Public-Private Partnership of sorts has been prevalent in all sectors, including health for centuries throughout the world. In the health field, from the pre-Independence period, the government allocated the land and credit was provided at sub-market rates to private players to build health care facilities in return for making a few services available to the poor free or at nominal rates. The Alma Ata Declaration emphasized involvement of voluntary and private sector in health care to achieve the goal of Primary Health Care for All by 2000 and then by 2020.

This paper presents the experiences in public-private partnership. It also presents the critical areas where partnership is needed; and suggestions for effective partnership.

I Public Private Partnership in Health Care In India

During the last three decades, the central and state governments have initiated a wide variety of public-private partnerships in various sectors, including health. Examples of these partnerships have been:

(a) Training Programmes for various categories at various levels. ISHA has conducted over 100 training programmes for CGHS medical personnel; for NGOs, and for senior managerial personnel of central and state public sector enterprises. Large number of NGOs are involved to provide training in various areas including TB, Leprosy, Malaria, Family Welfare, Immunization, HIV-AIDS, blindness prevention, and related areas.

(b) Awareness Programmes: Central and State governments and international agencies have partnered with NGOs to conduct awareness programmes in various fields, specifically for HIV-AIDS – family welfare, MCH, Disasters Preparedness.

(c) Medical interventional services – conduct family planning clinics, HIV testing and counseling services, MCH, provide primary and secondary curative services.

(d) Contracting for maintenance services – cleaning and maintenance of the buildings, security, waste management, laundry, catering, immunization, counseling, blood bank, blood donation camps, eye camps, and allied services.

A list of major public-private partnership projects is enclosed. Most of these projects are “contract” services and project oriented. There is no real partnership. At the termination of the project, the NGO cannot sustain itself. The best example is USAID projects for PVOH (Private Voluntary Organizations in Health). After five years, at the end of the project, many NGOs could not continue the operations and many had to be closed.

Even in states where the government provided the land and infra-structure support, the experiences have not been favourable. For example, Delhi State provided land to

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Indraprastha Apollo Hospital and Escorts Hospital. It was expected that certain percentage of patients (both outpatients and inpatients) will be provided free or concessional services. Experiences have been very unfavorable. The international organizations, mostly financing institutions in the name of “public-private partnership” provide loans or supply medical equipment. These are not partnerships for health and development but agreements for profit or secret motives.

II - Burden of Diseases and Need for Public-Private Sector Partnership:

India has made major achievements in the health sector – manpower, infrastructure, pharmaceuticals and systems. Inspite of the extensive planning, programming, and appointment of committees, the burden of diseases is very high. Some of the major diseases are:

1. **Tuberculosis:** Half the world’s 20 million cases are Indians. It is estimated that 2.5 million are sputum positive. The prevalence is 10 times higher in urban slums than in rural areas. According to WHO, 1.7 million persons died of TB during 2005, in the world.

2. **Malaria:** Inspite of the Malaria Control and Eradication Programmes and availability of insecticides, spray equipment, and trained malarialogists, there is resurgence of malaria since 1970s, particularly in the urban areas.

3. **Diarrhoeal Diseases:** 1.5 million children under the age of one die every year. Lack of safe drinking water and increasing shortage of drinking water will increase this problem.

4. **Malnutrition:** Nineteen percent of the general population and 40% of mothers and children are malnourished. The IMR and MMR are very high compared with our neighbouring countries, which are less developed (Bangladesh, Bhutan, Nepal and Sri Lanka). Though per-capita income has increased, the purchasing power is reduced.

5. **Blindness:** It is estimated that there are nine million blind with cataract; 45 million visually handicapped. Much attributable to vitamin A deficiency. Need for health education. Forty to forty-seven percent of premature babies suffer from retinopathy of prematurity – a disease which affects the retina of infants causing pre-mature blindness. Every year, 7.8 million babies are born with low birth weight. As we cannot predict babies which will develop ROP, all must be screened within 3-4 weeks after birth.

6. **Leprosy:** Though officially, leprosy is eliminated, there are estimated to be still three million cases. The major problem is of rehabilitation and social stigma which is worse than the disease.

7. **Physically Disabled:** Due to industrial accidents, natural and man-made disasters, drunken driving, untrained drivers on the road, and birth defects, there are currently over 60 million disabled and five million being added every year.

8. **Mental Retardation:** There are over 15 million, adults and children, mentally retarded. Nutritional deficiency during pregnancy and occupational and social stresses attribute to mental retardation. Mental Development Centres need to be developed on partnership basis among the hospitals, NGOs, and the community.

9. **Mental Illness:** It is estimated that there are over 11 million serious psychiatric cases and over 200 million with neurosis and schizophrenia. Social stresses, unemployment, under-employment, income disparities and lack of facilities for early
diagnosis are the critical factors. Awareness programmes on mental hygiene need to be conducted for school and college students, industrial workers and general public through mass media.

10. **Cancer:** According to WHO, 7.58 million persons died of cancer in the world during 2005. This will increase throughout the world, particularly in developing countries. Seventy percent are preventable by early detection. Health education programmes, sanitation, environmental improvement are needed for prevention of cancer.

11. **Cardio-vascular Diseases:** According to WHO, 50% of the mortality in the world (17.5 million) during 2005. This will increase with the more stressful life in future. Life style changes and awareness programmes in preventive cardiology need to be emphasized.

12. **Aging Population:** Currently 90 million, the aging population will increase to 100 million by 2010. Geriatric health services are inadequate. There is no health facility in the country specifically providing geriatric services. Socio-economic conditions for the elderly need partnership efforts.

13. **STD/VD:** With urbanization, industrialization, and migration, as well as problem of sanitation, scarcity of water and poor hygiene, the sexually transmitted diseases are increasing. It is estimated that one in every three Indians is affected by STD. Partnerships are needed with NGOs, health centres in urban and rural areas for education and awareness programmes, early diagnosis and treatment.

14. **HIV-AIDS:** There are approximately five million HIV+persons. This is a silent disease in which women are affected. Awareness and education programmes and early diagnosis, counseling, nutrition are needed. More funds have been invested in prevention and control of HIV-AIDS than most of the major communicable and non-communicable diseases. International funding and national partnerships have in the last two decades attempted to control the epidemic.

15. **Rabies and Envenomings:** A neglected Public Health Issue. Rabies is the tenth leading cause of death due to infection in humans. More than 99% of all human deaths from rabies occur in the developing world. Half of those dying of rabies and requiring rabies immunoglobin are children less than 15 years old. There are approximately 50,000 snake bites deaths each year. Scorpion stings are estimated to be over one million each year. Partnerships are needed with pharmaceutical industry for donation and distribution of antiserum for post exposure rabies prophylaxis and for treatment of snake bite and scorpion sting envenomings amounts to 9 million vials of rabies immunoglobin and 10 million vials of antivenoms.

16. **Oral Health** is estimated to be very poor. Large percentage of the population do not brush their teeth; smoke and eat tobacco, pan parag, gutka, betel nut and other substances. Partnerships are needed for awareness programmes for dental hygiene, specifically school health so that the children develop the habit of brushing their teeth. Singapore is number one country in the world in oral health. In India, Tibetans have an excellent school health programme.

17. **Viral Hepatitis:** Virus A,B, Non-A and Non-B and Delta Hepatitis Occur. Hepatitis B forms a major problem and it is estimated that we have about 25 million carriers of VH-B. Partnerships are needed for health education programmes and immunization programmes. The pharmaceutical industry need to develop cost effective drugs and big industrial houses need to finance the immunization programmes.
18. **Sanitation:** There are serious problems of sanitation throughout the country. Ninety-eight percent of rural households have no latrines. One-third of urban (small town households) have dry latrines (manual collection and disposal of excreta). In urban slums, there is open defecation which lead to hookworms and intestinal parasites, besides ugly sites for the public specifically tourists.

19. **Worst Malaria District:** The government has identified 60 most malaria endemic districts that report 50% of the country’s malaria cases. Most of them are in north-eastern states, Orissa, Chhattisgarh, Jharkhand, Madhya Pradesh and Andhra Pradesh. The national and international agencies as well as private sector need to join hands in control of malaria in these districts.

**III Proposed areas for Public-Private Partnership**

As indicated in the earlier section of this paper, most of the partnerships are in the form of contracting. The private sector is primarily in curative services for revenue and profits; very few in preventive and promotive services. Voluntary organizations primarily work on contract services – education and training programmes, diagnostics. International agencies provide the loans for infra-structure development which is mostly not properly utilized.

Suggestions for areas of partnership and for effective governance are as follows:

- a. There are nearly 100 backward districts – where socio-economic and infrastructure development is required. Industrial Houses could partner with district administration in adopting one district each. Incentives should be provided to the industrial houses partnering in such development initiatives (concessional water, electricity, import and export of products/raw materials).

- b. Pharmaceutical Industry should manufacture cheaper drugs for the masses, donate drugs for HIV-AIDS, viral Hepatitis, Malaria, TB and other chronic diseases.

- c. India has largest number of teachers of primary, middle, high school and college teachers from village to state level. These teachers should be given responsibilities, territorial jurisdictions and the groups to educate, and monitor the implementation of the programmes. Very successful initiatives have been made in Himachal Pradesh.

- d. Non-formal leaders in rural and urban areas could be trained – carpenters, barbers, blacksmiths, preachers of all religions, shop keepers, and women leaders could be trained for health education programmes. Successful initiatives have been made in Punjab and Himachal Pradesh.

- e. Medical Colleges, Nursing and Para-Medical schools, public health training institutions could be extensively involved in organizing camps, early diagnosis, referral, and health education and awareness programmes.

- f. Large number of training institutions, chapters of Indian Medical Association, Nursing Associations, management schools could be involved in training programmes. The Indian Society of Health Administrators(ISHA) has trained over three lakhs personnel in various fields, particularly representatives of voluntary organizations, medical colleges, nurses, doctors working in the Central Government Health Scheme, and senior executives working in the Central Government Public Sector Enterprises.
Representatives of the Armed Forces and Border Security Forces need to be extensively trained to carry out awareness and training programmes for their members throughout the country.

Trade Union Leaders of all unions, need to be trained to conduct health awareness programmes for their members and their families.

For effective implementation of the partnerships, clear terms of partners should be spelled out, these terms should be in writing, agreement, trust, transparent and penalties for default.

The leaders/administrators of the partners should not be changed during the term of the project excepting death or other emergency reasons. In many projects at local, national, and international levels when leaders/administrators change, the projects fall through. The minimal period should be three to ten years, mutually extendable, if required depending on the nature of projects.

Employers of all public and private sectors in the organized sectors could provide health insurance for employees and their families, besides providing first aid primary care services. This will reduce the budget for referral services. All public sector industrial health centres / hospitals should become financially self-reliant and provide medical services to non-employees at economical charges which are affordable. This will make the medical services supported by the tax payer financially self-reliant and optimum utilization of services. Those working in the unorganized sectors and poor people should be subsidized by the State Governments in health insurance. The country has excellent health infrastructure from sub-centre to super speciality in the government sector. This should be utilized well by the public. In the 11th Five Year Plan government is setting up more medical colleges, public health schools and other allied institutions to upgrade the services.

Two year medical and health training programmes after BA/BSc for para-medical working personnel could be initiated to train junior health personnel/equivalent to China’s Bare Foot Doctors) to carry out primary health care services in rural and urban areas. As in UK, each junior doctor would be given 50 families to provide health care services. This model has been successfully implemented in Maharashtra (Jamkhed Project) and Visakhapatnam Urban Community Centre.

Partnerships on the lines of Visakhapatnam Urban Community Centres could be initiated (case study enclosed) for rural and urban development.

India has tremendous resources, achievements, and experiences. If some of the above recommendations are implemented, we can change the country in one decade and control the communicable and non-communicable diseases to promote health for economic growth and national productivity.

References:
- World Health Organization: Preventing Chronic Diseases - 2005
- Times of India: December 18, 2007
ENCL: A

Public Private Partnership

* Rajasthan:
  Partners: Medicare Relief Society, SMS Hospital Jaipur and Vardhman Scanning and Imaging Private Ltd.,
  Services: Contracting in Radiological diagnostic services in the public hospitals. Provision of quality drugs and supplies cheaper than market rate. All this free for BPL patients, above 70 years of age & freedom fighters: pre-negotiated rates for others.

* West Bengal:
  Partners: Govt. of West Bengal, Mediclue, Distt. Health & F.W. Societies, Private partners, M/S Doctors Laboratory and Non Profit NGOs.
Services: CT Scan in seven Medical Colleges, MRI in one medical college hospital, diagnostic facilities in 30 rural hospitals, & running of 133 ambulances for emergency transport under management of NGOs/CBOs at the level of Block PHCs.

* **Uttarakhand:**
  **Partners:** Govt. of Uttarakhand, Deptt. of Science & Technology, Government of India & Uttarakhand Institute of Scientific Research, Bhimtal (NGO).
  **Services:** Mobile Health Services – Diagnostic, Laboratory and Clinical Services through mobile vans. Dedicated health camps in 6 districts of Western part of Uttarakhand.

* **Karnataka:**
  **Partners:** Govt. of Karnataka and Apollo Hospitals Enterprises Ltd., Hyderabad Rajiv Gandhi Super Speciality Hospital, Raichur handed to Apollo hospital under management contract.
  **Services:** 350 bedded hospital. Free services to BPL patients, 40% beds for BPL (Govt. reimburses the charges) & remaining patients treated under special rates.
  **Partners:** Govt. of Karnataka & Karuna Trust
  **Services:** Contracting out adoption and management of Primary Health Centres and affiliated sub-centres in remote, rural and tribal areas in the State. 24 hrs health services – OPD, emergency services, ECG, X-ray, laboratory, immunization, national health programmes, RCH programme, 20 bed patient ward and ambulance.

* **Gujarat:**
  **Partners:** Govt. of Gujarat & Private Doctors (Obstetricians and Gynecologists)
  **Services:** Chiranjeevi Yojana: Private Doctors (Obstetricians) are contracted for deliveries both normal and caesarian; of BPL women at their facilities.

* **Arunachal Pradesh:**
  **Partners:** Govt. of Arunachal Pradesh & VHAI, Karuna Trust, Future Generations and Prayas.
  **Services:** Management of selected Primary Health Centres

* **Andhra Pradesh:**
  **Partners:** Government of Andhra Pradesh & Social Action for Integrated Development Services, Adilabad (NGO)
  **Services:** Urban Slum health care project. Contracting in (Performance contract but with out any public premises being handed over to the private partner)
  **Partners:** Govt. of Andhra Pradesh & New India Assurance Company
  **Services:** Arogya Raksha Scheme based on vouchers Funded by the government, operational management by the public sector company and service delivery by private health service providers.

* **Tamil Nadu:**
  **Partners:** Govt. of Tamil Nadu & the Seva Nilayam Society in association with Ryder-Cheshire Foundation (NGOs)
  **Services:** Performance contract for the provision of emergency ambulance services in the region. Ambulances are owned by the Government.
Case Study of Effective Public-Private Partnership – Visakhapatnam Slum Improvement Project

This Visakhapatnam Slum Improvement Project was initiated in 1987 by the Urban Community Development Department with the financial assistance of the overseas Development Administration (ODA), UK, and UNICEF. This integrated programme covered health, socio-economic, housing, engineering programmes, and a mother and child health programme. This project presents the success of the massive community participation. This project had multiple partners: voluntary agencies, medical college, private practitioners, banks, housing corporation, and other government departments.

This ODA assisted Visakhapatnam Slum Development Project covered a population of 1.91 lakhs (26% of the total population of Visakhapatnam city) residing in 170 identified slums of the city. Neighbourhood Committees formed for community participation. These committees working from 1982-86 under the Maternal and Child Health Project of UNICEF, had achieved substantial changes in mother and child health status, immunization coverage, nutrition awareness, intake of nutritious foods, improvement in income of mothers.

The project has shown the impact of effective leadership who have commitment to community development, involvement of private practitioners which is cost effective; involvement of medical and nursing colleges in training the community and training of students in community health; involvement of slum dwellers in construction of houses for themselves and development of infrastructure; utilization of external assistance through ODA and UNICEF by developing good governance systems. Today, these 170 slums are changed in every respect – no more slums. The residence have nice houses, roads, drinking water, health education, lower morbidity and mortality, very low IM and MM, economic upliftment of women through income generating schemes, schools and playgrounds for children and community centres for adults.