting baseline:** Costing of the project is critical for ensuring reasonable payments to the private partner to ensure high quality services. It is also important to discourage aggressive bidding by the private partner to garner projects and then cut corners to achieve minimum return expectations from their investment. Under bidding is as detrimental to the project as overbidding. Therefore, it is important that a "public sector comparator" is developed for the type of projects (in this case PHCs) taking into account all the costs, including the cost of finance. Such a comparator should also be developed with the assistance of experts. This ought to done before inviting participation from the private sector.

(v) **Savings vs Effectiveness approach:** Public officials mostly view PPP projects as a mechanism for 'savings', for reducing government expenditure and not for

bringing greater efficiency and effectiveness in the delivery of public service. There is a need for change in perspective to achieve higher quality of service delivery resulting in greater public satisfaction by putting more emphasis on efficiency and effectiveness and much lesser on cost cutting.

(vi) **Generating awareness about PPPs:** In order for PPPs to succeed, it is important to generate awareness about the PPPs and the manner in which they function through aggressive advocacy programmes. As mentioned in Chapter-1, PPPs are misconstrued as privatization whereas there are significant differences between the two and the same needs to be highlighted.

(vii) **Lowest bid may not always be the best bet:** Concept of awarding the project to the lowest bid may be transparent but is not necessarily the best manner to award the project in a social sector PPP. The reason is that in case of a social sector PPP the data on the financials etc. is rarely available and hence the private party without knowing the actual costing and other details may bid to win the project. Such projects are then difficult to run efficiently as the actual cost/expenditure in running the project is far greater than the rate at which it is awarded by the government. It is equally important to establish a floor price before bidding and not award projects to those who bid below the benchmark. It may also be useful to make the bidding criteria Quality cum Cost Based Selection (QCBS) with higher marks to quality and less to cost. This will ensure better partners with greater experience and capacity to deliver quality services which are not out priced by fly-by-night operators.

(viii) **District level monitoring**: In the present governance structure of PPPs, the district level monitoring system is abysmally weak and person oriented. In some instances, some district officials take interest but the system is not institutionalized and falls into disuse once the concerned official leaves. Therefore, district level monitoring is critical for all

the PHCs and in particular for those which are running on the PPP mode to ensure the contractual obligations are fully met. This would also assure greater public satisfaction.

(ix) **Ease in contractual requirements of PHCs operating in remote and inaccessible areas**: The state government may also consider including more flexible terms including greater cure period for defaults such as absence of staff for certain periods before imposing penalties. This would attract a greater number of private partners to serve in areas where public officials are usually not willing to go and remain absent or on "deputation" to urban or peri-urban areas.

(x) **Turnaround time:** Some mobilizing and stabilizing time should also be built in the RfP, for the period immediately after the PHC is handed over to the private sector, as the complete handing over process is not very smooth and takes some time. The field visit experience shows that there is a lot of resistance from the government staff which hands over the PHC to the private sector and hand holding support in the initial period is also withdrawn from that PHC once the private partner takes over. Therefore, it may be in the interest of both the government and the private partner if some turnaround time is given to the private partner to make the PHC functional as per the standards set by the government.

(xi) **Benefits to the staff:** It is important to create a bridge between staffing of the PPP PHCs and government staffing. It is also important to establish the difference between privatization and PPPs in the minds of the people and the local government officials. As the qualification set for the PPP staff is identical to those required for government recruitments, it would attract good talent to work in remote areas in PHCs for a number of years in the expectation that the experience would count for recruitment in the government. A certain weight could be assigned for experience of working for a number of years (say, three years) in PPP PHCs in remote and inaccessible areas for recruitment to

government service. This would also reduce high degree of attrition in the PPP staff, often resulting in high penalties for the private partner.

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APPENDICES

Annexure -I

List of rural PHCs running on PPP mode

Name of the private partner

Lords Education and Health Society (WISH Foundation)

Sl No	Name of PHC	Name of the District
1	Jaipala	Baran
2	Jajawer	Bundi
3	Dugari	Bundi
4	Bamangaon	Bundi
5	Losana Bara	Churu
6	Khandwa Patta	Churu
7	Sirsala	Churu
8	Richha	Dungarpur
9	Bhalta	Jhalawar
10	Chachhlab	Jhalawar
11	Kanwara	Jhalawar

Navjeevan Hospital

Sl No	Name of the PHC	District
1	Sukar	SawaiMadhopur
2	GurjarBardod	SawaiMadhopur
3	Sonad	Dausa

Navrang Ram Dayananda DhukiaShikshanSansthan

Sl No	Name of the PHC	District
1	Keru	Jhunjunu
2	NuniyaGothara	-do-

3	Bagola	-do-
4	Bajala	-do-
5	Luna	-do-
6	Sotwara	-do-
7	Bharewala	Jaisalmer
8	Madasar	-do-
9	Bhumbaliya	Pali
10	Kurkee	-do-
11	KotKirana	-do-

Chitraansh Education and Welfare Society

Sl No	Name of the PHC	District
1	Ramgarh	Banswara
2	TimidaBada	-do-
3	Panchwara	-do-
4	Varada	-do-
5	Bhavrani	Jalore
6	Ghana	-do-
7	Achneran	Rajsamand
8	Rampuriya	-do-

Bikaner Medical Relief Society

Sl No	Name of the PHC	District
1	Manadar	Sirohi
2	Bant	-do-
3	Alpa	-do-
4	Kudsu	Bikaner
5	Ladera	Jaipur

Vani Sanstha

Sl No	Name of the PHC	District
1	Badora	Baran
2	Kapuramaluka	Bhartpur
3	Andhwari	-do-
4	Samona	Dholpur
5	NaglaBeedhora	-do-

Geetanjali Medical College

Sl No	Name of the PHC	District
1	Loonada	Udaipur
2	Savina	-do-
3	Kun	-do-
4	Sagatra	-do-
5	MalwaKaChora	-do-

Jankalyan Rehabilitation and Development Society

Sl No	Name of the PHC	District
1	Barudani	Bhilwara
2	Luharikaran	-do-
3	Mandota	Jaipur-1
4	Rampura	-do-
5	Bagawas	Jaipur 2
6	Lahsoda	SawaiMadhopur
7	RawajnaChour	-do-
8	Kalmanda	Tonk

PCB Trust

SlNo	Name of the PHC	District
1	Chtamba	Bhilwara
2	Kot	-do-
3	Beru	Jodhpur
4	Gajpur	Rajsamand
5	Sameecha	-do-

Sparsh Children Emancipation Society for Social Change and Action

Sl No	Name of the PHC	Name of the district
1	Damroli	Alwar
2	Dabaravas	-do-
3	NangliBalaheer	-do-

Individual private partners

Sl No	Name of the PHC	Name of the District	Private partner
1	Bhanokhar	Alwar	St ConardShikshaSamiti
2	Udasar	Barmer	NavjeevanSevaSansthan
3	LalaSarbanirotan	Churu	YuvaBharatSansthan Bikaner
4	Sewa	Jaipur-2	Sparsh Hospital
5	Baloda	Jhunjunu	Naveen Bharat Jan Kalyan Trust
6	Gudhasalt	Nagaur	Ram Banu Garg
7	Chansada	Udaipur	MatraDarshanShikshaSamiti

Annexure-II

List of urban PHCs running on PPP mode

Sl No	Name of the district	Name of the private partner	Name of UPHCs
1	Alwar	Samarpan Society for Health, Research and Development, Dehradun (Bhiwadi)	Sehrod Nagar Parishad
2	-do-	Bikaner Medical Relief Society (Alwar)	Paharganj
3	Ajmer	Vani Sansthan, Sanganer(Kishangarh)	Chenpuriya
4	-do-	Lords Education of Health Society (WISH Foundation) (Beawar)	FatehpuriyaDoyam
5	-do-	-do-	GariThoriyan Housing Board
6	Bikaner	MaruVikas Bikaner	SarvodayBasti
7	Churu	India Society of Health care Professionals, New Delhi (Sardarshahar)	HarijanBasti, Ward 2
8	-do-	-do-	SubedarkiTanki , ward 13
9	Dholpur	Vani Sansthan ,Sanganer,Jaipur	Odela Road
10	-do-	-do-	SagarPada
11	-do-	-do- (Bari)	Bari city
12	Ganganagar	Samarpan Society for Health, Research and Development, Dehradun	Ashok Nagar
13	Jaipur-1	Lords Education of Health Society (WISH Foundation), Jaipur	Ward 78, Near BairwaBasti
14	-do-	-do-	Neendand, Ward No 1
15	-do-	Norang Ram DayananadDukhiyaSikshaSansthan, Jhunjhunu	Old Vidhyadhar Nagar
16	-do-	-do-	Gokulpura Road, Kalwar road
17	-do-	Bikaner Medical Relief Society , Bikaner	Shri Rampuri, Newark road
18	-do-	-do-	Balaji
19	-do-	Vikalp India Society, Jaipur	Ambabadi,ward no 10
20	-do-	RawalHospital,Jaipur	Nirman Nagar, Ward 19

21	Jaipur-II	Apollo Hospitals, Hyderabad	Ward No 42,MangalVihar
22	-do-	-do-	Ward No 44,Maharani Farm
23	-do-	Lords Education of Health Society (WISH Foundation), Jaipur	Govardhan Nagar
24	-do-	-do-	Patrakar colony
25	Jodhpur	Chitraansh Education and Welfare Society, Jaipur	ChanvaBhakar
26	-do	-do-	Rajeev Gandhi KachiBasti
27	Karauli	-do- (Karauli)	Near the Stadium
28	-do-	-do- (Hindaun)	Ward no 45, Parshuram colony
29	-do-	-do-(Hindauan)	Chota bazar shahganj
30	Nagaur	Biknaer Medical Relief Society , Bikaner (Makrana)	Balaji Colony
31	-do-	-do- (Deedwada)	Salt Road
32	Sikar	MaharanaPratapAdhyanAvamJankalyan Jan Path, Jaipur (Fatehpur)	Nawalgarh Bus Stand
33	-do-	-do-	RaghunathPura, NH 11
34	Tonk	Lords Education of Health Society (WISH Foundation, Jaipur	Rajasthan Housing Board Colony

Note: In column III, the name of the cities has been indicated in the brackets