6. PUBLIC-PRIVATE PARTNERSHIP IN PUBLIC HEALTH PROGRAMMES IN INDIA

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Introduction:

Health care delivery in India is governed by the Ministry of Health & Family Welfare (MOH&FW). Even though the public health system in India is responsible for delivering health care and preventive services, they bear less than 30% of the burden of providing health care. More than 70% of the burden is on the private health care system (Govt. of India, 2003). As a result, it is being realized more and more, the need for bringing the private health sectors such as medical colleges, hospitals, industrial/corporate hospitals, nursing homes, NGOs and practicing doctors/specialists under the umbrella of MOH&FW for the success of public health programmes. Rapid urbanization and migration of the rural population to urban and peri-urban areas is increasing demands on private health sectors.

Though this trend is encouraging, the national governments, World Health Organization and donor agencies are increasingly concerned regarding the practices by these private health sectors regarding standard national guidelines for the methods of diagnosis; treatment with approved drugs, dosage and combinations and duration; declaring cure and managing related issues etc. Efforts are being made by these agencies to popularize the user-friendly products acceptable to customers (patients) at a reasonably low cost through medical professional associations.

More and more national health programmes are being supported by private health sectors including NGOs/charitable health agencies such as Polio eradication, EPI (extended programme of immunization), Family welfare, TB-DOTS, HIV/AIDS care, Leprosy treatment (Multidrugtherapy) and malaria are some of the important areas where joint participation is increasing geographically and patient coverage. However, reporting of disease surveillance data/patient treatment data is far from satisfactory from private sectors. The recently implemented national programme “Integrated Disease Surveillance” should provide more information from the private sectors, as the District Surveillance Officers and State Surveillance Officers will coordinate the activities.

This brief communication is just picking a few stories on this partnership enterprise in health in India.

1. Public-Private mix for TB-DOTS:

The Second meeting of the Public-Private Mix (PPM) Subgroup for DOTS Expansion reviewed the progress of PPM projects in India and other countries in 2004. Six projects are in progress in Hyderabad, Mumbai, Kannur, New Delhi, Punalur and Thane. These projects showed increasing trend in detection of sputum positive cases by 14% (Thane), 15% (Kannur), 19% (Mumbai), 23% (Hyderabad), 36%(New Delhi) and 50% (Punalur). Treatment success rate was more than 80% in Hyderabad and Kannur. Other projects showed a success rate between 60-80%(WHO, 2004a). Assessment of cost and cost-effectiveness of Hyderabad and Delhi PPM projects indicated that PPM-DOTS could be effective, affordable and cost-effective approaches in improving TB control in India (WHO, 2004b).
2. Public-Private partnership for Leprosy treatment:

Though it has been realized too late in the field of leprosy, the National Leprosy Eradication Programme (NLEP) has initiated participation of private physicians (general medical practitioners and dermatologists) through Indian Medical Association (IMA) to accelerate leprosy elimination in India (Dillon 2004).

Bombay Leprosy Project in Mumbai tried such approaches as early as 1979 as a health system research scheme under ICMR. 152 general medical practitioners in M-ward of Mumbai oriented in diagnosis and treatment of leprosy during DDS monotherapy (1979-1980). These doctors were provided technical assistance in their clinics. An assessment after 18 months, revealed that 90(59%) of the 152 doctors suspected 514 leprosy cases. 478(93%) of them were confirmed as leprosy by the investigating team of Bombay Leprosy Project. 178(37%) were treated by the doctors in their clinics. The rest were referred to leprosy hospitals/private dermatologists/municipal hospitals (Revankar et al 1982).

Subsequently, similar project was undertaken with WHO assistance (SAPEL) involving practicing dermatologists in Mumbai during MDT era by Bombay Leprosy Project. This study revealed that participation of private medical fraternity could be achieved satisfactorily if specialized leprosy agencies (public or NGOs) simplify guidelines and provide technical assistance whenever required.

NLEP, India’s current initiative should be welcomed and supported by the specialized leprosy agencies /NGOs to promote participation of private doctors and integration of leprosy into general health services.

3. HIV/AIDS programme:

Support from Global Fund in India would expand services from 125 centers to 450 within the next two years including private clinics. The Public-Private partnership would provide antiretroviral treatment to 15000 people living with HIV. National AIDS Coordinating Organization (NACO) would provide 60% of the funds to non-governmental organizations and more than 20% to private and academic sectors (Global Fund, 2004).

4. Integrated Disease Surveillance:

Integrated Disease Surveillance Project (IDSP) of Government of India, which is being implemented gradually in India since the beginning of this year (2005), is laying stress on participation of private doctors/hospitals as sentinel centers. The NADHI (North Arcot District Health Information) project of Christian Medical College, Vellore is encouraging private doctors to send information on reporting of communicable diseases in their clinics (the author had opportunity to visit this project). This is a system of prompt reporting of cases of childhood vaccine-preventable diseases, encephalitis, meningitis, and hepatitis and rabies; together with a sentinel laboratory surveillance of cholera, typhoid fever, malaria, HIV infection and anti-microbial-resistance.

Sustaining the partnership:

Achieving sustained partnership between Public-Private health sectors for the benefit of the national health programmes is a challenging task. This demands a lot of advocacy, flexibility, simplified recording and reporting system, provision of technical assistance as per doctor’s convenient time etc. Short-term results of such ventures with heavy inputs may be very promising and encouraging. However, sustaining interest, motivation and involvement of private doctors/hospitals in chronic disease programmes (both communicable & non-communicable) as per the national objectives is a major challenge to the concerned health authorities. What is more important is that the private
health sectors should be ready to contribute financially to strengthen the state/national governments.

References:


3. WHO. Cost and cost-effectiveness of Public-Private Mix DOTS: Evidence from two pilot projects in India. 2004b

