

## **Disease Surveillance: Engaging the Private Sector**

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1. It may appear quite bewildering to an outside observer as to why our National Health Programmes remain steadfastly shy of engaging with the private health care providers even though they have an overwhelming share in the provision of health care services. With an 80% share in outpatient and 60% in inpatient care,<sup>1</sup> it is one of the highest proportions in the world, including developing economies. The default mode is to place reliance upon public sector health facilities- perceived as being exclusively in the Government domain, and therefore inherently more trustworthy – and, to some extent on not for profit organizations.
2. Admittedly, the private health care sector is characterized by heterogeneity of qualification, quality, cost and system of medicine practiced. Ineffectual statutes and severely constrained regulatory capacity has engendered a deep distrust for the private facilities among the public authorities on quality concerns as well as cost parameters. So there are no simple solutions to engagement. However, the lack of systematic government initiatives to steward the entire health system, both public and private, has resulted in a fragmented health system that has consistently performed well below its potential. The role of Government extends beyond that of direct delivery of health services through its own infrastructure (which may in-itself be indispensable).
3. Against this background, one persisting public health issue remains the higher-than-expected mortality burden (28%) on account of infectious diseases despite rapid economic growth.<sup>2</sup> Most countries show a much sharper decline in the prevalence of communicable diseases that accompanies economic growth. Among the top twenty-five causes of premature mortality, communicable diseases (including diarrheal diseases,

respiratory infections, tuberculosis, measles and other infections) account for almost half the years of life lost.<sup>3</sup>

4. It is well settled that the poor are much more vulnerable to infectious diseases. The loss of wages on account of morbidity and out-of-pocket expenditure on treatment exacerbate their deprivation. Public health functions of prevention and control of such diseases are therefore vital. Any laxity or lack of promptitude in this effort is morally and ethically unconscionable. However, the lack of availability of accurate data on infectious disease burden in India hampers our planning and decision making in responding to these challenges.
5. Data from the National Vector Borne Disease Control Programme (NCVBDP) is acknowledged to be more representative of a trend in disease incidence rather than the true estimate of disease burden.<sup>4,5</sup> Independent field studies to estimate malaria and dengue find gross under reporting in the national data quantifying the burden of disease (See Table 1).

**Table 1:** Differences in nationally reported data and study estimates for malaria and dengue

	<b>Malaria (2010)<sup>6,7</sup></b>	<b>Dengue (2010)<sup>8</sup></b>
<b>Official data</b>	1023 deaths	12,484 cases
<b>Study data</b>	46,970 deaths	32,541,39 cases

6. While several factors are associated with developing accurate disease estimates, the near total reliance on data supplied from the government owned health facilities (and non-reportage of data from private sector facilities) is a major contributor to this under-reporting. An exception to this general trend is the polio surveillance programme. The Integrated Disease Surveillance Project (IDSP) was initiated among other reasons to address this limitation with little success. Published studies as well as reports from the

field suggest inadequate interactions with private sector coupled with a lack of trust for the purpose of disease reporting.<sup>9</sup>

7. Wherever an attempt has been made to involve the entire health delivery mechanism- public and private- the public health goal achievements have been far superior as in the case of Polio Campaign (eradication achieved) or in the Public-Private Mix(PPM) approach for Tuberculosis control(significantly improved case detection)<sup>10,11</sup>.
8. The factors involved in successful linkages between the tuberculosis control programme and PPs include, (a) the presence of a strong functional national programme (b) initiative of officers of the national programme that approach private sector for participation (c) adequate hand-holding, supervision and monitoring (d) sustained communication through intermediary programme field staff or NGOs.<sup>12-15</sup>
9. These strategies hold significance for application to disease surveillance programmes such as the IDSP. Enforcing compliance merely through regulation is an approach that is unlikely to work in the absence of the right frameworks for engagement with the private sector. The limited success of mandatory notification of TB which has been in place since May 2012 is a case in point. Early studies suggest without appropriate means of creating awareness, providing appropriate tools for reporting cases and building trust between the public and the private sectors, the usefulness of this measure remains limited.<sup>16</sup>
10. A surveillance system does not require hundred percent of health providers to report data. Local pilot studies may be initiated by health authorities that list and identify suitable health practitioners to be included in a long term surveillance system. Methods of engagement with private providers and sustaining contact, developing simplified reporting mechanisms such as through the telephone may be tested along with feedback mechanisms. Similar models have been developed and tested in South India and Maharashtra.<sup>17-19</sup> Locally designed initiatives that build on evidence based strategies where available are required to establish a functional sustainable surveillance system that generates data representative of the population.

11. While the private health sector plays a dominant role in the health service delivery, there is under-utilization, and in most cases a complete exclusion of the resources of the private sector to achieve public health goals. Government's stewardship role of the health system cannot be limited to public health facilities alone; it encompasses all providers and a myriad of functions of which regulation is only one. It is proposed therefore that incremental steps are taken towards the engagement of private sector health providers by government through evidence based strategies that seek to tap the full potential of the mixed health system prevalent in India. That is achievement of public health goals is critically dependent on engaging all health service providers- public and private.

***[Note: The views expressed in this article are those of the authors and do not necessarily reflect the official position of the NITI Aayog.]***

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