

Health and sanitation

A symbiosis between state clout and private resources can give health a renewed lease

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For an outpost town with little hope, it's nothing short of a miracle. Just some 20 km away from the Nepal border, Narkatiaganj village is one of Bihar's dens of extortion and kidnapping. But a bit more reassuring picture emerges when you visit its primary health centre (PHC), buzzing with activity as seven doctors attend to nearly 300 patients a day. Barely a year ago, both patients and doctors had abandoned this post. The docs had simply refused to attend, the patients preferred the private clinics nearby—whatever the treatment cost.

Today, patients come in hordes, many by foot or on bullock carts. The Narkatiaganj PHC boasts of an operating theatre and a manager from a private firm to track finances. Taking a leaf from other states in healthcare public-private partnerships (PPP), Bihar has equipped the Narkatiaganj PHC with an ambulance service and an X-ray machine operated by private parties. At the clinic, the X-ray charges are Rs 50 as opposed to Rs 80 in private clinics. Says Dr Arun Kumar, who runs the hospital like a battleship: "We deliver 10 babies every day. While we could do with two more doctors and an unlimited supply of medicines, the centre does not turn away a single patient."

There's more: with the click of a mouse, officials in state capital Patna monitor the doctors and the number of patients they attend to. "This allows us to keep track of absentees," reveals a senior official at the health department of Bihar. The software to track the docs has been developed by a private firm. The state clearly wants private players to step in and fill the gaps in healthcare—be it ambulances, equipment or operations. "We will provide the necessary infrastructure and the reputed players can look after the upkeep," says Uday Singh Kumawat in the health department.

Initial steps they may well be, but states like Bihar and Uttar Pradesh are taking the PPP route to increase low usage of public healthcare. The reality is that the private sector is dominating healthcare. According to the Union ministry of health and family welfare, the private sector accounts for 58 per cent of the hospitals and 81 per cent of the doctors in the country. All told, government spends only 20 per cent of the total expenditure on healthcare. And while there's a perception to the contrary, experts point out that the relatively affluent are greater users of public sector hospitals.

Says Amit Sengupta of Jan Swasthya Abhiyan: "We spend only 0.9 per cent of the gdp on health, so the scope for public funding in health is immense. Also, it might seem prudent to involve the private sector in the short term, but it can't be the template for a policy laid down by the state." Virtually everyone agrees that only a greater government role can lift the quality of healthcare services. Particularly as the private sector has been widely and correctly perceived to be expensive, over-indulging in clinical procedures and opaque in its actions.

Yet, ironically, private sector healthcare is better managed than its public counterpart. Under these skewed circumstances, PPP has emerged as an option to persuade the private sector to commit itself to social welfare. "Rather than replace private services, the government should try to improve the private market with the carrot of training and the stick of public information," says N.C. Saxena, former secretary, Planning Commission.

Consider these examples: the Gujarat government has roped in the services of obstetricians in the private sector to bridge the gaps in public health service. In Agra, the state is providing vouchers to bpl families to get healthcare at a place of their choice. Tamil Nadu has roped in private nursing homes to

supplement efforts of public hospitals—accredited private nursing homes are paid Rs 200 for attending to a public healthcare card-holder. Chhattisgarh has identified 27 not-for-profit hospitals and 131 commercial hospitals for offering all services to patients below the poverty level, and for family planning, sterilisation and IUDs to all clients. And though the details are sketchy, Bihar is providing land to private players through two reputed agencies to set up laboratories.

Both the Tenth Five Year Plan and the National Health Policy 2002 have focused on the participation of the private sector and recommended legislation for regulating minimum infrastructure and quality standards. So, we have had many schemes—the National Malaria Control Programme, National AIDS Control Programme, Revised National Tuberculosis Control Programme and so on—which have involved NGOs and private practitioners. While alliances are being forged, experts stress the need for a commitment to public health and an appetite for risk-taking. But this is rare. Ultimately, the onus of improving and making affordable healthcare available to the average person rests with the government.

Says Deoki Nandan, director of National Institute of Health and Family Welfare (NIHFw): "The healthcare delivery has improved considerably at the district level, and substantially at the community level. But you need better focus in all spheres—capacity building, quality of care and human resources." NIHFw has initiated a public health education research partnership with the community medicine department of 175 medical colleges and 100 nursing colleges. Six months back, it also forged tie-ups with 65 mother NGOs (ones that support field NGOs) for information-sharing aimed at bettering the local health system.

Whatever the route—contracting in, contracting out, subsidies, leasing—there are many positive examples of PPP. For instance, Sawai Man Singh Hospital in Jaipur has enlisted a private player to provide low-cost high-quality medicine and surgical items round the clock. Then, the Uttaranchal Mobile Hospital and Research Centre is a three-way partnership with the aim of providing healthcare and diagnostic facilities to poor rural people at their doorstep in the hills. In Andhra Pradesh—which is leading the way in PPP—the family welfare department provides free space in maternity hospitals for private clinics to operate. As Saxena notes, "It may be worthwhile to experiment contracting out PHCs to civil society and the private sector."

Apart from healthcare, many state governments like Himachal Pradesh, Karnataka, Orissa, Punjab, Uttaranchal and Delhi are opting to outsource services like cleanliness, maintenance and laundry in state hospitals. While the government stresses on disease prevention, sanitation is one area where things are going downhill. Diseases like chikungunya, encephalitis, meningitis, diarrhoea and dengue are on the rise. Why, even Surat, which famously woke up after the plague, is slackening on this front. "It is not only government, the mindset of people also has to change. There has been some improvement due to PPP, but real issues like handling and recycling of municipal waste needs to be substantially improved," says NIHFw's Nandan.

Kumar Alok, water and sanitation expert with UNICEF, points to several good models of PPP in Tamil Nadu. In Vellore, for instance, through organised collection and sorting, most of the discarded waste product is resold or recycled to minimise pressure on the landfill. "Whatever looks like waste—mineral water bottles, cardboards, plastics, polythene—are raw material or energy source for some industries. If efficiently sorted, rag-pickers can make a living," says Alok. Or there's Arbind Singh, who has created private firms of waste-pickers in Patna. These firms pick up government contracts for sanitation work.

Unfortunately, in urban centres—including major cities like Mumbai and Delhi—not much focus is given to waste management. Chennai's PPP to convert waste into energy has had partial success, with the Koyambedu bio-methanation plant operating way below capacity. Sure, there are exceptions like Excel in Mumbai or scope in Tiruchirappalli, which make compost from solid waste or using human waste for generating biogas. Yet overall, the entry of private sector hasn't improved waste management. They only retrieve things with maximum value and dump the rest at landfills, creating a health and environment hazard. Despite good models, efforts to promote solid waste management appear half-hearted.

Things may have changed since 1960s, when Sulabh International founder Bindeshwari Pathak broke through cultural taboos to bring focus on sanitation, but the government is yet to realise the employment potential through better infrastructure, training and funding channels. Urging the need to look at waste management and sanitation as a business model, Pathak says "Only if there is cross-subsidy can the public toilet system work. Only one agency should have control over one city or town as all the areas will

not be profitable."

Citing Sulabh's own example, Pathak churns out the numbers: of 6,000 public toilets the self-sustaining ngo manages, only 1,000 are generating profit, 2,000 are breaking even, while 3,000 in slum areas aren't even generating revenues to buy brooms. Then, as Chennai's experience with public toilets shows, maintaining cleanliness and ensuring that users are charged correctly are uphill tasks.

On the face of it, India's effort to eradicate open defecation has met with some success. Across the country, toilet coverage has increased from 22 per cent in 2001 to around 50 per cent now. There have been several innovations here, but implementation—and checking—remains tardy. It is estimated that only a third of the toilets installed are being put to use. Thanks to cultural taboos, most of them get converted into stores. Clearly, there's a lot of cleaning up left to do.